SSB Carehomes Limited

Eagle Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Eagle Nursing Home is situated in the village of Eagle, seven miles from the city of Lincoln. The home is registered to provide residential and nursing care for up to 29 older people, some of whom lived with memory loss associated with conditions such as dementia. There were 22 people living in the home at the time of this inspection.

At the last inspection the service was rated 'Good'.

We carried out this unannounced inspection on 25 and 26 January 2017.

A newly appointed manager was in post who had not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with 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 service is run.

During our inspection we found some areas in which improvement was needed to ensure people were provided with care that was safe, effective, caring, responsive and well-led and that the provider's regulatory responsibilities were being met in full.

This was because the registered provider had not ensured the arrangements for the safety, housekeeping and maintenance of the building were consistently being planned for and managed.

People and their relatives were not fully involved in planning how they wished their care to be provided. People were supported to make decisions for themselves. However, when people needed help to make specific decisions about how care was provided information about which decisions had been made and by whom had not been fully reflected in the care records. Care plan reviews did not give clear enough information about the effectiveness of the care plan, who had been involved in the reviews or any actions planned or taken after reviews had been completed. We also observed some of the care was task led rather than person focused.

Although people were supported to have access to the food and drinks they needed to keep them healthy the menus were not varied and access to a range of meal options and choices for people was limited.

The provider's quality assurance and audit systems were not reliably or consistently managed so as to enable them to quickly identify and resolve shortfalls in the services provided for people.

In other areas, the provider was meeting people's needs effectively.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of

Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of this inspection seven people who lived in the home had their freedom restricted in order to keep them safe and a number of other people were awaiting the outcomes of their assessments for a DoLS authorisation. The registered persons had acted in accordance with DoLS guidance to ensure people had their rights protected.

Staff understood how to identify report and manage any concerns related to people's safety and welfare. Staff knew how to manage and minimise any identified risks and care was supported through staff communicating with a range of visiting health and social care professionals. Clear arrangements were also in place for ordering, storing, administering and disposing of people's unused medicines.

The registered provider had clear recruitment processes in place and background checks had been completed before new staff were appointed to ensure they were safe to work at the home. Staff were well supported by the new manager to provide care in a way which ensured people's needs were met and they were provided with training to develop their knowledge and skills.

The provider, manager and staff recognised people's right to privacy, respected confidential information and there were systems in place for handling and resolving formal complaints. When individual concerns or complaints were raised with them the provider and manager took action to address them quickly.

People were invited to comment on the quality of the services provided the arrangements in place for people and their relatives to give regular feedback about the home were in place.

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 consistently safe.

Arrangements for security, housekeeping and maintenance of the building were not always robustly managed.

Staff knew how to keep people safe from harm.

There were enough staff on duty to give people the care they needed and background checks had been completed before new staff were employed.

The arrangements in place to support people to take their medicines were managed safely and people were supported to take their medicines at the times they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported to make decisions for themselves. However, there was a risk people's legal rights may not be protected due to shortfalls in care records.

Staff had received the training and support the provider had identified staff needed.

Staff helped ensure that people received the healthcare they needed and people where helped to eat and drink enough to keep them healthy.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some of the care practices were task focussed and people's privacy, dignity and choice was not always respected.

Staff understood the need to maintain the confidentiality of people's personal information.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People and their relatives had not always been consulted about how they wanted their care to be provided and care plans did not always support the consistent delivery of care.

People had their care needs met in a timely manner and were supported to pursue a range of meaningful activities and maintain their individual interests.

There was a system in place to make sure any concerns or complaints raised with the provider could be responded to in the right way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The provider's approach to supporting the management of the service was not consistent.

Quality checks and audit processes had not always led to problems being identified and quickly resolved.

People and their relatives had been asked for their opinions of the service so that their views could be taken into account.

The manager promoted good team work and staff had been encouraged to speak out if they had any concerns.

Eagle Nursing Home

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 was 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.

We undertook this inspection on 25 and 26 January 2017. There were 22 people living in the home at the time and the inspection team consisted of a single inspector 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. The expert by experience who undertook this inspection together with us had experience as a family carer of older people who have used regulated services.

