Shaw Healthcare Limited

Warmere Court

Inspection report

Downview Way
Yapton
Arundel
West Sussex
BN18 0HN

Tel: 01243551827
Website: www.shaw.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 and 5 August 2016 and was unannounced.

The home provides nursing care and accommodation for up to 40 older people including older people living with dementia. The home is purpose built and has two floors accommodating up to 20 people on each floor. People who required nursing care lived on the first floor and those who needed personal care on the ground floor. At the time of the inspection 37 people lived at the home. Each person had their own bedroom with an en-suite facility. Communal areas consisted of lounge areas, dining rooms and rooms where people could meet others. There was a garden which people could access. A day centre for up to eight people was run in one area of the home and residents were able to attend. This facility is not registered with the Commission and therefore did not form part of this inspection. The home had a staff team of four registered nurses: two full time and two part time plus staff for catering and domestic duties. The provider was taking action to recruit additional nurses.

The home did not have a registered manager, but there was a manager in post who was in the process of applying to register with the Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

The previous inspection report for an inspection on 2 June 2015 made two requirements where we found breaches of the regulations:

- Care was not always provided safely to people. This included people being placed at risk when being moved in a wheelchair and a lack of care planning for managing pressure areas on people's skin.
- Staff did not always respond to people's requests for assistance.

The provider submitted an action plan on how these requirements would be met. At this inspection we found the provider had taken action to address these requirements, but there were still some areas for improvement. People were observed to be safely moved in wheelchairs. Care records showed pressure areas on people's skin were well managed. However, we found air mattresses used to reduce pressure on people's skin were not always set correctly. This negated the benefits of the equipment to relieve pressure on people's skin. The manager took action to address this at the time of the inspection. Risk assessments clearly identified areas of risk to people and care plans gave staff guidance on how to mitigate risk. Staff were observed to help people when they needed it, but we observed two occasions when staff were slow to support two people with their food at lunch time.

Sufficient numbers of registered nurses were not employed. This included a lack of a registered nurse who could act in a role to co-ordinate nursing care to people as well as a lack of nurses appropriately trained to

provide catheter care to some residents.

The Commission were not always notified of incidents as required by the Regulations.

Staff were trained in safeguarding adults procedures and knew how to report any concerns.

Since the last inspection, concerns were raised by the local community nursing team regarding medicines procedures for people living with diabetes. At this inspection we found people's medicines were safely managed. Staff were trained and assessed as being competent to handle and administer medicines.

People told us they were supported by staff who were well trained and competent. Staff had access to a range of relevant training courses and said they were supported in their work.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff and the manager were aware of the principles and guidance associated with the MCA. Where needed, assessments of people who lacked mental capacity to consent were carried out and applications made for DoLS.

People were supported to eat and drink and to have a balanced diet. Special dietary needs were catered for and nutritional assessments carried out when these were needed so people received appropriate support. There was some criticism from people about the quality of food and the provider confirmed this was already being addressed after being highlighted during the provider's quality audit.

People's health care needs were assessed and recorded. Care records showed people's physical health care needs were monitored and that people had regular health care checks.

Staff treated people with kindness and had positive relationships with people. Staff were observed to ask people how they wanted to be supported. People and relatives described the staff as caring and helpful.

People's care needs were assessed and care plans reflected people's preferences on how they wished to be supported.

A range of activities were provided for people and there was an activities co-ordinator.

The complaints procedure was displayed and people said they knew what to do if they were dissatisfied with the service they received. A record was made of any complaints along with details of how the issue was looked into and resolved.

The manager had a good awareness of the issues facing the service and of the care of each person. The provider sought the views of people and their relatives about the service. A number of audit tools were used to check on the effectiveness of care plans, medicines procedures, the environment, catering and cleanliness. These were carried out by the manager and by the provider.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service did not employ sufficient numbers of appropriately qualified staff, especially registered nurses.

Staff knew how to recognise, respond and report any suspected abuse of people.

