Rheola Healthcare Limited

Rheola Care Centre

Inspection report

Broad Leas
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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Rheola Care Centre (Rheola) is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The home accommodates up to 42 people in one adapted building, which is divided into a number of units. One of the units provides care to people living with advanced dementia. Nursing care is not provided.

At our previous inspection in November 2015 the home was rated Good. At our inspection on 3 and 10 January 2018 the service had deteriorated to Requires Improvement. The inspection visits to the home took place on 3 and 10 January 2018. On 3 January 2018 the visit was unannounced. We arranged with the registered manager to return on 10 January 2018.

There was a registered manager in post who had been managing the home for five years. A registered manager is a person who has registered with the CQC to manage the home. Like 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 home is run.

During our first visit to the home we found that medicines were not always being managed safely and care planning was not complete or up to date. By our second visit, the registered manager had strengthened the systems in place to check medicine management and care plans had been re-written. Safeguarding concerns had not always been discussed with the local authority safeguarding team. Quality assurance processes were in place but were not always robust enough to ensure that a quality service was being provided.

People felt safe living at the home, with the staff and with the care and support the staff gave them. Assessments of all potential risks to people were carried out and guidance put in place to minimise the risks.

There was a sufficient number of staff with the right experience, skills and knowledge deployed to make sure that people were kept as safe as possible. There was an effective recruitment process in place to reduce the risk of unsuitable staff being employed. Staff followed the correct procedures to prevent the spread of infection.

Assessments of people's support needs were carried out before the person was offered a place at the home, to ensure that the staff could provide the care and support that the person needed and in the way they preferred. Technology and equipment, such as a mobile phone for use when people went out unescorted, electronic care records and hoists were used to enhance the support being provided.

Staff received induction, training and support to enable them to do their job well. People were provided with

healthy, nutritious and appetizing meals and special diets were catered for. A range of external health and social care professionals worked with the staff team to support people to maintain their health.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People and their relatives praised the staff, had good relationships with them and described them as caring, supportive and professional. Staff made people feel they mattered and knew each person and the details about the care and support the person needed, very well.

People and their relatives were involved in planning their care. Information about advocacy services was available if anyone wanted an independent person to assist them with their affairs. Staff respected people's privacy and dignity and encouraged people to remain as independent as possible.

At our second visit staff had updated care plans and they were more personalised than previously. Activities, entertainment and outings were arranged if people wanted to join in. A complaints process was in place and people were confident that any issues would be addressed by the management team. End-of-life care was planned and provided when required

The service had received a number of compliments from people and their relatives and staff and external professionals would happily recommend this home to other people who needed this type of care. The registered manager ensured that staff were clear about their role to provide people with a high quality service. Staff were happy to be working at the home.

People and their relatives were given opportunities, such as written questionnaires and meetings, to give their views about the service and how it could be improved. The home had strong links with the local community.

The manager was aware of their responsibility to uphold legal requirements, including notifying the CQC of various matters. The management team worked in partnership with other professionals to ensure that joined-up care was provided to people.

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

The service was not always safe.

People were not always protected from avoidable harm. Medicines were not always managed in a way that ensured people received their medicines safely and as they had been prescribed.

There were enough staff deployed to keep people safe and provide them with the care and support they required. Staff recruitment reduced the risk of unsuitable staff being employed.

Potential risks to people were assessed and guidance put in place so that the risks were minimised. Staff followed infection prevention and control procedures.

Is the service effective?

Good

The service was effective.

Staff were trained so that they had the skills and knowledge to deliver effective support to the people who used the service.

Appropriate arrangements were in place so that people's rights were protected if they did not have the mental capacity to make important decisions for themselves.

Holistic assessments of people's needs were undertaken. Technology was used to enhance the care provided and arrangements were made to meet people's diverse needs.

Is the service caring?

Good

The service was caring.

People were supported by caring, kind and respectful staff who knew each person and their individual needs well.

People and their relatives were involved in planning their care and support and staff showed people that they mattered. Visitors were welcomed.