Before we undertook our inspection we reviewed the information we held about the home. This included information that had been sent to us by other organisations and agencies such as the local authority and health authority who commissioned services from the registered provider, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion for health and social care. We also reviewed notifications of incidents that the registered persons had sent us since they had been registered with us. These are events that happened in the home that the registered persons are required to tell us about.

During our inspection we spoke with six people who lived at the home and two visiting relatives. In addition we received written feedback from three healthcare professionals and a social care professional who had undertaken visits to the home. We also spoke with the provider, the nurse in charge, six care staff, the home's activity co-ordinator, a newly appointed 'well-being consultant,' the homes maintenance staff member and an agency cook. We also spoke with the manager by telephone as they were unavailable on the day of our inspection.

We spent some of our time observing how staff provided care for people. In order to do this we used the Short Observational Framework for Inspection (SOFI). This was to help us better understand people's experiences of care and because some people, for example those who lived with dementia and were unable to tell us about their experience direct.

We also reviewed the information available in five care plan records. A care plan provides staff with detailed information and guidance on how to meet a person's assessed social and health care needs. Other information we looked at as part of our inspection included; the provider's care staff recruitment information, staff duty rotas, staff training and supervision arrangements and information and records about the activities provided. We also looked at the process the provider and the manager had in place and were developing for continually assessing and monitoring the quality of services provided at the home.

Requires Improvement

Is the service safe?

Our findings

The provider confirmed they employed domestic staff and we looked around the home we saw it was clean. However, at the start of our inspection we noticed one part of the home and the surrounding areas was malodorous with a strong stale smell. We brought this to the attention of the provider. They told us the smell related to the drainage in this part of the home and they intended to address this as part of their environmental improvement audit plan. The provider said domestic staff cleaned the area each day to minimise the odour. We found once the area had been cleaned the odour diminished but was still evident. The provider assured us they would be undertaking the necessary environmental work as soon as possible to fully eliminate the odour.

We spoke with the member of staff responsible for carrying out routine environmental checks and any maintenance work needed the home. These included changing light bulbs, updating the decoration in the home and carrying out safety checks in relation to the utilities in place. The staff member also confirmed they checked the equipment used by staff to provide care to people. During our inspection we saw they were carrying out a repair of one of the homes trolleys used for serving food. However, we also noted a door to a cellar store room being used by the maintenance person had been left unlocked and unattended. The door had a sign on it stating it should be kept locked at all times was open. The steps leading to the cellar were steep and we saw this could present a risk to anyone who tried to access the stairs. We spoke with the maintenance person and the provider about this and they said they would ensure the door would be locked at all times unless they needed to access it and that when this was the case it would not be left unattended. After we completed our inspection visit the manager confirmed a new coded lock had been fitted to the door to make sure it would be safely closed at all times when unattended.

People told us they felt safe living at the home one person remarked, "I feel safe and happy here. It's nice and warm and it's my home." Relatives we spoke with told us they felt staff adhered to health and safety, their loved ones were safe and that the care staff supported them in a safe manner. One relative commented, "Yes I think the staff manage the residents safely. I think they have training in it." Another relative told us, "I am happy with my family member being here and know they are safe. The staff have nursed [my family member] in bed for a while now as they do not want to get up any more. [My family member] hasn't had any bed sores or anything. It's totally home from home here."

The provider told us how they ensured the home environment was being safely maintained and that where it was needed, they were undertaking environmental improvements to the home. We saw some of the home's vacant bedrooms had been redecorated and a relative told us, "They are putting a new flooring down today in the wash area in [my family members] room. There was only a little water leak and the carpet wasn't really spoilt but they insisted."

The provider confirmed they had systems in place to make sure people could evacuate the home in an emergency. These systems included including fire drills and alarm testing. The provider told us they had worked to requirements set by the local fire officer following their last visit and had completed all of the actions they had been set. We saw personal evacuation plans were available so staff would know the help

each needed to have if they needed to leave the home quickly.

Staff told us they knew how to take action to people were kept safe from harm and were clear about external agencies they needed to report any concerns to. This included the local authority safeguarding team, the police and the Care Quality Commission (CQC). Staff told us and the provider's training plan showed staff had received or were due to undertake training in this area. In addition staff said they were confident that if required, any concerns or allegations would be investigated fully by the provider and manager.

