Athena Care Homes (March) Limited

Aria Court

Inspection report

Coronation Close
March
Cambridgeshire
PE15 9PP

Tel: 01354661551

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
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

Aria Court is registered to provide nursing and personal care for up to 92 people. People living at the home have physical needs and some of the people live with dementia. The home offers long and short-term stays. There are four dedicated units, called 'communities'. The communities are named Nene, Eastwood, Heron Court, and Wendreda. At the time of our inspection there were 74 people being looked after at the home.

This comprehensive inspection took place on 7 December 2016 and was unannounced.

The provider is required to have a registered manager as one of their conditions of registration. A manager was in post at the time of the inspection and the CQC was considering their completed application to be registered. 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 service is run.

People were kept safe and staff were knowledgeable about reporting any incident of harm. People were looked after by enough staff to support them with their individual needs. The provider was aiming to reduce the number of agency staff by recruiting permanent staff into vacant positions. Pre-employment checks were completed on staff before they were assessed to be suitable to look after people who used the service. People were supported to take their medicines as prescribed. Audits of people's medicines were carried out although this was an area for improvement. This was to ensure that people's medicines continued to be managed safely.

People were supported to eat and drink sufficient amounts of food and drink. They were provided also with choices of food and drink to meet their individual dietary preferences and requirements. However, additional helpings were not always offered. Menus were not consistently followed as the catering staff had the need to make changes on the day. Nevertheless, people were satisfied with the changes. People were helped to access health care services. This was to ensure that their individual health needs were met. However, the management of some people's individual health needs placed them at risk of harm to their health and well-being.

The CQC is required by law to monitor the Mental Capacity Act 2005 [MCA 2005] and the Deprivation of Liberty Safeguards [DoLS] and to report on what we find. The provider was aware of what they were required to do should any person lack mental capacity. People's mental capacity was assessed and people were able to make decisions about their day-to-day care. Staff were not yet fully trained in the application of the MCA: there was an inconsistent level of understanding about this piece of legislation and the application of this in staffs' working practice.

People were looked after by staff who were trained in some areas and supported to do their job. Staff were supervised and worked well with each other. Induction training and on-going training programmes were in

place to keep staff up-to-date to provide people with the right care.

People were often looked after by kind staff who treated them with respect and dignity. Most, but not all, staff respected people's right to confidentiality and privacy. This was because some staff members inappropriately discussed some people's sensitive information in communal areas where other people were in hearing distance. Staff were attentive to people but this was not carried out in a consistent way. People living with dementia, and who were of a quieter nature, had less staff interaction than other people who were more vocal and active. People and their relatives were given opportunities to be involved in the setting up and review of people's individual care plans. People were able to receive their guests at any time and had made friends with other people living at Aria Court. Information about advocacy services had not yet been made available.

Care was based on people's individual needs and helped to reduce the risk of social isolation. However, in some instances, the care provided failed to meet people's individual social and care needs. Recreational activities were limited and people living with dementia did not always have the right care to meet their individual needs. Furthermore, there were delays in helping people to be more comfortable and help to eat their meals. Staff had access to up-to-date care plan guidance and had knowledge about meeting people's individual care needs. There was a process in place so that people's concerns and complaints were listened to and action was taken to address them.

The manager was supported by a team of management staff, ancillary staff and a team of nursing and care staff. Staff were supported and managed to look after people in a safe way. Staff, people and their relatives were able to make suggestions and actions were taken as a result. Quality monitoring procedures were in place and action was taken, or planned, where improvements were identified. A number of changes had been made to improve the culture and quality of people's care. Work was in progress to embed such changes into practices and overall improve people's experience of living at Aria Court. There were community links with various external agencies. Not all staff were aware of the whistle blowing policy and procedure. This reduced the provider's ability to demonstrate their aim to operate an open and transparent culture.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual needs were met by sufficient numbers of staff.

People were kept safe as there were recruitment systems in place which ensured they were looked after by suitable staff.