Risks to people were assessed and action taken in line with care plans on how to mitigate against risks.

Checks were made that newly appointed staff were suitable to work with people in a care setting.

Medicines were safely handled and administered.

Is the service effective?

Good

The service was effective.

Staff were trained so they had the skills to provide effective care.

Staff were trained in the Mental Capacity Act 2005 and assessments were carried out where people did not have capacity to consent to their care and treatment.

People were supported to have a balanced and nutritious diet and the staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good

The service was caring.

Staff interacted well with people and treated them with kindness and humour.

Staff showed a commitment to caring for people and ensuring people were treated well.

People's privacy and independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed and care plans provided guidance for staff on how to support people. The service employed an activities coordinator so people's social and recreational needs were met. .

There was an effective complaints procedure which people, and their relatives, were aware of. Complaints were investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications regarding possible neglect of people were not always notified to the Commission.

The manager was in the process of applying for registration with the Commission. There was a lack of a lead registered nurse for coordinating nursing care.

The provider sought the views of people and their relatives about the service and took action to make improvements.

There were systems of audit and checks on the standard of care, the environment and medicines.

Warmere 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. The inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 and 5 August 2016 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

Some people who used the service were unable to verbally share their experiences of life at Warmere Court because of their complex needs. We therefore spent time observing the care and support they received in shared areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spoke with seven people and to two relatives.. We also spoke with six staff, the manager and the operations manager for Shaw Healthcare Limited. Two members of staff from the management teams of two of the provider's other services registered with the Commission were present and involved with the inspection.

We looked at the care plans and associated records for seven people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision records.

We spoke with three community nurses who supported people in the home and with a social worker and social service's team manager. We also spoke with a local GP and to a GP practice manager. These professionals gave us their permission to include their comments in this report.

The service was previously inspected on 2 June 2015 when two requirements were made as a result of breaches to regulations.

Requires Improvement

Is the service safe?

Our findings

At our inspection on 2 June 2015, we found people were not safely supported when they were transferred in wheelchairs. Also, where assessments highlighted people were at risk of developing pressure areas on their skin, or had pressure areas, care plans did not always give guidance on the action staff should take to prevent this. This was in breach of Regulation 12 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made and action had been taken regarding these shortfalls. Staff were observed to support people safely when transporting or transferring them in wheelchairs. The manager had taken action to refer people for specialist equipment such as a specialist wheelchair supplier so people could be assessed and provided with a more suitable wheelchair. Care plans and assessments identified those at risk of developing pressure areas on their skin. Monitoring charts showed people were supported with repositioning and turning as set out in care plans. The manager informed us there were no instances of people who had pressure sores and that senior care staff have received training in the management of pressure areas.

Risks to people were assessed regarding the safe use of bed rails to prevent people falling out of bed. Moving and handling risk assessments were carried out and there were 'safer handling' care plans which gave clear guidance for staff to safely support people in moving and handling. The manager used an assessment called, 'Individual Vulnerabilities Audit Tool.' This covered care needs such as skin integrity, pressure area care, catheter care, risks of malnutrition and falls which was used to monitor and make changes to the delivery of care to people.

The inspection, however, identified areas where closer attention to the safe management of pressure areas on people's skin was needed. Pressure relieving air mattresses were in place for those at risk of developing pressure areas or sores. Two air mattresses were set at an incorrect pressure which increased the person's risk of pressure areas developing. The manager took immediate action to address this. Following the inspection the manager confirmed a monitoring sheet had been introduced to check the pressure relieving mattresses were at the correct air pressure to meet people's assessed risks.