We observed care staff correctly using equipment such as mobile hoists and working together in pairs when it had been identified as necessary to help people to move safely. Staff were vigilant in communal areas and noticed and took action to assist people when they chose to be mobile. Care records showed a range of additional information which staff referred to which demonstrated they worked in ways which kept people safe. For example, we saw people had records to show when they needed help to move or turn over in bed to reduce the risk of them becoming sore.

The manager had safe systems in place in order to recruit new staff. We looked at the staff recruitment information for staff members who had recently been recruited. The administrator showed us how they kept detailed record logs to ensure all information related to an applicant's identity, previous employment and reference checks requested were recorded and maintained. Checks were also undertaken to ensure nurses employed by the provider were appropriately registered to carry out their role and that their registrations were active. The provider had also completed checks with the Disclosure and Barring Service (DBS). These checks helped ensure new staff would be suitable and safe to work with people who may be vulnerable.

The provider told us the manager planned rotas in advance and kept them under regular review to make sure there was the right level of skill mix and staff experience required for each shift. The homes administrator provided us with copies of the care staff rotas completed and those planned. This information showed the manager had established how many staff needed to be on duty for each shift and that this had been decided by assessing the level of care each person needed. We saw advanced planning ensured routine shift arrangements were being filled consistently and records showed any changes in staff at short notice had been covered from within the staff team. The provider told us if they experienced any difficulties in maintaining the right staffing levels the staff worked together and covered additional shifts to support their colleagues. The provider and the nurse in charge also told us when needed they had been able to utilise their own bank staff and external agency staff, for example to make sure nursing staff levels were being maintained. We noted the use of agency staff was being reduced as the provider continued to recruit more permanent staff. When we spoke with the bank nurse who was working they told us they had previously been employed at the home and knew people well. This meant the required cover was in place and the staffing levels and care remained consistent.

During our inspection we observed care staff responded quickly when they were called to help people in their rooms. One person told us, "If I press my buzzer, the girls always come as soon as they can, unless they are dealing with an emergency of course." Another person added, "They always answer my buzzer calls if I need to press it. Relatives we spoke with also said they felt there was sufficient staff on duty, and that it was no different at weekends.

The nurse in charge told us and records confirmed, the staff who had the responsibility to help people take their medication had received training to make sure they did this safely. The nurse in charge showed us how they ordered, recorded, stored and disposed of medicines. including those which required special control measures for storage and recording. We saw this was in line with national guidance. People's care records

showed how and when they were supported to take their prescribed medicines. We observed staff carried out medicines administration in line with good practice.

Senior staff and the manager also carried out audit checks to identify and if needed address any areas related to the processes in place for medicines. For example, following the managers latest audit action was being taken to update some people's identification photographs, and care staff were asked to make sure medication refusals were always reflected in care plans and fully discussed as part of staff handover meetings.

Requires Improvement

Is the service effective?

Our findings

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.

A senior staff member told us that some people who lived in the home did not have capacity to make important decisions including those related to how the care and support they needed was given. Care records for those people who needed support with their decision making contained an assessment document to confirm this. However, the information the documents contained gave only a broad indication of the person's capacity and they did not fully reflect the type or range of decisions each person could or could not make for themselves.

In addition, care records did not contain enough detail to demonstrate that people had been involved in the assessment of their capacity to make decisions for themselves. Nor did they clarify how people communicated their decisions and choices and how staff should support people to do this. For example, some people had needed bed rails to support them to be safe in bed and sensor mats had been assessed as needed to alert staff when some other people were mobile so staff could respond quickly and keep them safe when they were up and about. However, although there were records in place to show that these arrangements were in place there was no clear information to confirm how this decision had been made and who had been involved in making it. The information was not fully aligned to the MCA. This meant that people, or those who lawfully acted on their behalf could not be assured that their capacity to make decisions had been suitably assessed or taken into account when care was planned.

