Regal Care Trading Ltd

The Park Beck

Inspection report

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Date of inspection visit: 20 and 22 July 2015
Date of publication: 06/10/2015

Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The Park Beck accommodation and personal care for up to 37 older people most of who were living with dementia. There were 17 people living at the home at the time of the inspection. People required a range of help and support in relation to living with dementia, mobility and personal care needs.

The Park Beck is owned by Regal Care Trading Ltd. Regal Care Trading Ltd had been in administration since 2012 and was purchased by the Nicholas James Care Homes in April 2015.

The home is a large Edwardian building and accommodation is provided over two floors. There was a passenger lift at the home and due to the layout of the home a chair lift was available to some of the first floor rooms which could not be accessed by the passenger lift.

People spoke well of the home and a visiting relative confirmed they felt confident leaving their loved ones in the care of staff.

There is a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was an unannounced inspection which meant the provider and staff did not know we were coming. It took place on 20 and 22 July 2015.

The provider had not ensured The Park Beck had been maintained to an appropriate standard. Areas of the home presented risks to people for example the lift was subject to breaking down and due to the location of the smoking area people who did not smoke were subject to the odours and effects of cigarette smoke from others.

There were systems in place to assess the quality of the service. However, when quality and safety issues were identified for example the maintenance and décor of the home the provider had failed to ensure necessary improvements were carried out.

People enjoyed the activities that were provided. However, there was a reliance on these being provided by the activity co-ordinator and staff did not use opportunities to engage people in activities throughout the day.

People were looked after by staff who knew them well, were kind and caring and treated people with respect.

Care plans were personalised and regularly reviewed. They reflected people's individual assessed needs. However, some aspects of daily records did not consistently reflect the care people received.

Staff understood the procedures and their responsibilities to safeguard people from abuse. Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

There were enough staff on duty to meet the needs of people. Staff were provided with a full induction and training programme which supported them to meet the needs of people. Appropriate checks had been undertaken to ensure suitable staff were employed to work at the service.

People's nutritional needs had been assessed and regularly reviewed and they were supported to maintain a balanced and nutritious diet. People told us they enjoyed the food and were always able to have a choice.

People were supported to maintain good health and had access to on-going healthcare support. People were able to see their GP or dentist whenever they needed to.

The registered manager was using nationally recognised guidance when new standards were introduced to drive improvement in the home.

There were a number of breaches of the regulations. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Not all aspects of The Park Beck were safe.

The provider had not ensured the home had been properly maintained. The lift was subject to continually breaking down. There was water staining on a number of ceilings and one ceiling was bulging and distorted and in need of immediate attention.

There were enough staff on duty, who had been appropriately recruited, to meet the needs of people.

Staff had a clear understanding of the procedures and their responsibilities to safeguard people from abuse.

Medicines were managed appropriately and people received the medicines they had been prescribed.

Is the service effective?

Good

The Park Beck was effective.

Staff were trained and supported to meet people's individual needs.

Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

People were supported to maintain good health and had access to on-going

healthcare support.

Is the service caring?

Good

The Park Beck was caring.

Staff knew people well; they treated them with kindness, compassion and understanding.

Staff supported people to make their own decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Requires improvement

Not all aspects of The Park Beck were responsive.

Care plans were personalised and reflected people's individual needs. However, some aspects of daily records did not consistently reflect the care people received.

Summary of findings

People enjoyed activities however there were occasions when staff did not use their knowledge of people to engage them in more meaningful activities throughout the day.

Staff knew people well and had a good understanding of their needs and choices.

A complaints policy was in place and complaints were handled appropriately.

Is the service well-led?

Not all aspects of The Park Beck were well-led.

There were systems in place to assess the quality of the service. However, when quality and safety issues were identified the provider had failed to ensure necessary improvement.

The registered manager had created an open, relaxed atmosphere in the

home where staff felt supported.