The manager said staffing levels were assessed using a dependency tool and in agreement with the local authority who purchased care at the service. Staffing was planned on the following staff to people ratio: one staff to four people on the first floor where nursing care could be provided and one staff to five people where personal care was provided on the ground floor. Staffing was organised on a staff duty roster which showed staffing was provided at the planned levels. Each floor of the home had its own staff team. On the ground floor, which had capacity for up to 20 people with personal care needs, three care staff and one team leader were on duty from 8am to 8pm each day. Nineteen people were accommodated on this floor at the time of the inspection. At night time there was one support worker and one team leader. On the first floor, which had capacity for up to 20 people with nursing needs, one registered nurse and four support workers were on duty. There were 18 people accommodated on the first floor at the time of the inspection. At night time there was one registered nurse and two support workers. The manager's working hours were in addition to this and catering, laundry, cleaning and maintenance staff were also employed.

The local authority said there was a shortage of trained nurses and in particular a nurse with overall responsibility for co-ordinating nursing care. The local authority told us there was still a lack of confidence that the service had nursing staff with the skills to safely provide catheter care. For this reason the provider had made a decision not to admit people who required catheter care. A community nurse said there was a lack of staff in general, especially registered nurses who were specifically qualified to provide catheter care for male persons. The community nurse also commented they had observed staff were not always able to respond to people promptly due to the staffing levels being insufficient. The provider confirmed there was a shortage of trained nurses including a lack of a lead nurse for co-ordinating nursing care and there had been a reliance on agency nurses. The provider had taken steps to recruit a registered nurse to lead in clinical nursing care but had so far been unable to appoint. The service also had 42 hours of nurse hours unfilled and were taking action to recruit to fill these hours. The manager confirmed nursing support for catheter care was being provided by an appropriately trained nurse from another of the provider's services.

We observed there were generally enough staff to meet people's needs when we inspected, with the exception of a meal time on the first floor where staff were too busy to provide the right support to two people due to carrying out other tasks. One person was left for 30 minutes before staff supported them with their food even though staff had observed the person needed help and said to the person, "I'll be back to help you." Another person needed encouragement to eat but it was 13 minutes after the meal was served before staff helped them as staff were serving meals to people in their rooms. Following the inspection the manager confirmed this was addressed by the introduction of a system whereby there were two lunchtime sittings so staff could support people with their meal. The provider also stated the lack of availability of staff at this time was due to two staff having to attend the personal care needs of one person.

Staff gave mixed views on whether there were enough staff. One staff member said there not enough staff to safely meet people's needs and, in particular registered nurses, which had led to an over reliance on agency staff. The service sent us a notification in December 2015 to say there was one shift where the service was unable to provide any nursing staff despite attempts to use agency nurses or nurses from other sources. An arrangement was made that a nurse from another nursing home run by the provider would provide nursing care if it was needed. The provider confirmed this was an isolated incident. On the first day of the inspection an agency nurse was on duty from 7.45am to 8pm followed by an agency nurse overnight. On the second day of the inspection the registered nurse on duty was employed by the service. The provider had been unable to appoint a registered nurse to lead in clinical nursing care and staff were not always deployed flexibly to meet people's needs promptly. The provider had not ensured there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people. This is in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe in the home. For example, one person told us how they were moved by the use of a hoist which was always carried out safely with two staff. This same person said, "Yes, I feel safe. You can't fault the staff-there's always enough of them around." People said staff responded when they used the call points in their rooms to ask for assistance. Call points were positioned so people could easily reach them to request assistance although we noted one was out of reach for one person for a short period of time.

The service had policies and procedures regarding the safeguarding of people. Staff confirmed they were trained in adult safeguarding procedures and that the importance of knowing these procedures was stressed by the provider. For example, one staff member said, "Safeguarding is a major policy. It's drilled into us. We report any concerns straight away." Staff had a good awareness of what constituted abuse of older people and how to report any concerns.

The manager said any safeguarding concerns were reported to the local authority and she maintained a record of any referrals along with details of the concern and any actions being taken by the provider and the local authority safeguarding team. A representative of the local authority safeguarding team said the provider, manager and staff co-operated with any safeguarding investigations.