We discussed our concerns with the provider and lead nurse. They informed us that they had recognised the records needed to be improved and that together with the new manager were in the process of updating them to confirm how decisions had been reached and ensuring the mental capacity information and best interest information for each person was decision specific. The provider also told us they were arranging additional training sessions for the care staff team and that the manager would be ensuring all staff attended these. After we completed our inspection visit the provider and manager confirmed dates for the training had been scheduled.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found that seven people were being deprived of their liberty at the time of our inspection visit. This was necessary to ensure that they remained in the service so that they could safely receive the care they needed. Records showed that in the case of each person the manager had applied for the necessary DoLS authorisation. By doing this the manager had ensured that only lawful restrictions would be used that respected people's rights.

Care staff told us the new manager was supportive to them and offered guidance to them in their roles. One care staff member said, "The manager is new and good. We needed someone like her here. She is disciplined and has a good overview of what needs to be done." Team meetings had previously been held with staff and staff told us the new manager wanted to ensure she met with staff as soon as possible and had arranged a team meeting to do this for 9 February 2017. The manager had a supervision plan in place and was in the process of ensuring each staff member had received a one to one supervision session. Staff we spoke with said they had received supervision from the manager and senior staff told us the manager had also competed group supervision with the registered nurses.

We found that staff had the knowledge and skills they needed to provide people with the care they needed. A visiting relative commented that, "Staff come and check [my family member] regularly day and night. The staff are competent and well trained.

We noted that new staff had undertaken introductory training before working without direct supervision. One care staff member told us about their induction and that it involved shadowing other colleagues and completing training to ensure they were competent to undertake the care staff role. The staff member also described how their induction had been organised in accordance with the requirements of the Care Certificate. This is a nationally recognised model of training for new staff that is designed to equip them to care for people in the right way. The provider told us any new staff they recruited would be undertaking the certificate as part of their induction. We also found that a most of the established care staff team had obtained a nationally recognised qualification in the provision of care in residential settings.

Information was available about the training staff had received and the future training the manager had planned for staff. The training matrix in place had recently been updated by the manager and any gaps in training for new staff were being planned for completion. During our inspection we observed staff applying their skills in the right way when they did things like helping people with their personal hygiene needs and to move around safely through the use of equipment. Staff worked together in co-ordinated ways to make sure those people who were at risk of developing sore skin or who needed extra help to promote their continence were cared for consistently. Other examples included us seeing staff correctly following good infection control practices such as regularly washing their hands and wearing disposable gloves and aprons when providing close personal care.

People had been supported to receive a range of healthcare services. This included having access to a visiting chiropodist and other healthcare professionals, including their local doctor when they were unwell. When it had been needed, people were also supported to attend hospital appointments regarding any specific health needs they had which required further assessment.

Throughout our inspection visit we saw drinks were readily available and offered to people. Care records showed that where people were at risk of poor nutritional intake, their weight was checked regularly to ensure it was being maintained. Care staff told us when it was needed they knew how to make any referrals to specialist services such as dieticians in order to request additional support and advice when required.

The provider also confirmed they had a vacancy for the cook's position and that whilst they were in the process of recruiting to the post they had been employing an agency cook. We spoke with the agency cook who showed us they planned the menus using the menus already in place at the home. They showed us they had access to the information about each person's dietary needs and preferences and that they understood how to provide the range of meals people wanted and it the way they needed to be served.

There was a large board near the entrance to the main dining area with lots of pictures depicting various

foods on it. We saw this had been set out to provide information about the meal options available for lunch and the evening meal. However, menus were not displayed on the notice board and the day's menu choices were not actually shown on the board. Care staff and people we spoke with told us they had one main option at lunch unless they asked for an alternative. Comments we received from people about the food they were provided with included; "The food could be better – we don't have choice really. I never know what's for lunch. We used to get to know earlier in the mornings, but we don't anymore. We have sandwiches for tea. I have jam, tuna, or egg as I like them. At around 8.15pm we have a last cup of tea with a biscuit for bedtime" and "They used to let you know what the meal was, but that's gone by the by now. Some of the stuff isn't very good. Mind you last Friday we had proper fish & chips from the local chippy and they were amazing. We should do that more often. Every Friday would be brilliant."

We discussed the feedback and our observations with the provider, two of the care staff team and the nurse in charge. They told us they had a full range of pictures which matched the menus but had been unable to locate them. During our inspection a staff member found them and they were placed on the board. After we completed our inspection visit the manager sent us confirmation that they were working together with the provider's agency cook to develop a new menu through discussions with people and their families and that any changes would be kept under review.