Staff respected people's privacy and dignity and encouraged people to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Care plans were in place for each person and the care and support was personalised to meet individual needs. End-of-life care was planned and provided when required

Activities, entertainment and outings were arranged. A complaints procedure was in place and complaints and concerns were responded to well.

End-of-life care was planned and provided when required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Audits and quality monitoring checks did not always identify shortfalls in the quality of the service provided. Staff did not always feel supported and their views were not always sought or acted on.

There was a registered manager who was approachable and made sure staff were clear about their role in providing people with a high quality service.

There were strong links with the local community and the home worked well with external professionals so that people received joined-up care. Legal requirements were upheld, including notifications being sent to the CQC as required.

Rheola Care Centre

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 home, and to provide a rating for the home under the Care Act 2014.

This inspection included two visits to the home. On 3 January 2018 the visit was carried out by two inspectors and an expert by experience, and was unannounced. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of caring for someone with complex and challenging needs. On 10 January 2018 the visit was carried out by one inspector and was announced.

Prior to the inspection we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

We wrote to a number of external health and social care professionals who the registered manager told us had regular contact with the home. Three external professionals replied and their comments have been included in this report. We also contacted the local authority contract monitoring and safeguarding teams, the fire safety officer and Healthwatch. We used this feedback to help plan our inspection.

In November 2017 the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We used this information to assist with planning the inspection. In between our two inspection visits, the registered manager sent us some information that we had requested about an aspect of people's care. The registered manager also sent us additional information, including records of compliments and photographs of people enjoying activities.

During our visits we observed how the staff interacted with people who lived at Rheola. We spoke with twelve people who lived there, six relatives of people who lived there and eight members of staff: five care workers (including senior care workers), one member of the domestic team, the deputy manager and the

registered manager. We looked at two people's care records as well as other records relating to the management of the service. These included records relating to the management of medicines, meeting minutes and audits that had been carried out to check the quality of the service being provided.

Requires Improvement

Is the service safe?

Our findings

We found a number of errors in the way medicines were managed. Variable doses of medicines, such as 'take one or two tablets', had not always been recorded so it was not clear whether a person had been given one or two tablets. Care plans did not clarify the reason for giving one or two tablets. This meant we did not know that the person's need for pain relief had been met. One person had run out of one of their pain killers so that for 24 hours this medicine, prescribed to be taken 'when required' had not been available if they had needed it. Following the inspection, the registered manager told us that the medicine had been available in the stock cupboard. Nevertheless, staff had not been aware of this and the person had not received this medicine. We checked whether the number of tablets remaining in their packets tallied with the number received, less the number recorded as given, for five medicines belonging to five different people. The numbers tallied for two of these but did not tally for the other three. This meant that we could not be assured that people had been administered all their medicines as prescribed.

Medicine administration record (MAR) charts should have been signed by staff to show that a medicine had been given, or a code used to explain why a medicine had not been given. In a high number of instances it was very unclear whether the mark on the MAR chart was a signature or a code. This meant it was not always possible to tell if medicines had been given or not.

The provider's medicines policy required staff to record on the MAR chart the reason why a medicine prescribed to be taken 'when required' had been given. Senior staff confirmed that this meant that the reverse of the MAR chart should have been completed every time the medicine was given. Staff had not followed the provider's policy on numerous occasions. These issues meant that there was a risk that people were not given their medicines safely and as they were prescribed.

We also found that some aspects of medicines' management were carried out well. For example, medicines were stored securely and at the correct temperatures; there were additional checks in place so that anti-coagulant medicine was given as prescribed; and clear procedures were in place for the administration of eye drops and nasal sprays. People told us they were happy with the way staff gave them their medicines. One person said, "I'm on medication. It's on time and they stand and watch me take it so I don't forget." Another person told us, "I get my medication on time. If I ring for a couple of [pain killing tablets] they (staff) are quick to come and give it to me."