Since the last inspection there have been several safeguarding investigations by the local authority regarding the safe care of people. At the time of the inspection the local authority confirmed this had included a period of suspension of people being admitted to the home with nursing needs but this was now lifted.

Pre-employment checks were carried out on newly appointed staff and staff were interviewed to check their suitability for care work. Staff confirmed their recruitment included reference checks and an interview. Application forms were completed by staff and these included an employment history for the staff member. References were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. The DBS maintains records of any criminal convictions or where staff are not suitable to work in a care setting. The provider also checked that nurses were registered with the Nursing and Midwifery Council (NMC) as fit to practice.

Staff were trained in health and safety and in emergency procedures. Each person's care records included guidance for staff to follow to safely evacuate people from the home in an emergency. All team leaders were trained in first aid, which ensured there was always a staff member on duty who was trained in first aid.

People's medicines were safely handled and administered. The service used an electronic system of recording and handling medicines. We spoke to two registered nurses who used this system and both said they preferred this to paper records as it was a safer system. They said the recording system highlighted when staff had not made a record to say a person had not had their medicines. The system relied on an internet connection and staff said this was not available in all areas of the home; the provider said this issue was being looked into. A paper records system was available to use if the internet connection was lost. Nursing staff showed us how the system worked and the records they entered. It was noticeable that the registered nurses took several minutes to find the records we asked to review. The records showed staff made an entry to show they had administered medicines to people. We looked at how the system worked for administering medicines which were variable in the doses given for some people and saw this followed the blood test results guidance. The provider informed us there had been 10 medicines errors in the last 12 months and that each error was looked into and any action taken to remedy the mistakes. Some of these related to medicines for diabetes. One of the registered nurses showed us how the electronic system was used to record the time and results of blood sugar tests which then prompted staff to administer insulin within the correct timescales. The records showed people received insulin at the correct times, although we noted staff had not recorded whether a person had received their morning insulin by 11am on the day of the inspection.

Checks were made by suitably qualified people of equipment such as the passenger lift, gas heating, electrical wiring, fire safety equipment and alarms and electrical appliances. Temperature controls were in place to prevent any possible scalding from hot water, and the temperature of water was also checked periodically. Risks and measures to prevent Legionella were in place.

The service was clean and free from any odours. People commented on how clean the home was kept. For example, one person said, "It's spotlessly clean." Hand sanitiser dispensers were available for staff and visitors. Staff were employed to maintain the premises and laundry.

Good

Is the service effective?

Our findings

People said staff generally had the right skills to provide the effective care and support. For example, one person said, "You can't fault the staff. You get every help possible."

People said they were consulted about their care needs and that staff asked them how they wished to be supported.

People gave mixed views about the food. Some said the food was good. For example, one person said, "The food is really nice. I hardly leave any," and another said, "They make really good porridge." Others expressed reservations about the quality of the food. For example, one person said it varied in quality and another said they did not like the food at all. One person said the availability of fresh fruit could be improved. People said there was a choice of food and that they were asked in advance what they would like to eat. The provider was aware of the negative feedback regarding the food and was already taking action to address this.

People said they were supported with their health care needs and arrangements were made for health checks when these were needed.

Newly appointed staff received an induction to prepare them for their role, which involved enrolment on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers. The four day induction also involved newly appointed staff working with experienced staff in a 'shadowing' role and observational assessments of staff competency. A member of staff who started work at the service since the last inspection told us the induction covered a number of mandatory courses such as moving and handling and person-centred care. This staff member said the induction was sufficient to prepare them for the job. The manager told us the competency of newly appointed staff was assessed before they were deemed competent to work with people. Records of these assessments were available.

Staff said the training was good and included a range of subjects. For example, one staff member said, "You can't knock them for their training. You can't fault the training." Another staff member said there were mandatory training courses staff had to complete such as moving and handling, fire safety, food hygiene and health and safety. Staff also said they received regular supervision with their line manager where they were able to discuss their training needs and that the provider supported them to attend other courses to enhance their skill base. For example, one staff member said they would be starting a six month course on the care of people living with dementia.