Requires improvement

The Park Beck

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was an unannounced inspection on 20 and 22 July 2015. It was undertaken by an inspector, an inspector manager and an expert by experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We did not request a provider information return (PIR) on this occasion. This was because of some of the information received led us to inspect at an earlier date than originally planned.

We met with all the people who lived at The Park Beck; we observed the care which was delivered in communal areas to get a view of care and support provided across all areas. This included the lunchtime and teatime meals. As some people had difficulties in verbal communication the inspection team spent time sitting and observing people in areas throughout the home and were able to see the interaction between people and staff. This helped us understand the experience of people who could not talk with us.

We looked around the home, including the bathrooms, sluice rooms and some people's bedrooms. We spoke with six care workers, a domestic worker, the cook, the maintenance man, the deputy manager and the registered manager, the administrator. Following the inspection we spoke on the telephone with three more members of the care staff.

We reviewed a variety of documents which included five care plans and risk assessments along with other relevant documentation to support our findings. We 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed the records of the home. These included information in regards to the upkeep of the premises, staff recruitment, training and supervision records, medicine records complaint records , accidents and incidents, quality audits and policies and procedures.

Requires improvement

Is the service safe?

Our findings

The provider had not ensured the home had been properly maintained. There was a maintenance plan in place which identified areas of the home were in need of maintenance and general redecoration throughout. However, there were areas that had been identified where no or limited action had been taken. It was clear the home was in need of redecoration and general maintenance throughout. The paintwork in the communal areas was chipped and the paint was flaking. Wallpaper in some bedrooms was peeling and there was evidence of staining to a number of ceilings around the home. We were told this was water damage and related to a leak on the flat roof and the chimney stack. In one bedroom there was a sloped ceiling over a bath and as a result of the water ingress the ceiling was bulging and distorted. This bathroom was used by one person who was living with dementia and would not be able to identify if this presented any deterioration or danger of collapse. This person was at risk of harm or injury from premises that were not properly maintained.

Although there was a regular servicing contract in place there were ongoing problems with the passenger lift. Whilst the dangers had been identified the problem had not been addressed. During the inspection the lift failed to rise to the first floor on two occasions. There was a notice which stated no more than three people should use the lift at one time, but the lift failed to operate correctly on one occasion when used by two members of the inspection team. As the lift did not stop at the floor level we were required to step up out of the lift. Some people who used the lift were frail and at risk of falls. If they were required to step up they would be at increased risk of falling. In addition people were at risk of psychological harm, for example increased anxiety, should they become stuck in a lift that was not working. This meant people were at risk of harm or injury from premises and equipment that are not properly maintained. The provider had not acted on the findings of the health and safety risk assessments without delay.

During the inspection an area of flooring outside a ground floor toilet gave way under an inspector's foot. This was a toilet that people accessed independently and unsupervised. The weak damage appeared to be related to water damage. Although it was rectified immediately other areas of the home, particularly outside of bathrooms and toilets may be at risk of similar deterioration. People at the home would not all be able to identify any deterioration or danger of potential of flooring collapse. People were at risk of harm or injury from premises that were not properly maintained.

There was a pleasant seating area outside of the main lounge which was secure and provided level access. This was used as a smoking area by people who smoked, and the area was covered to ensure people who smoked could do so comfortably during bad weather. However, during our inspection the weather was warm therefore the doors to the lounge remained open. This resulted in the cigarette smoke entering the lounge and could be smelt throughout the ground floor of the home. People's needs had not been taken into account with the design of the home. People who did not smoke were subject to the odours and effects of cigarette smoke from other people. This could leave people at risk of harm from respiratory conditions associated with passive smoking. It did not enhance the well-being of people who lived at The Park Beck.

We saw there was an alternative seating area with level access in the garden and although this was not covered people could smoke away from the home, at least during dry weather. However, this area was currently inaccessible to people unless they were supported by staff. The registered manager told us the pathway to the back garden was slippery and needed to be replaced. People were not able to come in and out of the building easily and independently. At the time of our inspection the garden was overgrown in areas and the grass had not been cut.