At our second visit to the home the registered manager told us that they had carried out a number of actions to improve the safety of medicine management. These included reminding staff about the policy and procedure for 'when required' medicines and observing staff's practice. The provider had devised a new audit form, which the registered manager said they would be completing at more frequent intervals than they had previously audited medicines. It will take time to be sure that these changes have improved the management of medicines.

The provider had systems in place to ensure that people were protected from abuse and avoidable harm. A leaflet produced by the provider and entitled 'Keeping people safe from abuse' was available in the home's

foyer. Staff had received training in safeguarding people and told us they would know how to recognize and report any issues which caused them concern. However, there was a situation developing between two people living at the service. Information in one person's care plan showed that staff were aware that the person was not always happy or comfortable with the situation. We considered that this should have been discussed with the local authority safeguarding team, which the management team had not done. They did this on the day of our visit and told us the safeguarding team were satisfied with the actions the management team had put in place. Nevertheless, this lack of reporting meant that we could not be assured that people were always safeguarded.

People told us they felt safe living at Rheola. People made comments such as, "I feel safe because everybody's on hand to answer my questions or concerns or if I need anything"; "I feel safe here because it's like being at home. I can shut my door if I want and there's always the girls (staff) passing by"; and, "I am safe here… no-one can come in without permission." One person with a severe sensory impairment said, referring to all the staff, "When you have to depend on someone you need to be able to trust them and feel safe with them, and I do."

The provider had a risk management system in place to ensure that risks were managed and minimised, whilst ensuring that people had choice and maximum control over their lives. Potential risks to each person were assessed and guidance put in place for staff so that the risks were reduced. Risks included mobility, falls, malnutrition and pressure areas. Staff repositioned one person in a different chair when they became distressed, which made them more comfortable and reduced the risk of them developing a pressure ulcer.

The home had signed up to the Herbert Protocol. The Herbert Protocol is a national scheme, introduced by the police in partnership with other agencies, which encourages carers to compile useful information which could be used in the event of a vulnerable person going missing. It is a simple risk reduction tool to be used in the event of an adult with care and support needs going missing. It consists of a form that contains vital information about a person at risk and a photograph of the person that can be passed to the police at the point the person is reported missing.
The provider had procedures in place to make sure that people were protected in the event of fire. Fire alarm systems were checked regularly as required and staff told us they had been involved in regular fire drills. The fire safety officer visited the home in October 2017. The registered manager had acted on their recommendations and removed a vending machine in November 2017 from a corridor area as it could have been a hazard.

There were enough staff on duty to keep people safe and meet their needs in a timely manner. Staff were very busy and two members of staff said there were not always enough staff, however, people and their relatives had no complaints about staffing numbers and how people's needs were met. One person told us, "If I want anything I only have to press the button and [staff] are there. It is very important to me because I have [a medical condition] so I need [staff] around 24/7." An external professional wrote, "I always see enough staff when I visit, I have visited during meal times and first thing in the morning." The registered manager explained that they used a tool to calculate staffing based on people's levels of dependency. They also used their in-depth knowledge of people to judge when people needed extra support and they increased staffing numbers. Additional staff were on duty to escort people to appointments or to assist with activities.

Staff told us that their recruitment included thorough checks and they had not been allowed to start work before the results of the checks were returned and were satisfactory. Checks included references from previous employers and a criminal records check. Staff had received training in topics that enabled them to keep people and themselves safe, such as moving and handling and the use of equipment to assist people

to move.

Staff had undertaken training in preventing and controlling infection and followed the provider's procedures relating to wearing gloves and other personal protective equipment. A member of the housekeeping staff explained about different coloured buckets and mops for different areas, such as kitchens and bathrooms. They told us about wearing a new pair of gloves for cleaning each area. Some areas of the home, especially some of the toilets and bathrooms, were in need of refurbishment so were not as easy to keep clean and hygienic. We noted a smell of stale urine, particularly in one area. This was also commented on by a relative who told us that some areas always had an unpleasant odour. This showed us that where offensive odours were present they had not always been effectively dealt with.