The registered manager maintained a spreadsheet record to monitor staff had attended training which was considered essential for their role. This showed 96% of staff had completed the mandatory training courses.

Staff also had access to nationally recognised training qualifications such as the National Vocational Qualification (NVQ) in care and the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they

have the ability to carry out their job to the required standard. The manager confirmed that of the 38 care staff, 12 were trained to NVQ level 2, seven at level 3 and one at level 4. The manager was completing a level 5 Diploma in Dementia Care. Staff also said they were trained in courses which meant they were able to train other staff, such as in moving and handling.

A registered nurse described how they maintained their portfolio of training so their registration with the NMC was maintained. The manager informed us registered nurses were trained in venepuncture, using syringe drivers and catheter care. The skill level of registered nurses regarding catheter care and the availability of nursing staff is covered in the 'Safe' section of this report.

Staff confirmed they felt supported in their role and that they could seek advice from their line manager. Records showed staff received regular supervision and appraisals of their work. A monitoring spreadsheet was used by the home's management team to check staff received regular supervision and appraisals, so any omissions could be addressed. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

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

The service had policies and procedures regarding the Mental Capacity 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). These gave clear guidance for staff in assessing people who did not have capacity to consent to their care and treatment and for making decisions on their behalf, which are called best interests decisions. Care records showed people's capacity to consent to care and treatment was considered by the use of a Mental Capacity Act 'checklist.' There were procedures for making applications to the local authority where someone who lacked capacity to consent had their liberty restricted for their own safety. At the time of the inspection three people were subject to a DoLS and the manager stated she was in the process of assessing other people for a possible DoLS application.

Care plans showed people were consulted about their care where they had capacity. For example, one person was assessed as needing bed rails for safety reasons and this was discussed and agreed with the person. Where people did not have capacity, records showed this was assessed and a 'best interest' meeting held such as for medicines put in people's food as the only way the person would accept the medicine. We noted one of the records of a 'best interest' meeting did not have a date on it.

All staff were trained in the MCA and team leaders had completed additional training. Staff had a good awareness of the principles of the MCA.

People's nutritional needs were assessed using a Malnutrition Universal Screening Tool (MUST). Care records showed people were referred to the dietician or speech and language therapist (SALT) for assessment and advice on how to support people who had dietary needs. Care records included guidance from a SALT and dieticians on supporting people who had swallowing needs. We noted there was an inconsistency in one person's records as one document said the person did not have any special dietary needs, whereas other records showed the person was assessed as needing food which was 'fork mashable' to help them swallow. Where needed food and fluid intake was monitored and recorded. People had access

to cold drinks in their rooms. People's weight was monitored and we saw people's weight was maintained. Cultural preferences for food were catered for and this was recorded in people's care plans. There was a choice of food and people were asked in advance what they wanted to eat. We spoke to the chef who explained how specialist diets were catered for. There was a four week menu plan showing varied and nutritious meals. Stocks of food showed fresh fruit and vegetables were used. The chef informed us that high calorie foods were used to supplement food to ensure people received sufficient nutrition.

We observed the meal time on both days of the inspection: once on the first floor where nursing care was provided and once on the ground floor where personal care was provided. The meals looked appetising on both days. People were give the right support and help on the ground floor, but this was not always the case on the first floor which is highlighted in the 'Safe' section of this report.

Care records included details about people's health care needs and liaison with health care providers such as checks and treatment with the dentist, optician, psychiatrist and GP. There were Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms completed by GPs in people's records. One of these was incomplete as the section regarding consultation with the person had not been completed even though the form stated the person had capacity. This needed to be followed up with the GP.

Records were maintained to show people's temperature and blood pressure was monitored.

Good

Is the service caring?

Our findings

People gave generally positive feedback about the caring nature of staff and their relationships with them. For example, one person said the staff were, "Kind. Cheeky… and you can have a laugh with them." This person also said the staff were caring adding, "Even the cleaners care." Another person said how kind the staff were, adding, "They couldn't be better." One person, however, felt that staff talked to them in a condescending manner.