Requires Improvement

Is the service caring?

Our findings

People and relatives we spoke with told us staff were caring toward them and treated them with respect. One person said, "I know the staff well and feel well cared for. The staff and the manager including the home owners are respectful and it feels homely because of the way they care."

A relative said, "I come and go and all times of day. Take for example on New Year's Eve. I just popped in, they didn't know I was coming late and I just turned up. A massive buffet was laid out with wine and beer and everything. They were all having as really good time."

Another relative said, "They keep me well informed and always ring if there's anything. If [my family member] says they want to talk to me, well they just ring me and we have a quick chat and then [my family member] is okay again. It gives us both peace of mind and settles [my family member] back down again. Even on Christmas day, I came and had lunch here and the owner because he heard me say I was going home to then go and see my poor neighbour who was on their own insisted I took a turkey dinner for them, free, from here. How kind and thoughtful is that? That tells you what sort of place this is. [My family member] would certainly not be here if it wasn't the best. [My family member] has been in three different places before this. You can't fault this place."

We observed staff and people knew each other well and called each other by their first names when they spoke together. People were well dressed and we noted they had clocks and calendars in their rooms which were up to date. There was an up to date call system in place and we saw people could summon help using this system at any time. We saw staff responded to calls quickly. We also noted people's privacy was respected and doors to people's rooms had a sign saying "Please knock before entering" Signage was also clearly set out to guide people to communal toilets and bathing areas. The provider told us new uniforms had been ordered and was about to be delivered for all staff so that staff were would be easier to identify for visitors to the home.

However, we also observed that although staff were kind and caring they mainly focused on the tasks in hand. For example, we saw one person we spoke with in their room had some staining on their nightdress which had not been cleaned. We discussed this with the provider who responded to ensure the person had their needs fully met.

Whilst we spoke with one person in their room a member of the care staff brought the person a fortified yogurt. The person asked, "What's for lunch." The staff member explained the main course was gammon. The person indicated they were not keen on the option available. The staff member then offered an alternative saying, "Maybe a poached egg then?" the person responded positively and this was provided. We were concerned that choice had not been offered and an alternative was only given after the person had indicated they did not want the main meal option. At lunch time we also noted there were no table cloths on the dining tables, no napkins and one table had a cruet set but the other did not.

Lunchtime was a social occasion for those people who had their meals in the dining area. One person said

they liked to watch television when they had their lunch and we saw they were able to do this. Care staff knew where other people liked to sit and people were helped to prepare for their meals. As part of this preparation two people were supported to have protective aprons put on to maintain their dignity and we saw staff wore plastic protective aprons when they served the meals. However, we also observed some of the staff responses toward people were inconsistent. For example, one person really enjoyed their meal and ate it heartily. A member of the care staff offered another person a second helping after they had finished their meal which the person accepted and relished. Another care staff member sat at one of the dining tables with people and was helpful saying, "There you are, would you like any help?" and "Would you like your meat cutting up for you." We then we observed when one person had fallen asleep and a care staff member stood over and nudged the person saying, "Come on. Are you awake mate? "One person had a doll with them at all times during lunchtime at the table and was busy hand feeding the doll food from their plate. Staff enabled the person to do this as they understood they liked to do it. However, there was little encouragement for the person to eat the food themselves. Another person eat a little but left most of their meal. One of the care staff said "Would you like anything different?" but when the person did not respond the care staff member took the meal away and no alternative was brought.

We noted that in another part of the home there was a second dining room/sitting room which the provider told us was not currently being used as they were considering how best to utilise it. This room was light, bright and airy. We saw that some staff used this room for their meal breaks. When we asked why the room was not being used by people at lunchtime the nurse in charge told us it was less accessible and more difficult to serve the food there as it was further away and less convenient. They were not sure if any options for greater use of the room had been explored.

People's bedrooms were clean and had been personalised by people and their families with photographs, pictures, personal furniture items and memorabilia. All of the people we spoke with said they liked their private rooms and that they had control over when they wanted their doors shut. One person commented that, "I eat my meals in my rooms because I choose to as I am not as bad as the others in here you see."