People's medicines were safely managed. Audits were in place and areas of these identified where improvements were needed. However, remedial actions had not been completed.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was acting in accordance with the Mental Capacity Act 2005 legislation to protect people's rights. However, staff were not fully trained or knowledgeable about the application of the MCA when looking after people.

People's individual mental and physical health needs were not always met to keep them well and comfortable.

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

Is the service caring?

Requires Improvement

The service was not always caring.

People were often looked after by kind and attentive staff but this was not carried out in a consistent way.

People's rights to independence, privacy and dignity were valued and respected. However, people's right to confidentiality was not always upheld.

People were involved and included in making decisions about what they wanted and liked to do.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's individual health and social care needs were met but this was not carried out in a consistent way.

People's needs were kept under review to ensure their planned care was appropriate to their needs.

The provider had a complaints procedure in place which enabled people and their relatives to raise their concerns. These were responded to, to the satisfaction of the complainant.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were community links with external agencies. However there was an inconsistent standard of staff knowledge about whistle blowing procedures. This reduced the provider's ability to demonstrate their ethos of openness and transparency.

Management systems were in place to ensure that staff were aware of their roles and responsibilities in providing people with the care that they needed. However, these were new and needed to be embedded to improve and sustain the quality of people's care.

Quality assurance systems were in place which continually reviewed the quality and safety of people's care.

Aria Court

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 7 December 2016 and was unannounced. It was carried out by one inspection manager, two inspectors, 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 provider completed a provider information return (PIR) and sent this to us before the inspection. 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.

Prior to the inspection we made contact with a local authority monitoring officer; local commissioners [employees responsible for people's placement], and a nurse from a local NHS continuing care department. We also received written information from a local fire safety officer [FSO]. This was to help with the planning of the inspection and to gain their views about the quality and safety of people's care.

During the inspection we spoke with the manager; the operations director, and a care and quality manager. We also spoke with an activities co-ordinator; the head chef; one team leader; one laundry assistant; two registered nurses; one agency member of care staff; two community leads [staff who were in charge of each unit]; one clinical lead nurse, and seven members of care staff. In addition, we spoke with nine relatives and sixteen people living at the home, some of whom were able to tell us about their experience of living at Aria Court. We observed how people were being looked after. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at seven people's care records and medicines' administration records. We also looked at records in relation to the management of staff and management of the service, including audits and minutes of meetings.

Good

Is the service safe?

Our findings

We found people were kept safe from the risk of harm because of how they were looked after. People told us that they felt safe because of how staff treated them. One person described the staff as being "kind". Another person told us that they felt safe because of how the staff helped them transfer by means of a hoist.

We found that people were kept safe from the risk of harm because there were safeguarding procedures in place. The provider told us in their PIR that, "All staff receive training prior to starting work on the floor including SOVA [safeguarding vulnerable people from abuse] training. All staff are informed that they can report to the manager, CQC and the local SOVA team." Members of staff were aware of their roles and responsibilities in safeguarding procedures. They were able to describe the types of harm people might experience. In addition they were able to describe the signs of symptoms that people could show if they were being harmed. The clinical lead nurse said, "[The person] could be withdrawn; look neglected. Bruising or marks on their skin." One member of care staff said, "There would be change in [person's] behaviour. Or bruising." Staff members were aware of the correct safeguarding reporting procedures and they had access to information about this. The provider had submitted notifications to us which showed that they had followed the correct reporting procedures.

We found that only suitable staff were employed to look after people. The provider told us in their PIR that "references and police checks are obtained before employment [of staff]." Members of staff described their recruitment experience. One nurse told us that they had to have two written references and said, "One reference from my previous employer." They added that they had completed an application form; attended two face-to-face interviews and had a satisfactory Disclosure and Barring Service police check. One member of care staff also told us that they had such checks in place and these were "definitely" carried out before they started their new job. Recruitment checks were kept on file and these confirmed what staff told us. When staff were found not to be suitable to look after people, or failed to meet the expectations of their role, the provider had carried out disciplinary procedures. New staff were also subjected to a probationary period during which time they had to demonstrate that they were suitable to look after people. Otherwise their contract to continue to work would be terminated. The PIR read, "Probationary reviews are carried out and under performance in probation is managed."