People told us they felt safe living at The Park Beck. One person told us, "It feels as safe as houses." Another person said, "No problem, I feel safe." We asked a visitor if they felt their relative was safe they said, "We certainly do." People told us they received their medicines when they needed them.

The provider had not ensured the home was properly maintained and suitable for the purpose for which it was being used. This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The maintenance staff were responsible for day to day maintenance of the home. They were aware of the maintenance plan and areas where improvement was required for example the bedroom ceiling that was bulging and water stained. However, they told us they did not have

Requires improvement

Is the service safe?

the time to address all the issues. The maintenance staff were also responsible for the regular checks that were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. Regular environmental and health and safety risk assessments and checks had been completed. This included a fire checks, call bell tests, window restrictor and pressure mattress checks. There were regular servicing contracts in place for example gas and electrical servicing, lifts and hoists. We saw evidence of on-going redecoration for example the reception area and a number of bedrooms.

There were systems in place to deal with an emergency. There was guidance for staff on what action to take. Personal evacuation and emergency plans were in place. The home was staffed 24 hours a day and there was an on-call system. Staff were aware who to contact in case of an emergency. This meant people would be protected in case of an emergency at the home.

There were systems in place to assess risks for people and to respond to them. People were routinely assessed regarding risks associated with their care and support needs. These included risk of falls, skin damage, nutritional risks and moving and handling. Where risks were identified the information was transferred to a risk assessment care plan. This gave staff clear information about how to reduce risks. For example one person was at risk of developing pressure sores due to their immobility and incontinence. The risk assessment care plan contained information for staff which included personal hygiene guidance and the use of a pressure relieving mattress.

Although risk assessments were in place people were supported to take well thought out risks to maintain their independence. Some people smoked and risk assessments contained information to help people do this safely. We observed a person who was going to sit down in a chair. This person took a long time to adjust their position and get seated. Staff explained although it took the person some time they liked to do it themselves to retain their independence.

Some people were subject to falls. There were risk assessments in place and evidence of actions taken and ongoing measures, for example discussions with the GP to reassess medicines, to prevent people falling. There was falls analysis to identify themes and trends across the home. However, there was no formal protocol for staff to follow when people did fall. Staff told us what actions they would take but the lack of guidance meant there was not a consistent approach. We raised this with the registered manager as an area for improvement.

Staff received safeguarding training and regular updates. They understood potential signs of abuse. They explained how they would report any concerns they had to the most senior person on duty. If their concerns related to the managers then they would report this to the company head office. Not all staff were able to tell us which external services they would report to. However, they said they would find the appropriate information. Staff were able to tell us where that information was kept. We saw this was displayed on noticeboards in the staffing area. We were aware the registered manager was currently working with the local safeguarding team in relation to concerns had been identified at the home.

There was a robust medicine procedure in place. Medicines were stored, administered, recorded and disposed of safely. We observed medicines being given at lunchtime; these were given safely and correctly as prescribed. Some people were prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. PRN protocols were in place. These were clear and provided guidance about why the person may require the medicine and when it should be given. Not everybody who experienced pain was able to express this verbally, there was guidance in people's care plans which informed staff how people may express they were in pain. This included not eating their meal, becoming angry with staff, restlessness or agitation. Prior to administering PRN medicines people were asked if they had any pain or required any pain relief. Where appropriate they asked staff who had been caring for the person if they had displayed any signs they may have been in pain.

Guidance within the medicine administration record (MAR) charts files contained information for staff to ensure people received the appropriate treatment. For example some people had health needs which required varying doses of medicine related to the specific test results. Where staff were required to undertake tests the results were recorded to demonstrate it was appropriate to administer the medicine.

Requires improvement

Is the service safe?