Good

Is the service effective?

Our findings

The registered manager told us that they, or the deputy manager, almost always visited each person before the person was offered a place at Rheola. A full assessment of the person's care and support needs was carried out to make sure that the home's environment and its staff could meet those needs. The information from the assessment formed the basis of the person's care plan.

The staff ensured that any equipment the person might need was in place so that the person was enabled to remain as independent as possible. This included hoists and other equipment used to assist people to move safely. The electronic care planning system flagged up events that staff needed to remember such as hospital appointments.

There were processes in place to ensure that there was no discrimination. For example, when assessing one person for a respite stay, staff realised they would require additional support and a special diet to meet their religious needs. Food deliveries were arranged so that the person could have a nutritious diet whilst at the home, which met their needs. Staff also became aware that the person did not speak English. Staff who could speak the person's language typed up some commonly used sentences so that all staff were able to have some communication with the person. Staff rotas were arranged so that there was always a member of staff on duty who could communicate effectively with the person, especially necessary if the person had any health needs. The registered manager told us that the person's family "were very happy and stated that we went beyond anything they could have expected."

When a new member of staff started working at Rheola they underwent a period of induction. This included introductory training in a wide range of topics and shadowing experienced staff. Further training was then provided so that all staff were equipped to carry out their role effectively. People were confident that staff had been well trained and knew how to do their job. One person said, "I think [staff] are very skilled." Another person told us, "They do their job well."

Staff received supervision and an annual appraisal to give them the opportunity to discuss in depth subjects such as what was going well for them, if there were areas for improvement and any training they wanted to undertake. One member of staff told us that the team leaders "are really supportive – they're just so helpful."

People were supported to maintain a healthy, nutritious and balanced diet to ensure their nutrition and hydration needs were met. People told us they had choices about what they ate and mostly enjoyed their meals. Our lunchtime observations confirmed this. People's comments included, "The food is very good…all freshly cooked"; "The food is lovely. More than I can eat and always plenty of choices"; and, "I'm very happy with the food – all nice and fresh." Risk assessments were carried out to identify people who had complex needs in relation to eating and drinking and special diets were provided for those who required them. One person told us they were very happy with the way staff supported their dietary needs and preferences. They said, "Nothing is too much trouble for them." Another person told us, "I think they do pretty good to accommodate everyone's tastes." Staff explained that for one person they gave them a small plate with a very small portion of food because if they gave them more the person would not eat any of it.

Healthwatch (the independent national champion for people who use health and social care services in England) carried out an 'Enter and View' visit to the home in May 2017. This was part of a three-month project to look at how care homes were ensuring that people who lived there could choose from a healthy and varied diet that met their needs and cultural diversity. Healthwatch's Authorised Representatives summarised their findings, stating, "Overall we think our findings make a positive contribution to good nutritional care for residents."

Rheola had a very good example of one way in which they worked with other services to make sure that people received a high standard of consistent care when they moved between services. The staff had adopted the 'red bag' scheme, in use by local hospitals. Following The National Institute for Clinical Excellence (NICE) guidance, a red bag was used to transfer a person's paperwork, medicines and belongings between the care home and the hospital. The red bag stayed with the person throughout their hospital stay and returned home with them. The standardised paperwork ensured that everyone involved in the person's care had necessary information about their health, their medicines and any social information about them that would help staff who did not know them.

People told us they were supported to maintain their health through regular visits from their GP, community nurses and other healthcare professionals when needed. These included a chiropodist, optician, dietician and other therapists. People were happy that staff called in medical help when they were not well. One person told us that staff calling paramedics to the home had probably saved their life. Another person said, "[Staff] called a doctor quite quickly to see me. They don't waste time – they're very good like that." External professionals confirmed that staff followed their advice. One external professional told us, "Staff listened to my recommendations and followed my guidance."