People were looked after by enough staff. One person said, "There are a lot of people [staff]." One relative said, "There's always someone [staff] walking around to check. So yes, I feel [family member] is safe." We saw there was enough staff and people's call bells were answered within less than one minute.

The provider told us in their PIR that a high number of staff [51] had left their employment. There were vacant staff positions and a high number of hours were filled by agency staff. However, there was successful recruitment of new staff to fill some of the vacant posts. Since receiving the PIR, the provider had made progress in reducing the number of agency staff and increasing the number of permanent staff. The manager said, "I have appointed new staff. We were heavily reliant on agency nurses." The agency member of care staff said that they had frequently worked at the home and this ensured that the people who they looked after, had a continuity of care. The head chef told us that their work situation had "got a lot better"

and attributed this to an increase in the numbers of catering staff. Members of other staff also told us that there was enough staff. The clinical lead nurse said, "I would say we have enough staff." One member of care told us that, on occasion, the numbers of staff had been less than usual. They said that other permanent staff were asked if they wanted to work extra to cover. They added that, although there had been times when there had been a reduced number of staff, people's care needs were still being met. They said, "Everything gets done but people are waiting." The PIR read, "Sickness and annual leave management is overseen by the management team, this includes allocating annual leave where necessary and back to work interviews."

People's assessed needs determined the number and type of staff to meet people's individual needs. In their PIR the provider wrote, "Staffing is adapted to number of residents [people living at the home] and their dependency." However, the local commissioners told us that they were not fully satisfied with the quality of one-to-one care. Before the inspection a visitor told us that staff members had failed to follow one person's one-to-one planned care. As a result of the lack of this close supervision, the person and other people had been placed at risk of harm. Because of these concerns we looked at this further during our inspection. The manager had taken satisfactory action to address the concerns. We found that people, who had been assessed to need one-to-one support, had the one-to-one care which was in line with their planned care.

We found action was taken to keep people safe due to the management of people's individual risks. These included risks associated with development of pressure ulcers; inadequate nutrition and falls. Measures were in place to manage the assessed risks. These included, for instance, the provision of pressure-relieving aids; fortified foods and equipment provided to minimise people's risks of falls. Risks were well-managed with good outcomes for people. For example, one relative told us that since their family member had moved in to the home, they had not experienced any falls. This was compared to the high number of falls that they had experienced before moving into the home.

Before the inspection the fire safety officer [FSO] told us that they had inspected the home during October 2016. They reported that they were satisfied with the fire safety arrangements of the home. Staff had attended training in fire safety and people had individual evacuation plans in place. This was so that staff had the guidance to help people to safety in the event of a fire or any other untoward event, such as a flood.

We checked to see how people's medicines were managed. We found that people were satisfied with how they were having help with taking their medicines. One person said, "I'm a diabetic. I'm on tablets." They said that they had these when they needed them. Another person told us that they were on a number of prescribed medicines and that these "helped" them keep well. One member of care staff demonstrated their knowledge about maintaining people's skin with the use of a range of prescribed creams and shampoos. One nurse told us that they had no concerns about the ordering of or stock levels of people's medicines. They showed that they had a good oversight of the ordering and obtaining of people's prescribed medicines. Through their auditing they had found one person's amount of available prescribed medicines failed to reconcile with the records. They advised us of the satisfactory action they were taking to address this issue.

People's medication administration records [MARs] showed that people had taken their medicines as prescribed. This included 'as required' medicines and protocols were in place to advise staff when these should be used. We found that one person was given 'as required' medication to make them feel calmer. However, their care records failed to show the justified reason for the administration of the medicine. We brought this to the attention of the manager.