Staff who administered medicines had received training and had an assessment of their competency prior to being allowed to administer unsupervised. Staff also had regular competency checks to ensure that their knowledge and practice was of a suitable standard.

People were protected, as far as possible, by a safe recruitment practice. Records seen included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring check (DBS) as these checks identify if prospective staff were suitable to work at the home.

During the day there were five care staff, domestic staff, a cook and kitchen assistant, there was a member of maintenance staff at the home five days a week. The registered manager and deputy manager worked each day during the week. There were two care staff on duty at night. Currently two care staff were working their induction period and although they were counted as a member of staff they did not work unsupervised. Staff told us when staff working were being supervised they were busier, as although five staff were on duty the staff member being supervised was always working with someone else.

Due to the layout of the home and the fact that two lounges were in separate areas of the building people were left without any interaction from staff for up to 10 minutes. People told us, and we saw, staff were available to help them when they needed it. People said they didn't usually have to wait long for staff to respond to the bell. They said they had to wait, "Only if staff were very busy." During the inspection, call bells were answered promptly. We observed staff were busy throughout the day and more especially in the morning. Whilst staff were attentive to people's needs they did not have any time to sit and chat. Staff told us although they were busy there were enough staff on duty to meet people's needs. One staff member said, "It would be nice to be able to spend more time talking to people during the morning."

There were adequate staffing levels in place to meet the current needs of people living at the home. The registered manager told us staffing levels were continually assessed according to the numbers of people and their individual needs. He told us this was identified through ongoing observation, discussions with staff and reassessment of people's needs. The deputy manager had recently introduced a dependency tool which looked at the level of individual support people needed but did not take into account the layout of the home. This tool had only been in place for one month so there was not enough information to assess if it would be helpful.

Good

Is the service effective?

Our findings

People told us staff would help them if they were not well. They told us staff would get them pain relief if they had a headache and they would call the GP if they were unwell. People told us the food was good and they had choices. They said there was always an alternative if they didn't like what was on offer. A visitor told us they felt the staff were all well trained and were able to tell them about treatment their relative may be receiving.

When staff commenced work at the home they received a period of induction which included new staff spending time with the administrator, being shown around the home and introduced to policies. Staff received a handbook which included policies for example safeguarding and whistleblowing. The registered manager had introduced an induction programme based on the care certificate. The care certificate is a set of 15 standards that health and social care workers follow. The care certificate ensures staff who are new to working in care have appropriate introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. Two new members of staff were currently working towards the care certificate. During this time they did not work unsupervised and were supported by a mentor. One of these new staff members told us they were well supported by their mentor. They told us they were learning and understanding how to provide good quality care through support, observation and supervision. If staff had previously worked in care they completed a care certificate self-assessment to identify areas where they required further training or updates.

Staff received regular training and annual updates. We saw all staff including maintenance and housekeeping staff received training in relation to safeguarding, dementia, challenging behaviour, death, dying and bereavement, equality and diversity. This meant all staff who worked at the home had an understanding of the needs of people that lived there. In addition to the essential training staff were able to undertake further training. This included the diploma in health and social care and a number of distance learning courses. Staff told us that, during supervision with the registered manager, they identified further training they needed to support them in their roles. This included further dementia training, diabetes and dignity and safeguarding.

Staff told us they said they were well supported by the registered manager, deputy manager, the administrator and their colleagues. They told us they could talk to the registered manager about concerns at any time.

We observed staff supporting people appropriately when helping them to mobilise. Some staff were reluctant to tell us about people who lived at the home. They told us this was because it breached confidentiality guidelines. We explained our role, and staff spoke with the registered manager to ensure this was acceptable. This demonstrated to us staff were aware of their roles and responsibilities and had the knowledge and skills to support people effectively.

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The registered manager understood the principles of DoLS, how to keep people safe from being restricted unlawfully and how to make an application for consideration to deprive a person of their liberty.