People also said they were able to exercise choice in how they spent their time. For example, one person said, "It's my room and I can do what I want. I like to get up at 6am and there's always someone on call."

Staff were observed to treat people with warmth, humour and kindness. There was a rapport between staff and people. Staff joked with people and asked people how they were; people in turn responded to this. At lunch staff asked people how they wanted to be helped and there was close attention to detail in making the experience a pleasant one for people. We observed staff knew people's needs and preferences and those who had communication and dementia needs responded to staff. Staff knew people's needs and moods; for example, a staff member said they could tell if someone was upset or in discomfort from the person's facial expression.

A health and social care professional described the staff attitude towards people as, "really pleasant" and "lovely" and that management took action where staff did not treat people well.

Staff also demonstrated they cared about people and said it was the right of people to be treated well. For example, two staff said they saw the people at the home as members of their family and another said they treated people as they would like a member of their family treated. Staff also said they treated people with respect and tried to always accommodate people's wishes. For example, one staff member said, "Whatever they want we try to provide. It's their home."

The provider told us that staff attitudes and approach to people was central to the philosophy of Shaw Healthcare Limited and was integral to the induction, training and development of staff. We saw how the staff recruitment process assessed potential staff's understanding of providing person- centred care.

People had personalised care plans which showed care reflected people's preferences as well as their individual needs. There was an 'Essential Lifestyle' folder for each person which included details about people's preferred routines. For example, one care plan stated, 'After breakfast I usually like to sit quietly in the lounge near the window and read a book.' This person confirmed this was how they liked to spend some of their time.

Each person had their own room so were able to spend time in private. One person said they liked to stay in their room and listen to music and other people said they enjoyed their room. Bedrooms were personalised with people's belongings and ornaments which reflected their interests and personality. People were able to have a key to their bedroom door for privacy and security and this was recorded in people's care plans. Staff

were observed to knock on people's doors before entering.

Information was displayed for people and visitors to see in the entrance hall. This included the home's brochure, information about the adjoining day centre, photographs of each staff member and information about CQC as well as forthcoming activities and events.

Relatives told us they were able to visit the home whenever they wished and that staff were receptive to them.

Good

Is the service responsive?

Our findings

At our inspection on 2 June 2015, we found staff did not always respond to people who requested assistance from staff. We observed one person had long and dirty finger nails which they said staff failed to take action about unless they asked for help. Records showed that people did not receive care as set out in the care plans as monitoring charts were not completed accurately. This was in breach of Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan to say how this was being addressed. At this inspection we found improvements had been made and action had been taken regarding these shortfalls.

At this inspection, people told us they received the care and support they needed. For example, people said staff arrived promptly when they asked for help using the call points in their room. One person said, "You ring the bell and they come straight away. I get the care I want. A chap comes in with biscuits. He knows what I like." Staff were observed to respond to people who asked for assistance. Staff did not always have time to support people to eat within the nursing part of the service and this is included in the 'Safe' domain of this report.

Each person had an assessment of their needs. These were comprehensive and assessed a wide range of care needs such as personal care, mental state and dietary needs as well as lifestyle and relationships. These assessments were subdivided and showed care needs were assessed well. For example, the assessment of mental state included details about the person's orientation, memory, mood, anxiety and agitation, behaviour, emotions, and response to care intervention. Care plans also covered a wide range of needs and gave staff guidance on how to support people. There were instructions on how often to support people with needs such as eating, drinking, personal care and the safe management of pressure areas on skin. Corresponding monitoring charts were used for staff to record each time they supported someone and these reflected the care plans. For example, where care plans recorded people needed to be repositioned to relieve pressure areas on skin, monitoring charts showed this took place.