In their PIR the provider wrote, "Medication is managed with regular training, competency tests and monthly

audits with subsequent action plans." We found evidence to support this statement. Staff members, who were responsible for managing people's medicines, told us that they had the qualifications and training to do this. Records showed that they had their competencies assessed to ensure they were safe in managing people's prescribed medicines. Monthly audits of people's medicines were carried out and remedial actions were identified to rectify any deficiencies found. This included, for example, lack of detailed 'as required' medicines protocols. However, it was unclear when the remedial actions had been completed. For instance, we found 'as required' medicines protocols, were insufficient for staff to be guided in the course of actions to take before such medicines were to be used. The manager said, "It's [audit of medicines] is not robust enough and the process has not yet been embedded enough. I have every confidence that we have the right people [staff] in place to provide consistency and embed the process we have in place."

Requires Improvement

Is the service effective?

Our findings

We checked to find out if people were being looked after in a way that protected their rights. We found that the provider was ensuring that people's rights were respected in line with the Mental Capacity Act 2005 [MCA]. The 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 MCA 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 registered services are called the Deprivation of Liberty Safeguards [DoLS]. We checked whether the provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We received mixed feedback about how people's rights were being protected. The nurse from a local NHS continuing care team said that people's mental capacity had been assessed and relevant DoLS applications had been made to the appropriate authorities. In their PIR the provider wrote, "Where best interest decisions are required to keep a resident [person living at the home] safe we use the relevant MCA and DoLS processes." However, local commissioners told us that the provider had some but not a full understanding of the application of the MCA. Because of this mixed feedback we decided to explore this further during our inspection.

We found that where people's authorised DoLS were in place, the conditions of these were being followed. This included, for instance, close supervision of the person. This was to ensure that such restrictions, including constant observation, were legally authorised. The manager told us that referrals had been made to the appropriate agencies to carry out DOL assessments for other people.

The provider had a process in place to assess people's mental capacity to make informed decisions for themselves. However, the documentation was that belonging to another provider. We brought this to the attention of the manager and the operations director. This was for them to make sure that the assessments remained legally valid. We saw staff offer people choices about their day-to-day care. However, staff told us that they had not attended training in the application of the MCA. In addition, they were unable to consistently demonstrate sufficient knowledge about this piece of legislation. We were not fully confident, therefore, that people's rights were being fully protected. For example we saw that a GP had approved the use of covert (hidden in food or drink) medicines as part of a 'best interest' decision. However, the GP's instructions lacked the individual names of the prescribed medicines, which they had authorised, to be given in a covert way. No action had been taken by staff to gain more detailed information from the authorising GP. Therefore, people who were prescribed covert use of medicines were at risk of unlawful care. We brought these findings to the attention of the manger and operations director. The manager advised us that arrangements were in place for staff to attend a local authority MCA training programme during

January 2017.

We checked and found that people were being looked after by staff who had some training and were supported to do their job. The provider told us in their PIR that "… all staff are well trained from induction onwards and training is updated as required." A newly appointed member of care staff said that they were attending induction training. This included 'shadowing' members of nursing staff. This 'shadowing experience included observing colleagues at work and alternatively being observed by them. Observations included moving and handling and medication practices. Other staff members told us that they had the opportunity to put forward training suggestions and the manager had listened to these suggestions. One member of care staff said, "If we suggest a training course that you are interested in they [management team] get on to it." There was a training and development plan in place which identified up-to-date and out-of-training needs for staff. The manager told us that the training of staff was one of their priorities and arrangements were in place for staff to attend training during 2017.

Staff told us that they had attended supervision session and records supported what we were told. One member of care staff said that they had their one-to-one supervision "two months ago" during which they discussed their training needs. Staff said that they felt well-supported and worked well as a team. Staff said that they felt that the spirit of team work had improved with the increase of permanent staff and reduction in the use of agency staff. One member of care staff said, "Staffing levels have improved and it is more supportive [team work]."