At the time of the inspection there was one DoLS authorisation in place and further applications had been made. Information about people's mental capacity assessments was recorded in their care plans. Care plans contained information about how people with limited or fluctuating capacity could be supported to make decisions. For example people were shown a selection of clothing for them to choose what to wear. Staff had an understanding of consent and caring for people without imposing any restrictions. Before offering any care or support they asked people for their consent to ensure they were happy with

Good

Is the service effective?

what was offered. Staff told us if people declined care they would respect their decision. One staff member said, "We try to persuade people, but it's up to them, we don't force them to do things."

People's nutritional needs had been assessed and regularly reviewed and people were supported to maintain a balanced and nutritious diet. When risks were identified these were reflected within care documentation. For example, records were in place to monitor the intake of people who were at risk of not eating or drinking adequate amounts. People were weighed monthly so staff could identify when people were at risk of weight loss or malnutrition.

People's dietary needs and preferences were recorded in the kitchen and in their care plans. The cook and staff had a good understanding of people's likes, dislikes and portion size and food was offered accordingly. Soft drinks were available in the lounges and hot drinks were served regularly throughout the day.

People were offered a choice of meals and this was done before each meal. The menu for each meal was displayed on a whiteboard in the main dining room and we saw people referring to this throughout the day to see what was on offer. At each meal time people were asked what they would like to eat. If people declined the meal they were offered an alternative. One person declined the meal they were offered, and an alternative was given. Another person did not eat their lunch and was offered a jam sandwich which they ate. When people required support this was provided appropriately.

Some people required prompting and encouragement and others required more support. This was provided appropriately and discreetly. We observed staff sitting on chairs, speaking softly to people and maintaining eye contact with people throughout the mealtime. Meals were nicely presented and served hot. Soft drinks and water were given and topped up when required. There was coffee and tea at the end of the meal. People told us, they enjoyed their meals and we observed plates were returned empty.

Just prior to mealtimes we saw some people came and sat at the dining tables in preparation for their meals. Others were asked if they would like to come to the dining room for their meals. People chose where they wanted to sit. We saw some people sat on tables on their own and others remained within their friendship groups. One person declined to eat in the dining room and was supported to remain in the lounge.

People were supported to maintain good health and received on-going healthcare support. They told us they could see the GP when they wanted to. Records confirmed that staff liaised effectively with a wide variety of health care professionals who were accessed regularly. This included the community nurse, continence service, GP and chiropodist. Healthcare professionals we spoke with told us staff referred people to them appropriately and acted on the advice given. One healthcare professional told us they had requested a person to drink more prior to a test they were having and staff had supported this person to do this. Another healthcare professional told us where appropriate, prior to contacting them about people's healthcare needs observations such as urine tests had been undertaken. This meant people received care and treatment from the appropriate healthcare professionals.

Good

Is the service caring?

Our findings

People told us staff were caring and kind. One person said, "On the whole I can't complain." Another, "Staff are brilliant." Another person told us, "I don't have to worry about anything, it's all laid on for you." Those who were able told us the staff always knocked on their bedroom doors before entering their rooms. People also said they were treated with dignity and respect. Visitors told us they were made welcome whenever they visited the home. A visiting professional told us staff were, "Genuinely caring."

There was a calm atmosphere at the home and it was clear staff had an understanding of the people they cared for. There was information in people's care files about them and their life before they moved into the home. Where possible these were detailed and contained a full history of the person. Staff treated people as individuals and they were able to tell us about people's choices and their likes and dislikes.

People were involved in decisions about their day to day care and support. Some people spent a lot of time on their own. Staff told us this was people's individual choices and they were able to tell us how people had made these choices. For example one person liked to spend their time quietly as this reflected their previous lifestyle. Another person became distressed when with a lot of people or in a noisy atmosphere. People who were able moved freely around the home. Spending time in their bedroom then joining others for a cigarette or at mealtimes. Staff promoted people's independence and ensured they were able to make choices about all aspects of their daily living.