Rheola has been a care home for many years and was starting to look tired and in need of refurbishment. For example, some of the bathrooms and toilets looked grubby even when they had been cleaned; some wallpaper was torn and paintwork badly marked; some curtains were faded and not hanging properly on their rails; and some of the carpets were stained. One external professional summed it up when they wrote, "[The provider] needs to invest more funding to improve the aesthetics of the home." A relative told us, "I do think the home is in need of a major 'refurb'. I suppose that's down to the owners."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff had received training and understood the principles of the MCA. Staff were applying the principles of the Act in their everyday work. They gave people choices in all aspects of their lives and asked people's consent to carry out care tasks. The registered manager told us that at the time of the inspection there were a number of people living at Rheola who did not have the capacity to make their own decisions. However, formal assessments of people's capacity had not been carried out and recorded. Applications had been made to the local authority for DoLS authorisations but no-one had as yet been assessed. This meant that we could not be sure that people's rights in this area were being upheld.

Good

Is the service caring?

Our findings

People, their relatives and external professionals who wrote to us all made positive comments about the staff. People told us they were treated with kindness and respect. People's comments about the staff included, "They are very caring and lovely girls…they always take their time with me, not rushing me"; "[All the staff] are the same the way they look after me, kind and respectful"; "I think the girls that look after us are very caring"; and, "The girls are very kind to me." A relative summed up many positive comments with, "I have to say, the care is fantastic."

An external professional told us, "[The staff are] enthusiastic, helpful and genuinely seem to care about the residents, which is something that I've not always seen in other care homes I visit." Two other external professionals described the staff as, "Consistent, helpful, willing, caring, proactive, warm and approachable" and, "Competent, caring and have a 'can do' attitude." Following a visit to the home, another external professional had written to the registered manager: "It was great to see you and your lovely team today. I really enjoy visiting Rheola as there is such a good atmosphere between the staff and the residents. The residents told me that the staff are very pleasant and kind."

People told us that staff made them feel that they mattered. Staff showed that they knew each person, including their likes, dislikes and preferences, very well. One person said, "[Staff] are very helpful but they know I like to wash myself as far as I am able to." Another person told us, "[Staff] know I prefer to use my commode and I think that is very caring of them to respect my choice to do so."

Staff used various methods of communicating with people, based on each person's needs and preferences. For example, they communicated with one person by using a portable whiteboard, offering them choices at lunchtime. This included writing "are you ready for your pudding yet [name]" rather than just delivering the pudding as soon as the person had finished their main course. This was very caring and showed they were treating the person no differently to everyone else.

There were warm, friendly and caring relationships between the staff and people they were supporting. Staff showed that they cared about people and enjoyed their company. Staff bent down to speak with people to give eye contact and spoke in a calm, slow way which people responded to with smiles. An external professional who visited the home frequently said that they saw staff "talking to the residents individually about their daily needs and I hear them asking how they are today." Another external professional told us, "I think the relaxed atmosphere and homely feel is a really nice thing about the home. All the residents seem very cheerful. I often hear them laughing and joking with the staff."

People, and their relatives when people wanted them to be, were involved in the care and support they wanted and needed from the staff. Each person had a keyworker who was responsible for making sure that people had the care and support they needed. Keyworkers supported people with additional tasks, such as doing some shopping for the person or taking them out. Advocacy services were available if someone wanted an independent person to assist them with their affairs. These were advertised on notice boards.

Staff respected people's privacy and dignity and confidential information was stored securely. People told us that staff always respected their privacy and dignity. Staff knocked on people's bedroom door and waited for an answer before entering. People confirmed that doors were shut, curtains kept closed and the person kept covered up as much as possible during personal care.
Staff did not talk about people in communal areas of the home and did not discuss people's affairs with other people living at Rheola. Personal care was offered very discreetly.

Staff supported people to retain as much of their independence as they wanted to. One person told us, "I like to wash myself as far as I can reach. [Staff] will pass me my flannel and encourage me to do so." Another person said, "[Staff] let me stay in the bathroom on my own…that way I know I can still look after myself, they're very supportive like that."