We checked to find how people's nutritional health was met. People told us that they had enough to eat and drink (although some people were not always offered extra helpings of food) and said that they liked the food. One person told us that the food was "hot enough" and they got a choice of what they wanted to eat and drink. We saw people were offered cold and hot drinks throughout the day However, for one person, we found that the amounts of what they had to drink were last recorded on 29 October 2016 and no other records were available. One registered nurse and the clinical lead nurse told us that the person had recently been treated for infections. The registered nurse advised us that the person was not able to drink or eat during the morning of our visit. Due to the lack of food and drink monitoring records it was unclear how the person's nutritional and hydration needs were being monitored. We brought this to the attention of the manager and operations director. Other people were prompted and encouraged to eat and drink and we saw good examples of this.

Before the inspection we had received concerns from visitors in relation to the differences between menu options and the actual food served. We therefore explored this further during our inspection. The menu for the day described the food options which included two hot dishes, gammon or scampi, and a dessert of tapioca. However, food served varied from that written on the menu. The head chef told us that the changes were made due to the lack of scampi and most people's dislike of tapioca. They advised us that remedial action would be taken to ensure that food supplies would not run low. This included providing catering staff with written information about what to do when they, the head chef, was not working. We saw people accepting and eating these changes of the menu. After eating their lunch we heard one person say, "That was lovely. I enjoyed that."On the day of our visit the menu stated that there were options which included two hot dishes, gammon or scampi, and a dessert of tapioca. However, food served varied from that written on the menu. The head chef told us that the changes were made due to the lack of scampi and most people's dislike of tapioca. They advised us that remedial action would be taken to ensure that food supplies would not run low. This included providing catering staff with written information about what to do when they, the head chef, was not working. After eating their lunch we heard one person say, "That was lovely. I enjoyed that."

People's individual dietary needs were catered for. The catering staff had information about these so that they were able to prepare food to meet people's individual dietary needs. This included, for example, gluten free and healthier eating diets for people with diabetes. Soft and pureed foods were available for people who had difficulty with swallowing. People who were at risk of unintentional weight loss were offered fortified foods and nutritional supplements, such as milk shakes. We saw one person, with a recorded low weight, accepting the offer of a milk shake from a member of care staff. The records of people's weights and risk assessments demonstrated that people's nutritional needs were being monitored and kept under review. These records showed that people's nutritional needs were being met due to stable weights.

We checked to see how people's individual health needs were being met. The provider told us in their PIR how people were helped to access a range of health care services. The PIR read, "We ensure that all residents [people living in the home] have access to relevant professionals such as dietician, SALT [speech and language therapist], TVN [tissue viability nurse], GP and also have access to services such as hairdresser, chiropodist, optician, dentist, alternative therapist and others." People's records and what people told us supported the provider's statement.

People's health needs were met but this was not in a consistent way. People at risk of pressure ulcers were being helped to reposition to reduce harmful pressure. People were also provided with aids to reduce the risk of falling. Furthermore, for one person who had high complex nursing needs, they had received a good standard of oral care and their skin was clean and intact.

However, we found examples where people's health needs were not being fully met. We found one person was complaining of neck and knee discomfort due to the way that they were lying in bed. In addition, we noticed that that their electric pressure-relieving mattress was put at an incorrect setting. We brought these concerns to the attention of a registered nurse who took remedial action. For another person, who had diabetes, they were found to be 'sleepy' the morning of our visit. Records of the date of when the levels of their blood sugar was last recorded was that of 29 October 2016. At our suggestion the registered nurse checked the person's blood sugar level and advised us that they would report this recording to the person's GP for their medical opinion. We saw that other people's well-being was met with how staff engaged with them but this was not consistently carried out. We found that staff readily engaged with people living with dementia who were more physically and vocally active than those who were quiet. Some people were asleep. The manager and operations director considered that this state of being asleep may be related to a lack of engagement by staff. The care and quality manager told us that, as part of the provider's improvement plan, the quality of how staff engaged with people was part of the staff training plan. They described the teaching methods used and how feedback to staff was to increase their understanding.

