

New Century Care (Hastings) Limited

St Pauls Care Home

Inspection report

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05 January 2016

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Ratings

Overall rating for this service

Requires Improvement ●

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

Summary of findings

Overall summary

We inspected St Pauls Care Home on the 29 December 2015, 04 and 05 January 2016.

St Paul's Care Home provides accommodation, personal and nursing care for up to 25 older people, some of whom have limited mobility, are physically very frail with health problems such as heart disease, diabetes and strokes. There were people at St Paul's also living with dementia and receiving end of life care. There were 15 people living at the home at the time of our inspection. Accommodation is arranged over three floors and each person had their own bedroom. Access to the each floor is gained by a lift, making all areas of the home accessible to people. St Paul's Care Home is a large detached house in a residential area of St Leonards on Sea, close to public transport, local amenities and some shops. The service is owned by New Century Care Limited and is one of six homes owned by them in the South East.

At the time of this inspection the local authority had an embargo on admissions to the home pending improvements. At the last inspection on the 22 and 26 May 2015, St Pauls Care Home was rated as inadequate and placed into special measures. The Care Quality Commission (CQC) issued three Warning Notices after the inspection in respect of safe care and treatment, dignity and respect and staffing.

We asked the provider to make improvements to meeting peoples nutritional and hydration needs, person centred care, consent and assessing the quality of the care and support provided. The provider sent us an action plan stating they would be addressed by December 2015. We found our concerns in some areas had been addressed, although continued improvements were required. We also found that improvements made, needed to be fully embedded in to practice.

A manager was in post. 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 and associated regulations about how the service is run.

People and staff commented positively about the improvements to the home, care and support received and their experience at St Paul's Care Home.

Whilst quality assurance systems were in place, we found some inconsistencies in medication audits and a lack of action points to address on-going issues in service delivery. For example issues with the menus and meal delivery. This is an area that requires further improvement.

At the last inspection care plans did not reflect people's assessed level of care needs and care delivery was not person specific or holistic. This inspection found that improvements had been made. There were still aspects of care delivery that were seen as task orientated, such as meal times. One staff member said, "We have always done it like this, it's hard to change." This is an area that requires further improvement.

At the last inspection we found that the provider was not meeting the requirements of the Mental Capacity Act (MCA) 2005. This inspection found that improvements had been made, however there were some mental capacity assessments that lacked clarity and were not underpinned with a best interest meeting. This is an area that requires further improvement.

Whilst people were complimentary about the food at St Paul's Care Home and the dining experience had improved. The meal delivery was still not efficient and people told us they often did not get a hot meal at lunchtime. This is an area that requires further improvement.

Staffing levels were seen as sufficient to meet people's needs but the deployment of staff had not ensured that people were appropriately supervised in communal areas. Arrangements for the supervision and appraisal of staff were effective. Staff told us that meetings took place about concerns, regular supervision and appraisals, and they felt supported and empowered by the management team.

Medicine practices had significantly improved. The management, administration and storage of medicines was safe.

Care plans contained sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Where people's health had changed considerably, care plans did reflected the changes and therefore staff were kept informed of important changes to care delivery. Information was available on people's life history and there was evidence that people were involved in their care plan. Activities were enjoyed and the activity co-ordinator was enthusiastic and committed to providing meaningful activities for people.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by St Paul's Care Home all had registration with the nursing midwifery council (NMC) which was up to date.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

St Pauls Care Home was not consistently safe. Whilst improvements had progressed to meet previous breaches of Regulation, we found that there were some areas of care that placed people at risk of harm.

People were placed at risk from equipment which was not suitable for their needs and poor moving and handling techniques. Risk assessments were devised and reviewed monthly. However, management of people's individual risk assessments to maintain their safety and well-being were not in place for everyone and therefore placed those people at risk.

Whilst there were enough staff on duty to meet people's needs, the deployment of staff did not ensure people's safety and well-being.

Medicines were stored, administered and disposed of safely and administration records were up to date.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe.

Requires Improvement ●

Is the service effective?

St Pauls Care Home was not consistently effective. Whilst meeting the legal requirements that were previously in breach, practices need time to be embedded.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not always clear.

The meal experience had improved with the introduction of dining tables. However people were not always offered the opportunity to eat in the dining area.

Nutritional records for people were completed competently and people were supported to eat when required.

Requires Improvement ●

Staff received on-going professional development through regular supervisions, and essential training that was specific to the needs of people had been undertaken.

Is the service caring?

St Pauls Care Home was caring and was meeting the legal requirements that were previously in breach. However, practices and ensuring a positive culture need time to be embedded.

The manager and staff approach was to promote independence and encourage people to make their own decisions.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

People were encouraged to maintain relationships with relatives and friends.

Relatives were able to visit at any time and were made to feel very welcome.

Requires Improvement ●

Is the service responsive?

St Pauls Care Home was responsive and was meeting the legal requirements that were previously in breach. However, practices need time to be embedded.'