All staff were observed to be caring, sensitive and calm. They treated people with kindness and respect. When staff supported people they did so with patience and worked at the person's own pace. When staff walked past people they acknowledged them, asked if they were alright and commented on what they were doing with interest. We saw staff talking with people in a caring and professional manner. We observed conversations and interactions that were kind and considerate. Staff and people chatted about all sorts of things not just care related topics.

Staff understood the needs of people who were living with a dementia type illness or were less able to express themselves verbally. One staff member said, "It's about knowing people, getting to know them and support them."

Another staff member told us through observation of people they were able to support them. They told us how they offered people a choice and watched their reaction for a decision. A further staff member told us, "I talk to people, I ask questions, I find out about them, which helps me support their decision making."

People had an allocated key worker. A key worker is a person who co-ordinates all aspects of a person's care and has responsibilities for working with them to develop a relationship to help and support them in their day to day lives. Key workers had regular meetings with people to get to know them and their family better and address any issues they may have. This gave people the opportunity to regularly discuss any concerns or issues they had and know these would be addressed. One key worker told us how they had identified one person would benefit from a specific type of cup and these were being obtained for them.

People's equality and diversity needs were respected. Staff supported people to dress in their preferred way. Staff explained how they offered people a choice of clothes to wear. One staff member said, "I get out two outfits and I show them, if they're not wanted I'll get out some more." The hairdresser was at the home on the first day of our inspection. We observed staff reminded people it was 'hairdressing day' and supported them to have their hair done. Staff then complimented people on their hair once it had been done.

Staff supported people and their privacy and dignity was respected. People were able to spend time in private in their bedrooms as they chose. Bedroom doors were kept closed when people received support from staff and we observed staff knocked at doors prior to entering. One person was having a blood test and chose to remain in the lounge for the procedure; we saw screens were in place to help maintain their privacy. Staff called people by their preferred name; on occasions we heard some staff use a term of endearment when speaking to people. Staff told us it was people's choice whether they were addressed in this manner. We saw this had been recorded in people's care plans.

There were two dignity champions at the home. A dignity champion is someone who believes that being treated with dignity is a basic human right, not an optional extra There was a dignity tree which had been displayed on the wall. People and staff had been asked what dignity meant to

Good

Is the service caring?

them and their responses were recorded on individual leaves on the tree. This included being listened to and trusting people/staff. There was a dignity board which included information about what dignity is and how people could expect to be treated. There were reminders in everyone's care plan that choice and ensuring people's dignity must be evident in all care plans. This showed there were systems in place to ensure people, visitors and staff were aware of their rights and responsibilities in relation to maintaining people's dignity.

The home was in need of redecoration throughout. However, we saw people's rooms had, as far as possible, been personalised with people's own belongings such as photographs and ornaments. Where redecoration had taken place people had been involved in choosing how they wanted their rooms to look.

End of life care plans were in place for some people, these had been thoughtfully prepared and contained information needed to act in accordance with people's final wishes.

Requires improvement

Is the service responsive?

Our findings

Daily notes were completed on an IPod system. This is a hand-held digital device on which staff record the care and support people have received. It includes information about the personal care people receive, support with continence and pressure area care. This information is then stored on the main computer. Some people had other daily charts in place. These included food and fluid charts and charts for the application of topical creams. We saw these charts had not been fully completed, for example the charts did not demonstrate people had received enough to drink or had the appropriate creams applied. We discussed this with the registered manager and care staff who showed us this information had been completed on the IPod system but not fully on the written records. This was confusing and did not show a consistent approach to record keeping. We highlighted this with the registered manager as an area for improvement.

The registered manager carried out an assessment before people moved into the home to make sure they could provide them with the appropriate care and support they needed. Pre-admission assessments were then used in developing the person's care plan. Care plans included the support people required for their physical, emotional and social well-being. Each care plan was personalised and reflected the individualised care and support staff provided to people. We asked staff about the care some of these people required and saw care plans reflected the care people received.