Requires Improvement

Is the service caring?

Our findings

We checked to find out if people were being looked after in a caring way. The NHS continuing care nurse told us, "On the whole the service users I saw appeared well cared for…" People told us that the staff were kind to them. One relative said, "Staff seem quite nice. [Family member] likes some better than others but has always said they are nice. If we require help they [staff] are always willing to [do] this for you." The team leader said, "I treat people like I want to be treated."

People's right to confidentiality was maintained but this was not consistent. People's recorded confidential information was held securely in offices with coded doors. However, other sensitive or confidential information was not consistently upheld. During lunch time care and nursing staff discussed one person's dentition in the dining room which was occupied by other people. We requested staff members not to discuss the personal subject in such a way. We also heard another example of a breach of a person's confidentiality. One registered nurse spoke with a community nurse about one of the people's medicine allergy. The discussion took place in a communal space where other people were present. We brought this to the attention of the manager and the operations director.

People's right to dignity was maintained. We saw that people were provided with a satisfactory standard of personal care. One person said that recently they been to the hairdresser. They said, "It's so important to look nice." One relative told us, however, that they had concerns about how their family member was helped to keep their teeth and spectacles clean. They said that they often found that the toothpaste had not been used and their family member's eye glasses were sometimes smeared. We saw that people wore clothes that were clean and well-ironed. During our visit to the laundry room we found that care was taken regarding the washing and pressing of people's personal clothing. One person's relative described the laundry service as being "excellent." People's rooms were personalised with ornaments, photographs and pictures. However, for one person we noticed that they had no means to tell the time and their room was void of personal items.

People's right to privacy was valued. The premises maximised people's privacy. In their PIR the provider told us that all bedrooms were for single use only. We found that communal bathing and toilet facilities were provided with lockable doors. People had access to communal lounges where they received their guests or in the privacy of their own room. We saw people were helped with their care and this was behind closed doors. We also saw one person was covered up when they were being transferred from their bedroom to have a shower in one of the communal bathing facilities. In addition to this, we saw staff also cover people up when their clothing had become disarranged.

People's right to independence was valued. One person told us that they were independent with washing, dressing and eating. Another person said, "I can do it [personal care] by myself." We saw people were encouraged to maintain their independence with eating and drinking.

People were able to choose what they wanted to do. One person said that they chose to sit in the quiet of their room but ate meals with other people in the communal dining room. Another person told us that they

liked to sit in the quiet of their room to watch television and eat their breakfast. One person's relative told us that, because their family member had difficulties sleeping at night, they were left to sleep on until it was time for lunch.

The provider told us in their PIR that people were provided with the opportunity to attend meetings. This was so that they were able to make decisions and choices about their care. Relatives told us that they had been included in the drawing up and reviewing of their family member's care plan. One relative told us that they received letters to invite them to attend such reviews. On a more informal basis they said that they discussed their family member's care with staff on a regular basis.

The manager told us that no advocacy services were being used but they were aware of the local availability of these and when people might need to access these services. The operations director advised us that information about advocacy services was to be detailed in the forthcoming service user's guide. Advocacy services are independent and support people to make and communicate their views and wishes.

Requires Improvement

Is the service responsive?