People also told us how they had been given the choice to bring their own furniture and any personal belongings, including pictures in to the home if they chose to. When people had chosen to be in their rooms we saw staff knocked on the doors to the rooms and waited for a response before going in to provide care for people. We saw staff always ensured the doors to rooms and communal toilets were closed when people needed any additional help with their personal care. We saw signage was also fixed on doors asking that anyone who wanted to go into the room should first knock before entering. One person told us how they had, "A lock on my bedroom door on the inside because some residents wander into my room and I can now lock my bedroom door at night from the inside. I feel safer that way. I also have a lock on my wardrobe too because some of them come and take things out of your room without you knowing."

Bedroom doors had numbers to identify them and names. However the names were on plaques high above the doorframes and difficult to read. The provider told us this was to enable staff to know who lived in each room and wanted these to be discreet. However, we noted one of the bedrooms included the name of a person above the door who the nurse in charge apologised and confirmed this had been an oversight as the person had died in November 2016. The information was removed immediately. The provider said they were considering how they could improve identification and was planning to explore the inclusion of memory boxes outside rooms in order to personalise each of the room entrances.

People told us they received timely support with their personal care needs from care staff. However, although people told us they had been given the choice about whether they wanted a bath or shower it was unclear whether this was offered every day. For example, one person we spoke with told us they were able to

shower once weekly and had had their shower yesterday. They were unsure if they had a choice to do this every day but did say they felt happy that if they asked they would be supported to have a shower at any time.

Care staff told us and information in the home confirmed there was a hairdresser who visited the home weekly and one person we spoke with said, "I had my feet done yesterday and have my hair done." We also saw information which confirmed some people were supported to maintain their religious beliefs and that a Baptist pastor visited the home weekly.

A relative commented that, "They have cared for [my family member] so well. My health has improved also. This is a great place. I have seen a gradual improvement in the grounds, the home, and everything which is great. You will not find anything amiss. They are doing well. The staff are always very good, kind and caring.

We noted there was limited written information available within the home regarding advocacy organisations and how people could access these. This meant that people would not have been able to access the information to make contact with an advocate should they need to do so. Advocacy organisations can provide people with support to express their views and opinions and are independent of the care service registered providers. We spoke with the administrator who told us advocacy information had been on the main notice board in the home but this had recently been taken down so they could check it and ensure it was up to date. The administrator took action during the inspection to check, update the information and make it available for people to access.

During the inspection we saw that people's personal information was stored in the nurse's main office which was locked when not in use. The administrator also confirmed computer records were password protected to ensure they were secure. Staff demonstrated their understanding of the need to maintain people's personal information in a confidential manner when we spoke with them. They told us how they knew that this information should only be shared on a 'need to know' basis with those whom people had agreed to share their information with. However, we also noted information about the help needed for people who needed to evacuate the home in an emergency was on display on the walls in two communal areas of the home. We spoke with the senior nurse in charge about our concerns regarding this information being on display for anyone to read. The information was taken down and the nurse in charge said this would be stored together with the information about each person's care needs and would be accessible for staff reference only.

Requires Improvement

Is the service responsive?

Our findings

A relative told us, "We are encouraged to get involved if we want to. I am always made to feel welcome. I help [my relative] with all their meals and the staff know me very well and me them. We have good banter and I feel valued."

We saw care staff had completed an assessment of people's needs before they had moved to live at the home. Following these assessments senior staff had produced care records for each person who lived in the home. Care staff told us the records detailed the levels of care each person needed and how this should be given. When we asked people about their care and their involvement in the planning and delivery of care one person told us, "I know about my care plan and that they keep records about fluid charts and things like that." A relative we spoke with told us they knew about the care plan of their relative and they were happy with the care provided. However, they also said they had not been consulted about the care plan or what it contained. When we looked at care plan records we noted they did not give enough detail to show people and their relatives had been involved in the production of the plan and subsequent reviews of these. One person told us how they had chosen to stay in their room and their decision had been respected. They said although they were happy with the arrangements they also felt this was the only option and they couldn't move out of their room because it would be difficult for staff to move the oxygen container and the tubes attached to it. When we spoke to care staff about the options for the person to receive care outside their room they were unable to tell us if alternative options or arrangements had been explored together with the person through a review of the care plan.