People were observed to be clean and well cared for. For example, male residents were shaved and their hair combed. People's clothes were clean. A social worker commented that people were "clean and well cared for." Records were maintained on a chart to show when people received personal care such as a bath, wash, oral care, nail care, continence care and when their bedding was changed.

We observed people taking part in activities; people confirmed activities were provided and they could choose whether or not to attend. People's needs were assessed regarding their interests and activities. An activities care plan was created for each person. Records of activities attended by people were maintained. An activities co-ordinator was employed for 37 hours per week and a display of activities provided.

The provider's complaints procedure was displayed in the home and people said they knew what to do if they were not happy or had any concerns. The provider told us eight complaints had been made in the last 12 months. Details of the complaints, any investigations and actions to make improvements were recorded. These showed the provider had looked into each complaint and responded to the complainant in writing

with the outcome of the complaint investigation. Where relevant the provider had made a safeguarding alert to the local authority. Records also showed the provider apologised to a complainant where this was needed.

Requires Improvement

Is the service well-led?

Our findings

The service maintained a record of any safeguarding alerts made to the local authority regarding concerns about the care of people. Generally these were also notified to CQC as required by the Regulations but two safeguarding alerts were not. The Commission must be notified of all safeguarding alerts, so that follow-up action can be taken as needed. This was in breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Since the last inspection the registered manager has left and a new manager started, but had not yet completed her registration with the Commission. The manager had a good awareness of the issues and challenges the service faced as well as having a good knowledge of people's care needs, current safeguarding investigations and staff performance. However, a local GP practice said the current management arrangements had led to a deterioration in the standard of nursing care. For example, we were told that a previous arrangement to supply the GP surgery with updates of people's health care needs such as blood pressure readings had ceased without explanation. Another example was given where instructions regarding nursing care were not followed. This GP said communication between nursing staff needed to be improved. The GP practice manager said a letter of concern was sent to the provider regarding the provision of nursing care and a reply had so far not been received. The GP also said the provision of personal care on the ground floor by contrast was "perfect" and that one of the senior staff who had responsibility for managing care was "extremely capable."

The service has struggled to recruit sufficient nursing staff to meet people's needs and this included a nurse with responsibility for co-ordinating nursing care, although there was a nurse 'acting' in this role as an interim measure.

People said they felt able to raise any concerns they had and were able to give feedback about the care they received. The provider used survey questionnaires to ask people and their relatives what they thought of the service. There were residents' and relatives' meetings where views about the service could be expressed and where the provider could consult people about any changes. We saw the record of the last residents' meeting in June 2016 included discussions about the food and the activities.

There was a system of team leaders who supervised care staff and staff said they were supported and had access to advice and guidance when they needed it. Staff also said they felt valued by their employer and worked well as a team. Staff meetings took place such as meetings of team leaders, care staff and nurses, which staff said allowed them to discuss any issues about the care people received or the policies and procedures at the service. The provider stated that staff views were listened to.

Staff were able to develop specialisms so that care practices could be developed in the home. For example several staff were qualified so they could teach safe moving and handling and two staff were dignity champions with a remit to promote choice, dignity and care of people. The provider carried out observations of staff working with people as part of its quality assurance called a 'Quality of Life' audit.

There was a system of regular checks of the service such as a monthly quality audit by the manager as well as an audit twice a year by a representative of the provider'. The monthly audits were comprehensive and included a review of care plans, information provided to people, activities and staff files. Action plans were devised to address any areas where it was identified improvement was needed. We noted the action plan for the audit of June 2016 was partly completed and the one for July 2016 not yet completed. Other checks were made regarding the quality of care such as medicines audits. Care records included charts which enabled the staff and manager to check care met people's needs. Incidents, accidents and safeguarding concerns were monitored and recorded showing action was taken where this was needed so people received safe care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not ensured the Commission were always notified of incidents where there was an incident of abuse or an allegation of abuse. Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. (1) (2) (b) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient staff, including registered nurses with the right training, so that service user's needs could be met. Regulation 18 (1) (2) (a) (b)