People told us that they were able to make everyday choices. There were meaningful activities provided for people to participate in as groups or individually to meet their social and welfare needs. Work was on-going to ensure everyone had the opportunity of social interaction in a way that they wanted.

Care plans reflected the most up-to-date information on people's needs, preferences and risks to their care.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Requires Improvement ●

Is the service well-led?

St Pauls and was meeting the legal requirements that were previously in breach. However practices need time to be embedded.

There was a registered manager in post, supported by a deputy manager. There was a strong management team in place.

Requires Improvement ●

Quality assurance systems were in place but there were some areas that lacked follow through. We also found discrepancies in medication audits that questioned the processes in place for auditing.

The home had a vision and values statement and staff were committed to improvement.

People spoke positively of the care. People and visitors had an awareness of changes of management and felt that the new management team of the home were approachable.

St Pauls Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on the 29 December 2015, 04 and 05 January 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Two inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over two floors of the home as the top floor had been closed for refurbishment. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, including six people's care records, four staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation.

We spoke with 8 people living at the service, two visiting relative, eight care staff, the registered manager, the activity co-ordinator, two housekeeping staff, two registered nurses, and the area manager.

Is the service safe?

Our findings

At the last inspection in May 2015, the provider was in breach of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risk assessments did not always include sufficient guidance for care staff to provide safe care. Others risk assessments were not being followed. Medicine practices were not safe and care records failed to demonstrate whether staff were monitoring the condition of people's skin to prevent pressure sores. Equipment to maintain people's skin integrity was not being used properly. Incidents and accidents were not being investigated. We also found that there were not enough staff to meet people's needs. People's individual care and nursing needs had not taken into account when determining staffing levels.

Due to the concerns found at the last inspection, we determined people were at significant risk of not receiving safe care and the delivery of care was inadequate. An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 December 2015. Improvements had been made and the provider was now meeting the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

People told us they felt safe living at St Pauls Care Home. One person told us, "I feel safe and I think the care is good." Another person said, "My room is safe, I stay in bed and I am treated safely."

At the last inspection the staffing levels were not sufficient to meet people's needs, medicine practices were unsafe, risk assessments were not up to date and accidents and incidents whilst documented lacked the follow up to keep people safe. We found on the day of the inspection that these concerns had been addressed sufficiently to meet the breaches of regulation. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery.

People told us there were enough staff to look after them. They said, staff responded quickly if they used their call bells during the day or at night. One person said, "Staff come when you need them." There were 15 people currently living in St Pauls Care Home and the staffing levels were calculated by a dependency tool that reflected people's needs.

Staff felt there were enough staff working in the home. One staff member told us, "Yes, there are. Some days are busier than others but we cope ok." Another staff member said, "We are using agency staff sometimes at the moment, but I know they are looking to recruit more staff." The staff rota revealed that staffing levels were consistent across the four weeks we looked at, with four or five carers on duty per shift, in addition to the nurse. However, these numbers were only achievable by allocating extra hours to existing staff or agency members.

There was one registered nurse (RN) with four care staff in the mornings and one RN and five care staff in the evening. At night there was one RN and two care staff. Staff told us that they were busy but felt it was manageable. We noted however that during the morning people were left for long periods of time without

any staff in the communal areas to supervise and assist if necessary. Some people were unable to use the call bell and a check list had been put into place. The staff used this chart but only ticked a box without engaging with people. The activity person was visible for short periods of time but was also visiting people in their rooms. People told us that 'staff poked' their head in their room to check them but didn't engage with them. Staff said it was because they were getting people up, washed and dressed. This meant that staff deployment had not ensured people were supervised appropriately. This was an area that requires improvement.

The area manager said they had advertised for nurses and care staff and records showed they had interviewed many prospective staff, but finding the right staff was proving difficult. The area manager told us they were working towards having a permanent and knowledgeable staff team; a clinical lead had recently been appointed to drive continued improvement in care delivery.

At our last inspection we found that risk assessments were not up to date and had not captured peoples changed needs. This inspection identified that peoples documentation had been reviewed and updated as people's needs changed and there was guidance to ensure staff provided appropriate care and support. These included waterlow scores to protect people from pressure sores, nutrition, risk of falls and moving and handling. We observed equipment, such as hoists, walking frames and pressure relieving devices were used to protect people, and risk assessments in the care plans identified the mobility aid people used or staff used to support each person. However we saw that not all equipment was safely used and was not specific for the persons use. For example one person was encouraged to walk with a walking frame. The walking frame was not one that had been assessed by a health professional for this persons use. It was not the right height for them and they were leaning forward and gazing downwards. This placed them at risk from falling. Another example was the unsafe transfer from a wheelchair into a dining chair. The person was asked to stand but lost their balance and staff grabbed the person under their arms, a transfer belt had not been used. Transfer belts are used to provide assistance if needed when a person becomes unsteady and needs support. Staff told us that the moving and handling training had not included supporting people with walking aids. This was discussed with the manager as an area for improvement.