We also saw that one person had been unwell and information about their condition had been referred to their local doctor. The record did not indicate if this had been responded to or followed up by staff at the home. We discussed this with the senior nurse in charge who told us a review and full discussion of the person's care had been completed with the doctor and a course of action decided upon together with the person and their family. However, this had not been recorded in the care plan to reflect the actions taken.

We spoke with the provider about the review process and they told us they and the new manager were in the process of reviewing and updating all of the care plans as they had not previously been kept up to date. They also said this would include more detailed records to confirm contact with healthcare professionals and for health professionals who visited the home. When we looked at the care records we saw this work was in the process of being completed but not yet finished.

The provider told us they had also been updating their home brochure and welcome pack to reflect the changes to the manager and team structure and that once it had been completed it would be available for all people and visitors to the home. In advance of this the provider said a draft copy could be provided for people at any time. However, at the time of our inspection we saw there was no information readily available for people to access to tell them about the home and what was provided.

People told us they had access to activities in the home and when we spoke with people about the support they received in making their own choices about the things they did one person said, "I have a friend who

comes and takes me out sometimes." Another person commented, "I don't go down and join the others. I prefer to do my crosswords and things. Mind you I don't watch the television much lately either. Let's face it its all Brexit and Trump isn't it just now?"

The provider told us they employed a part time activities co-ordinator at the home who also provided activities at another home owned by the provider. We spoke with the activities co-ordinator who told us they worked for 10 hours per week at each of the two care homes. They told us they had a four weekly planned activity programme in place and later during our inspection they showed us the planned activities they were undertaking. These included games, visiting entertainer's and one to one time with people. We also saw activities outside the home were scheduled and a trip to visit a local snow drop garden was being planned.

We observed the activity co-ordinator undertook some planned activities together with people including a large piece word jig-saw type puzzle with three people who they sat at a table together with. One person commented, "They have a chap comes in sometimes to do things and sing a longs." A relative said, "The activities lady comes to talk to [my family member] and chats to them now and then." [My family member] will only allow me to do certain things for them. [My family member] won't let the staff do things sometimes and that's fine. They are all kind and courteous and polite you really cannot fault them. They always deal with things appropriately. They are brilliant."

There was a range of photographs of people participating in activities and events, including visiting entertainers on the one of the homes main corridor walls. Staff and people told us sometimes relatives, friends and staff brought in their pet dogs and that people enjoyed this. During our visit a member of staff brought in their dog and people responded very positively to seeing the dog, engaging with it, stroking and petting it. We saw the home also had a resident cat, which people and staff said they were fond of.

The provider told us how they had also been supported recently by a newly appointed 'well-being consultant' to undertake some work to develop personal profiles regarding people's life history, backgrounds, interests and hobbies. We spoke with the consultant during our inspection and they showed us the profiles being devised wherever possible for each person. However, it was difficult to see how the work being completed was going to be incorporated in developing activities and the care plans. The provider told us they were due to discuss the work together with the new manager as part of the work being completed to further develop activities.

People and their relatives told us they were aware the provider had arrangements in place to respond to any complaints they had and there was a complaints policy and procedure contained in the providers statement of purpose. The manager had a concerns log which they used to record any informal concerns raised and the action taken to respond to these. Examples included the manager responding to issues related to lost clothing. People we spoke with confirmed this had been an issue and one person told us, "I have had missing laundry which is a bit annoying though. I have lost three brand new pairs of trousers recently." The provider told us the issues raised about clothing were in the process of being fully addressed and that this would form part of the discussions at a meeting being planned with people and relatives in the near future.

Three formal complaints had also received by the provider in the last year and the provider had kept records to show how they had responded, which was in line with the complaints policy. At the time of this inspection there were no outstanding concerns or complaints about the home.

Requires Improvement

Is the service well-led?