People were encouraged to keep in contact with their friends, both within the home and in the community, and relatives were made to feel very welcome. Relatives and friends were offered drinks and a meal if they were visiting at meal times. One relative told us, "We don't feel like we're visiting a 'home' when we come and visit [our family member]. It's like visiting her at home." Another relative wrote, "Visiting [name] is a pleasure and all the staff make us welcome."

Good

Is the service responsive?

Our findings

Assessments of people's needs were undertaken before the person was offered a place at the home. The person, their relatives and health care professionals involved in their care contributed to the assessment and to planning the care and support to ensure that staff knew what the person needed. The assessment formed the basis for the person's care plan. Most people were not sure what a care plan was, but told us they were regularly asked about the care they received and if "everything was okay". One person told us, "My [relative] is involved in my care plan."

The provider had an electronic care planning system in place. Staff reported that the tick-box nature of the system meant that care plans were not as personalised as they could have been. Some of the language was ambiguous. For example, one person's care plan stated "can become distressed" but there were no details about how the person showed that they were "distressed", nor what staff should do about this. These details about this individual's care were known by the staff but were not recorded in the person's care plan. In another instance we found that staff were not always following the guidance that was in the care plan. This meant that for some people their care was not as person centred as it could have been.

Staff showed that they knew about each person, their preferences, likes, dislikes and the care they needed. One member of staff said, "We get to know people well." A healthcare professional told us, "Consistent staff ensure they get to know their service users well; support plans reflect individual needs." They also said that staff were willing to work creatively to ensure people's needs were met.

We were given some examples of how the service delivered by the staff had been very responsive to people's needs. One relative told us how the staff had supported their family member when they returned home following an admission to hospital after a fall. The relative told us, "With the care here and the support of physios, we are in awe of how [name] has come on in leaps and bounds." Another relative told us their family member got their sleep pattern mixed up on occasions, getting up at 5am and asking for breakfast. They said, "Staff are great. They put her at her ease then they will bring her a slice of toast and a cup of tea to manage her till breakfast."

Two separate relatives had written to express their thanks to the staff at Rheola when their family members moved there from other care homes. One relative wrote, "I can't speak highly enough about the staff at Rheola…they are all lovely…I am really impressed with everything. [Name] has improved so much in two weeks: he is happy, smiling, eating and drinking…I only have positive feedback." After two weeks at Rheola, the second relative wrote, "My [family member] has been out of bed every day (at [the other care home] she hadn't got out of bed [for several months]). She is mixing with other residents, eating well and has put on weight, which was needed. The staff at Rheola have been fantastic with [family member] and she is happy here."

However, three people and/or their relatives told us that they did not get offered enough baths. The computer system was unable to provide us with a list of dates when each person had had, or had been offered a bath. Following the inspection visit, the registered manager provided us with dates when each of

these people had last had or been offered a bath. These were between five and 14 days prior to the date of our visit. The registered manager also gave us reasons why these people had not had a bath recently, including that one person had hurt their hand and another person had been unwell.

At our first visit, care plans were not fully up to date and some information was missing. By our second visit, the registered manager told us that all care plans had been updated and were complete. Those we saw were more personalised than those we had previously seen. Records showed that care plans were evaluated monthly. Many of the evaluations used identical wording month after month. However, we noted that when care had changed, this was reflected in the evaluation. Staff said that daily verbal handovers ensured that they were made aware of any changes.

An activities coordinator was employed on two days a week to arrange outings, entertainment and activities for people. People were generally satisfied with what was provided and were really pleased with some of the activities, such as a day at the seaside and a regular church service. One person told us, "I like the quizzes and bingo. We had a lovely banjo player the other day and had a good old sing-song." An external professional told us they thought that "good activity plans [are] in place" and we saw that these were given to each person to show them what would be happening the following month. Staff had made contact with a local nursery school and the children had started to visit regularly. We saw some photographs of people with the children, all enjoying parachute games. Care staff got involved by doing activities such as manicures and impromptu singing. However, two people felt there were not enough appropriate activities for them and staff said they thought some of the activities were "rather childish".