Care plan reviews took place monthly and keyworkers told us if they would update the care plan whenever people's care and support needs changed. Where reviews had taken place changes had been noted and the appropriate information recorded to update the care plan. We observed one person's care plan did not reflect their current needs however; staff had a good understanding of how this person needed to be supported. The registered manager had identified the care plan did not reflect how this person was now and was in the process of updating it. Staff were regularly updated about changes in people's needs at handover and throughout the day.

People and visitors told us they were asked about the care and support they or their relative needed. Where people may not be able to fully participate in care planning decisions we saw where possible their relatives or representatives were involved. When people moved into the home relatives were asked how involved they would like to be in the care planning process. For example one relative had expressed they would like to be updated about any changes in their loved one's needs but did not want to be involved in monthly care plan reviews. Visitors were welcomed at the home. One visitor told us they were able to visit whenever they chose and always felt welcome. This showed people and their relatives were involved in care planning decisions.

The activity coordinator and registered manager were committed to providing a varied and entertaining activity programme that people would take part in and enjoy. The activity coordinator worked at the home in the afternoons and spent time providing a variety of group and one to one activities that people enjoyed. Some days the activity coordinator was supported by a volunteer with providing activities for people on a one to one basis. However, the activity coordinator had sole responsibility for providing daily activities. Although staff knew people's care needs well not all staff had a good knowledge of people's lives before they moved to the home. This information had not been used to interact with people, develop conversations and encourage reminiscence.

During the morning staff were focussed on providing task based care and did not take advantage of opportunities to engage people who were less able to express themselves in meaningful activity. For example staff told us about one person who was sitting near a window because they enjoyed sitting in the sunshine. Although the weather was pleasant staff did not ask this person if they would like to sit outside. Another person was demonstrating they wanted to go out but this did not happen and staff distracted this person towards different activities. Other people told us they would like the opportunity to go out and said they would "like an outing." We discussed this with the registered manager as an area that needs to be improved.

Care plans contained information about what people liked to do. A number of people enjoyed watching the television and this was on during the day. We heard staff asking people if they wanted to watch television and then finding something people wanted to watch. Another person enjoyed doing jigsaw puzzles and was observed doing this. Someone else enjoyed crafts and although they did not participate in any crafts staff told us this person could do this independently if they chose to.

Requires improvement

Is the service responsive?

There was a complaints policy at the home and this was on display in the reception. People said they did not have any complaints at the time but if they did they would talk to the care staff in the first instance. They told us they were listened to and any worries were taken seriously and addressed. When complaints had been received the registered manager had investigated and responded to them in a timely way.

Requires improvement

Is the service well-led?

Our findings

There were various systems in place to monitor or analyse the quality of the service provided. Regular audits were carried out in the service including health and safety, environment and care documentation. Audits are a vital aspect to the provider's quality assurance framework. Quality assurance means raising standards and driving improvement whilst promoting better outcomes for people. The registered manager completed a series of checks and audits each month. These included care plans, maintenance, cleanliness and medicines. These checks were determined by the provider and completed by the registered manager. The results of the audits were returned to the provider and where possible the registered manager took action where shortfalls had been identified.

For example, there were areas of the home which were not odour free. The reasons for the odour and actions taken were recorded for the next month's audit to demonstrate what had been done to rectify the problem. However, during our inspection we identified a raised toilet seat and toilet support bars that were stained and rusty. These had not been identified in the monthly checks. We told the registered manager about our findings and received confirmation after the inspection that a new raised toilet seat had been purchased.

The last provider visit took place in February 2015 and the current audit system relied on the audits being accurately completed by the registered manager. The registered manager had worked at the home for three years. We asked about the support and supervision he received from the provider and were told he could contact the provider at any time however he had only received one supervision shortly after joining the company. This did not demonstrate the provider had an overview of what was happening at the home or ensure the registered manager was supported with a system of regular supervision.