Our findings

Before we undertook our inspection the provider had informed us that they had recently had a change in the manager position at the home and that a new manager had been recruited and appointed on 4 January 2017. The new manager was not available for the inspection but both the provider and manager had confirmed with us that they were submitting an application to register with us. People told us they already knew who the new manager was and said that they were accessible and always helpful. People and their relatives also told us how the manager had quickly become established and one person said, "I feel safe here, absolutely so. We haven't had a leader for ages and you do need the discipline. We have had two managers over the last year. Nothing ever got done. The new manager is good. You can now rely on her. Another person said, "I think the manager is a very nice lady. Although they are new I think she will make a good job of it here."

The manager understood their role and their responsibilities under the Health and Social Care Act 2008 and associated regulations. The manager had informed CQC and other appropriate agencies of any accidents, untoward incidents or events which happened within the home. When any accidents or incidents had occurred they had been recorded by staff, discussed with and checked by the manager. If required steps were then taken to help prevent or reduce the risk of them re-occurring.

The provider told us that prior to appointing the new manager they, the lead nurse and the homes administrator had taken responsibility for overseeing the management of the home. During this period the provider told us how they visited the home regularly and that they were accessible to people, visitors and staff at all times. They confirmed as part of the interim arrangements for managing the home they had received support from the senior staff and the homes administrator. People told us they knew the provider very well. Ione person commented, "The gaffer seems a nice chap." However, we also found through our discussions with senior staff that the provider had not clearly defined each of the roles or responsibilities assigned to members of the management team and it was unclear who was responsible for particular areas of the management role. Also, as highlighted in the 'responsive' section of our report, although the provider had been receiving support from a 'well-being consultant' to further personalise care records and activities, it was unclear how the work being completed was to be used.

When we fed back and discussed our findings with the provider they said they fully recognised the need to establish a management approach which included clear definition and delegation of roles and responsibilities to the management team with the new manager having a lead role in this process. The provider confirmed they continued to work closely with the new manager in carrying out a range of additional audits and produce and action plan to follow up on the areas we had highlighted.

We also found that although some of the provider's previous audits had been carried out in relation to the environment, the areas identified for improvement had not been fully followed up. For example, the odour in one part of the home, the planned replacement of conservatory windows, re-decoration of doors to some people's rooms and the fitting of blinds in the main conservatory. The provider had also not taken action to fully address all of the issues related to people's care which we had highlighted earlier in our inspection

report, for example related to people's capacity to make decisions and choice for people.

They also assured us they would further improve the care processes and showed us they had produced an updated a business improvement plan with timescales and told us that all of the environmental work we had identified as needed would be completed during 2017.

The provider also told us they had already been working closely with the new manager on an action plan to address the shortfall in care provision identified. We could see this work was progressing through the input being given by the new manager. The provider told us they would continue to support the manager in the completion of all actions needed.

Staff told us how the new manager was being pro-active in reviewing processes and procedures already in place. One example given was when senior staff told us they were involved in handover meetings between care staff at the end of each shift so they could share information about any changes in care needs they needed to be aware of. The provider told us the manager was in the process of auditing the handovers and would provide us with information regarding their findings any actions needed to improve them. Following our inspection visit the manager sent us their audit findings and confirmed they had actions in place to address the issues they had identified which included the production of a new handover form to ensure all relevant details were recorded to facilitate better communication.

The provider told us the new manager was available daily for and people said they could speak to the manager at any time. People and relatives also told us the provider was well-known to them. We saw this was the case during our inspection, with the provider referring to people, visitors and staff by their first names. A relative said, "I think this is a well led home. The manager walks the floor and has a presence, and it's much calmer and happier she is super." The relative also added, "The owner has a presence. He knows them all and they know him." The provider said that they were developing greater links with the relatives of people and that they and the new manager had set up quarterly meetings with relatives and that a meeting had organised at the local pub for the forthcoming week.

We saw survey forms were available for people and visitors to the home to complete at any time. The provider also undertook quarterly satisfaction surveys for people who lived at the home, their relatives and staff. We looked at the provider's findings from the surveys completed in July 2016, October 2016 and January 2017. Overall the feedback they had received was positive. In their evaluation reports the provider had highlighted recommendations and actions resulting from the feedback they received. These actions were being fed into the provider's action plan which was in the process of completion. They included the refurbishment of the homes laundry room and other parts of the home which hey told us were in need of updating.