Our findings

We checked to find out if people were being looked after in a way that their individual needs were being met. We found that people's needs were being met but this was not consistently carried out. For example, we saw people were offered a visual choice of what they wanted to eat for lunch. However, there was a delay of when they were served their choice of food. This meant that people with memory difficulties were not give their choice of food straight away. We saw another person was offered a choice of what they wanted to eat. They had fallen asleep while waiting for their lunch to be served to them. Other examples included one member of staff offering one person, who was living with dementia, a visual choice of what they wanted to eat. However, this good practice was not consistent: another person, who was also living with dementia, was not given the opportunity to make such a choice from a visual presentation. In Wendreda community people were not adequately supported to eat their food. There were sufficient numbers of staff but the meal time experience was insufficiently organised to be able to fully respond to people's eating needs. Furthermore, we heard a senior member of care staff correct one person's sense of reality. The person, who was living with dementia, had beliefs in place but the member of staff told the person that their beliefs were not factual. This action failed to demonstrate how the person's dementia care needs ought to be met.

The nurse from a local continuing care department told us that permanent staff members were aware of people's individual needs. People told us that they believed staff knew about them. We found that staff had knowledge about people and their care needs. This included, for instance, the reason why people moved into the home; their family and medical history. Information about people's life histories and what was important to them, was recorded.

People were enabled to maintain contact with their friends and relatives. The provider wrote in their PIR, "Residents [people living at the home] are encouraged to maintain friendships and relationships. Visiting to the home is open." One person said that they were able to have visitors at any time. One relative said that there were no restrictions when they could visit as there was "open visiting." We saw people receiving their guests and were able to do so for as long as they wanted to stay.

We found, however, that people's other social care needs were inconsistently met. During our visit we found that some people were encouraged to take part in activities, which included helping decorate a Christmas tree. People also told us that they had recently visited a local village to see Christmas decorations. Other people said that they had attended quiz competitions and had taken part in games of 'bingo'. One relative told us that they felt it would "help" if staff had more time to sit and talk to people. We saw some staff sitting taking to people during a quieter time of the afternoon. Nevertheless, we noted that there was a lack of activities provided for other people. One relative said that one of the activities co-ordinator "had done marvellous things" but believed there should be an increase in the number of activities co-ordinators employed to work at the home. The manager and operations director were aware that this was an area to be improved upon.

Before people were admitted to the home their individual needs were assessed to ensure that the home was a suitable place for the person to move into. The provider told us in their PIR, "A full pre-admission

assessment is carried out that recognises residents' [people living at the home] needs and wishes with regards to their care." Two relatives told us that they had been involved in their family member's pre-admission process. They said that the assessment was carried out by a senior member of staff during which the relatives contributed to the development of the initial care plan. One of the relatives described the pre-admission process as being "excellent." On arrival to the home the person and their relatives were met by a member of care staff who gained further information about the person's likes, preferences and care needs. These included food preferences and their need to have help with washing and dressing.

The provider told us in their PIR that people's care records were, "… reviewed regularly (monthly minimum or as changes occur) and are individualised and personal to the resident [person living at the home] concerned. Care plans include choices and wishes of each resident as to how they like to be cared for." The nurse from a local continuing care department told us that action was being taken to improve the quality and completeness of people's care records and risk assessments. They told us, however, that improvements were needed in relation to records for those people who required close one-to-one supervision. Because of the nature of this feedback we decided to explore this further during our inspection. We found that people's records to monitor and review their behaviours that challenge were in place and up-to-date. However, we found that there was no care plan or risk assessment in place for another person with mental health needs. Staff, however, were knowledgeable about how to look after and manage the person's behaviours that challenged.

We checked to find how the provider responded to any complaints raised. We found that, from notifications, the provider had investigated concerns and taken remedial action, if needed. This included, for example, providing staff with clearer guidance in how to meet a person's individual mental health needs. In addition to this, the provider told us that they had analysed the emerging themes from complaints that they had received. The two main emerging themes were related to staffing numbers and malodours within the home. Remedial action was taken to improve these two identified areas. Recruitment of permanent staff had been carried out and arrangements were in place for the replacement of flooring in the corridor of Nene community.

People were aware of who to speak with if they wanted to raise a concern or complaint. One person said, "I would speak with [name of a team leader]." Another person said, "I soon tell them if I am not happy." One relative told us that they would speak with the manager if they wanted to raise a concern or a complaint. Members of staff were aware of what action they needed to take to help people through the complaints process. The provider had a complaints procedure in place and the record of complaints showed that the provider was following its complaints procedure. Complaints were responded to within 28-days and action was taken, if needed.