The systems in place to monitor and assess the quality and safety of the service were not effective. The registered manager explained that whilst the home had been in administration he was responsible for the budget for the home. However, he was not able to spend any money on the fabric of the home. He had identified the need for general redecoration and maintenance throughout the home was a factor in not attracting people to live at the home and recognised the décor did not enhance people's feeling of well-being. There was a home improvement and maintenance programme in place and some of the work had been completed by the maintenance staff employed at the home. However, there was too much work for one person to complete in addition to the other commitments of the role. The registered manager had submitted a development plan to the provider in April 2015 where he had identified further areas of the home that required improvement. However, there was no further action plan or date to demonstrate when the work would be done or other actions that were being taken. Although issues had been identified by the registered manager there was no plan in place to show when these issues would be addressed. This meant that where quality and safety issues had already been identified, the provider had failed to ensure necessary improvement. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager worked at the home most days and had a good knowledge and understanding of people, their needs and choices. He promoted an open inclusive culture with the priority being the well-being and happiness of people who lived there.

The registered manager involved all staff in understanding the needs for improvements and development at the home. Through the provider and home audits, his knowledge of the home and people, he had developed action plans for the deputy manager and senior care staff with the action to be taken and the date for completion by staff. We saw the deputy manager, who was new to the home, was due to audit all care plans by the 12 September 2015 and this work had already commenced. The registered manager had his own 'to do' lists. This included actions he wanted to complete during July for example planning essential training for September.

As our inspection took place earlier than planned we had not asked for a PIR. However, the registered manager had started to gather information which he would be able to use to complete one. Therefore he was able to demonstrate his knowledge of the home, where it needed improvement and areas it had done well. He told us, "I know we're not perfect, I don't think anybody is, I've been in the business for years and I'm still learning." He told us he had developed the induction programme for new staff based on the care certificate and was planning to sign up for the social care commitment. He did not want to do this

Requires improvement

Is the service well-led?

until he had time to understand what was required of him and be able to share that knowledge with staff. This showed us the registered manager was aware of changes and was using nationally recognised guidance when new standards were introduced to drive improvement in the home.

The provider's vision and values were set out in the statement of purpose and included

privacy, dignity, independence, choice, rights and fulfilment. Although we found areas for improvement it was clear the registered manager and staff were working to uphold these values by developing an open culture at the home where staff supported each other and encouraged good practice. Staff spoke positively of the culture. They told us how they all worked together as a team to support each other. Comments included, "This is the most comfortable home I've worked in," "We're a good team, staff are cheerful and we work well together." One staff member told us the registered manager and other staff were, "The best things about the job." There was a clear management structure in place. Staff members were aware of the line of accountability and who to contact in the event of any emergency or concerns.

People, their relatives and staff were involved in developing and improving the service. We saw a recent survey which had been sent to people and their relatives. Feedback was very positive with people and relatives commenting on the activities, particularly the music. We saw minutes of a staff meeting which demonstrated staff were involved by asking each member of staff if they had any issues they wished to raise. There was also information for staff about upcoming training and issues for example with the IPod system.

Staff, resident and relatives meetings took place regularly. There were noticeboards around the home which informed people what was going on at the home and included information about their rights for example dignity and complaints. There were regular newsletters which included photographs of what had happened at the home in the past month and future events. It also included information and photographs of new staff who worked at the home. Feedback surveys had been sent out quarterly the last one was June 2015 when people said they were satisfied with the support they received. There were positive comments about the activities and music provided. A staff survey in June 2015 also showed staff were satisfied and felt supported working at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not have an effective system to regularly assess and monitor the quality of service that people received. Regulation 17(1)(2)(a)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered provider had not ensured the home was properly maintained and suitable for the purpose for which it was being used. Regulation 15(1)(b)(c)(e)

The enforcement action we took:
Variation of condition of registration