People were encouraged to maintain relationships with family and friends, both within and outside the care home. One person told us that in the evenings they went to sit and chat with another person who was "very poorly". Relatives and other visitors were welcomed.

The provider used technology in a number of ways to support care delivery. Each person had a call bell in their bedroom so that they could call staff if they needed to. Equipment such as hoists, hospital-style beds and pressure mats was in place to assist people, and staff, to stay safe. The provider lent one person a mobile phone to take with them when they went into town so that they could call staff if they needed help.

The provider had a complaints process in place, which was advertised around the home. People knew how and to whom to complain if they needed to, but they told us they had nothing to complain about. One person said, "I would report a concern to the staff [but] I haven't see anything that I would need to do so." Another person told us, "I know how to report concerns: I would tell a carer. If that was not addressed I would tell [name of registered manager]." A third person said, "I have no complaints - I'm well looked after." Staff were clear that they would tell the registered manager or the deputy manager if someone raised a concern. The complaints log showed that the very few complaints received had been responded to within the provider's timescale and to the complainant's satisfaction.

People were supported at the end of their lives. Each person had an end-of-life care plan in place. Some people had given some details about what they wanted, such as funeral arrangements, but most had preferred not to discuss this with staff. The registered manager said these plans would not be fully completed until they were required. The staff worked closely with the person, their family, their GP and the community nursing team to ensure that people's wishes were met and they were as comfortable as possible at the end of their life. The registered manager and deputy manager were undertaking further training in end-of-life care.

Requires Improvement

Is the service well-led?

Our findings

The provider had a system in place to monitor the quality of the service being delivered to people by the staff. Senior staff and managers undertook a number of audits of various aspects of the service. However, we found that the audits were not in-depth enough to give a true picture of the quality of the service. For example, audits of care plans had not shown that care plans were not up to date, not complete and did not include assessments of people's capacity. Audits of medicine management had not identified the issues we found. On one of the medicine audits, it was recorded that medicine trolleys were not kept locked. The deputy manager said that was a mistake – the trolleys were always kept locked. This meant that information in the audits had not been followed up and also could not be relied on to be a true reflection of what was actually taking place.

Senior staff were involved in auditing medicines. For example, a 'daily medication stock balance' record was in use to record the balance remaining of all medicines in their original packets. These records had not always been completed correctly, the records did not always match what had been recorded on the MAR chart and numbers of tablets remaining did not always tally with the number recorded as the balance. We found that no action had been taken to find out why the records did not tally. For one person, the MAR chart recorded that the medicine had been refused on every occasion it had been offered (four times a day for 16 days). However, the stock balance had reduced from 28 tablets on 12 December 2017 to 22 tablets on 3 January 2018. Staff were not able to explain this discrepancy. This meant that the provider's quality monitoring systems were not sufficiently effective to ensure that a high quality service was being provided.

Staff had mixed views about the level of support they received from the registered manager. Three of the staff we spoke with were happy that they received support from the registered manager. However, two staff told us that there had been occasions when the registered manager had not been supportive and these staff had been made to feel quite anxious about raising issues with them. The staff meeting minutes folder showed that meetings for different staff groups had been arranged, but we saw that a number of times the minutes stated 'no staff attendance'. Minutes of meetings that had taken place were very brief and gave no indication of any actions needed, nor whether any issues previously raised had been resolved. This showed us that staff's views were not always sought or welcomed.

The provider's electronic care planning system did not always support staff to record fully personalised care plans and information about people. Senior staff had difficulty interrogating the system to find some of the information that we needed. They told us that some of the information that we requested had 'disappeared' from the system so was not available when we asked for it. This meant that the technology did not fully support the staff to keep personalised, accurate and reliable records that were fully accessible.