Requires Improvement

Is the service well-led?

Our findings

We checked to find out how the home was being managed. The provider aimed to operate an open and transparent culture. In their PIR they wrote, "Whistle blowing is encouraged for staff, residents, relatives and visitors. The home manager has an open door policy. The manager carries out thorough investigations into any concerns received." Notifications and information about such concerns showed that the provider had investigated whistle blowing concerns. Some but not all of the staff were, however, aware of the whistle blowing policy and procedure. One member of care staff said that they knew where the confidential contact telephone number was held to use if needed. However, they told us that they were not aware of when to use it and how the process protected them. Another member of care staff said that they had not heard about whistle blowing before. Nevertheless, other staff members were able to tell us about this. Furthermore, all staff said that they would have no reservations in reporting poor practice if needed.

The provider aimed to operate an open and transparent culture. Following our inspection the operations director told us that community links had been made with local dignities; educational establishments; a visiting local choir, and charity and a named retailer who help to improve the external premises of the home.

Before our inspection the manager had applied to be registered and their application was in progress. During their interview with our registration team, the manager showed that they had identified a number of areas that required improvements. These were in relation to, for instance, the refurbishment of the premises; staff training and supervision and an increase of permanent staff to reduce the number of agency staff. Improvement plans were in place with set timescales for these actions to take place and be completed. In addition to this information we also received positive comments from a nurse of the local NHS continuing care team. They told us that, "In respect of the leadership of the home although they have had several managers in the home recently the impact of [name of manager] being at the home is that [manager] is an experienced care home manager who has specialised in dementia care and should have the necessary skills to successfully manage the home. When I have visited the home I have found that [name of manager] engages fully and admits there is work to be done and this is an on-going process."

The manager was aware of the challenges they faced in improving the quality of people's care and the culture of care within the home. This included reviewing the experience and qualifications of staff and their attitude to their work and adapting to change. They said that they were aware that such changes had created a newer team of staff and changes in practice were still to be fully embedded. The clinical nurse lead told us that members of nursing and care staff had listened to them. This was to change the way that they worked and improve the standard of care practice. They gave examples of this by ensuring staff followed correct infection control procedures and keeping hazardous equipment safe behind locked sluice doors.

People and relatives knew who the manager was and we saw good interaction between the manager and visitors to the home. Members of staff had positive comments to make about the manager. One member of care staff said, "I find it's [the home] more organised and more settled than ever in the three years since I have been working here." The team leader said, "It's [the home] better. They [management team] have turned it around a great deal. We have a 'settled' manager rather than having no stability and no

involvement with the residents [people living at the home]. This is much better now. The manager needs to know the residents and which they do."

People were actively consulted about the quality of their care. The provider told us that surveys had been carried out to obtain people's views. Action plans were developed based on the outcome of the surveys and work was in progress to complete the actions during 2017. In addition to surveys, the provider told us that there was another quality assurance system in place to listen to what people had to say. This was due to surveyed respondents asking for improved communication from the management team. The provider told us in their PIR, "Regular residents' [people living at the home] meetings are held to encourage them to be as involved as possible in the home's decision making." Minutes of these were seen and suggestions were made and actions were taken. One relative gave an example of how they suggested the rearrangement of furniture to aid more social engagement between people when they were sitting a communal area. They told us that staff had taken action based on what they had suggested.

Staff were also actively consulted about their views. Each morning senior staff from different departments met with the person in charge of the home. This was to keep all staff up-to-date with events occurring in the home and reviews of people's needs. The clinical lead nurse gave an example of providing up-to-date information in relation to people's changes in their conditions. The head chef said that, now there was more catering staff employed, they would have the opportunity to contribute to such meetings and also provide feedback about people's nutritional needs.