We received some very positive comments about the service that was provided at Rheola from people who lived at the home and their relatives. People's comments included, "We are extremely well looked after"; "I have only one word for living here – marvellous"; "I am very happy here"; and, "You can't get better than this can you." A relative said, "We are extremely happy with the care our [family member] receives." Another relative told us, "They look after [name] very well, which is the main thing." Relatives whose family members

no longer lived at Rheola had written to the home. One relative wrote, "The care and support you gave was invaluable to us all and made the process of putting [name] into a care home easier. [Name] was happy while she was with you and for that we are very grateful."

Staff told us they were happy working at Rheola. One member of staff said, "It's good here – I wouldn't be here if it wasn't.…the way we work feels like family. I'm more than happy." The registered manager and deputy manager told us, "We've got some really excellent [staff]" and "We have some amazing staff." The registered manager told us that staff rotas were adjusted for one member of staff at times when they needed to work different hours to support their religious beliefs.

The provider's vision and values and the home's mission statement and objectives were detailed in the information pack given to each person when they were moving into the home and in the staff handbook. Staff knew that they were aiming to provide "a caring and secure environment within which people are treated with respect and regard for their dignity and well-being."

There was a registered manager who had been in post for five years. People and their relatives knew who she was, knew her name and said they saw her around the home. One relative said, "[Name of registered manager] is always on walkabout. She's very approachable." They said they raised an issue with the registered manager, which was dealt with and the issue never happened again. External professionals made positive comments about the management team. One external professional described the team as "very efficient and friendly. Always find them approachable." Another external professional wrote, "Proactive, caring, hardworking, dedicated, protective, conscientious are just a few words to describe them." A third external professional said, "I feel the management of the home work hard to enable service users to remain in a safe and comfortable environment. I feel they are realistic and will listen when I make recommendations."

The registered manager was aware of their responsibilities to keep up to date with all legal requirements and with current good practice. This included the requirement to inform CQC of various matters via the relevant notifications. Staff knew about and understood the provider's whistleblowing policy.

People, their relatives and other stakeholders were given a number of opportunities to comment on the service being provided and to be involved in making suggestions for improvements. A written questionnaire was sent out every six months and meetings for people who lived at the service and their relatives were held regularly. Two people told us they did not want to go to the meetings but knew their relatives attended. People told us they were always being asked if they were satisfied with the care and support they received. A keyworker system was in place and people told us they could always approach their keyworker.

Rheola had some very strong links with the local community. They were part of the Time Bank scheme in St Ives, in which individuals and groups in the community earned Time by doing a 'good turn' for someone else. Rheola held a film afternoon and coffee mornings for the local community; invited people otherwise alone at Christmas to join Rheola residents and staff for Christmas lunch; welcomed a group of young children to practice singing with a choir at Rheola; and people who lived at Rheola visited the local library to read and book out books to school children. They spent their Time credits on having the garden 'spruced up' by a large group of scouts, cubs, beavers and others. The photograph in the local paper showed how much the young people and people who lived at the home had enjoyed working together on the project and everyone was very pleased with the results.

People who lived at Rheola had participated in an 'intergenerational art project', which had involved a group of young carers visiting the home and doing art work with people who wanted to join in. The artwork

was put forward for an award, displayed in a local museum gallery for several weeks and then put on display at Rheola. A weekly 'read-aloud' group from the local library visited Rheola regularly to read and reminisce with people who lived there. The young carers group organised a tea dance and tea party at Rheola.

The management team at Rheola worked in partnership with other agencies, including local commissioners, to ensure people received joined-up care. There was one place at Rheola that was used by the local authority for people who needed a respite stay. Following a visit to the home, an external professional wrote in praise of the staff and said, "I was made very welcome and everything I needed to do my job was made available to me." Another external professional wrote, "The staff/management have been consistent for many years. The home will consider working with complex service users which other homes decline: they will do their very best to ensure a placement is successful and only when all options have been trialled will a move into a higher level of care be sought. The home open their doors to family members and individuals from the community for Christmas lunch. The home often extend invites for activities/outings to individuals who have regular respite. Prompt to report any concerns or seek advice to discuss any issues."