At the last inspection in May 2015, poor medicine practices had placed people at risk. This inspection identified that there were now systems in place to monitor and audit medicine practices. We observed two separate medicine administration times and saw that medicines were administered safely and that staff signed the medicine administration records after administration. The clinical room was newly located to a bigger room. The room was well organised and all medicines were stored correctly and at the correct temperature. The new clinical lead said that he was undertaking medicine audits and had identified poor practices. There was a clear audit trail that defined what action was taken. He also told us that he was really pleased that medicine practices were improved and safe. We found however that the main audit undertaken by the management team had not reflected the errors identified by the clinical leads newly introduced weekly audit. This meant that the management team were not aware of areas that needed to be improved and this was an area identified for improvement.

At our last inspection we found that accidents whilst recorded had not been followed up and analysed to prevent a re-occurrence. This inspection found that a system was in place to record accidents/incidents with actions taken to prevent them as far as possible. Accidents were recorded with information about what had happened, such as an unwitnessed fall in person's bedroom. Why it happened, for example, person stepped around the alarm mat, and how to stop it happening again. The positioning of the mat was reviewed and found to be in the most appropriate position. Audits were carried out for the accident/incident forms to ensure sufficient information was recorded. Accidents were reported to the local authority in line with safeguarding policies.

Personal emergency evacuation plans (PEEPs) were in place and now provided guidance for safe evacuation. PEEPs stated the number of staff required to assist each person with additional information to guide staff in the safe evacuation of each person

Staff received training on safeguarding adults. All staff confirmed this and knew who to contact if they needed to report abuse. They gave us examples of poor or potentially abusive care they had seen and were able to talk about the steps they had taken to respond to it. Staff were confident any abuse or poor care practice would be quickly spotted and addressed immediately by any of the staff team. Policies and procedures on safeguarding were available in the office for staff to refer to if they needed.

The personnel files for four staff included relevant checks on prospective staff suitability, including completed application forms, two references, disclosure and barring system (Police) check, interview records and evidence of their residence in the UK. This meant the provider had undertaken appropriate recruitment checks to ensure as far as possible only suitable staff were employed.

Is the service effective?

Our findings

At the last inspection in May 2015, the provider was in breach of Regulations 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care delivery was not always effective and consistent, there was a lack of mental capacity assessments (MCA) and Deprivation of Liberty Safeguards (DoLS) referrals. Mealtimes were not an enjoyable experience. We also could not be assured that people's nutritional needs were met.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by 30 December 2015. At this inspection we found improvements had been made and the provider is now meeting the requirements of Regulations 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However these improvements were not, as yet, fully embedded in practice and need further time to be fully established in to everyday care delivery. The meal service in particular was still experiencing changes and challenges.

Staff had an understanding of MCA and DoLS. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. We were told applications for DoLS had been made when required. Staff asked people's consent prior to delivering any care or support. There was information in people's care plans about making decisions and how they were able to make unwise decisions. However, this was all recorded under a mental health care plan, which had not taken into consideration that they didn't have a mental health problem just needed to be supported to make decisions in their best interest. This is an area that needs to be improved.

At the last inspection we found that the meal service at St Pauls Care Home was not a sociable experience or made to feel like an enjoyable event for people. This inspection found that three dining tables had been set up in part of the communal day room. This meant that up to ten people could choose to sit at a table to eat. However it was still not being offered to people as a choice unless remembered by certain staff. We were told by one staff member, "It's something we should be doing but it's still new to staff." The second day of the inspection we saw different staff were on duty and saw that more people were being offered the choice of sitting at a dining table.

The meal service started on the ground floor and then food was taken up to the first floor in hot trolleys. However the trolleys on the first day of the inspection were not warm enough to keep food hot and the meals were luke warm when served. This was due to delays in the kitchen as the chef had called in sick. We also saw that the menu had changed and people were not verbally informed or offered an alternative. The food was not attractively served and for some people, by the time it had been cut up by staff it was unrecognisable. One person had requested an omelette, the omelette was served on its own. The person who received the omelette said it would have been nice to have potatoes, salad or chips. One person said,

"Food is still not particularly good, never hot and very little choice." We spoke with the area manager and manager who told us that new menus had been introduced and they were collating feedback and addressing on-going problems. We were also told that the management team were taking specific action with kitchen staff to ensure that the meal service improved. We have identified this as an area for further improvement.

We looked at people's food and fluid records. The care plans directed staff to monitor people's food and fluid intake when it had been identified the person was at risk from not eating and drinking. Records were complete and monitored, and therefore were an effective way of monitoring how much they had eaten or drunk.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Staff told us they had received training and further training was booked.

We were told staff received an induction programme which lasted a month and on-going training support. We were also told that newly appointed staff shadowed other experienced members of staff until they and the manager felt they were competent in their role. Recently employed staff told us that they felt supported by the organisation and that the induction programme was thorough.

Staff supervision was up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said, "I have had two supervision sessions, it was helpful as it has given me confidence to discuss the job." Staff records of supervision confirmed that staff supervision had been undertaken regularly for most staff. Staff told us they felt supported by the management and staff changes and that the home was going forward.

We looked at training records and saw that staff accessed training via the internet from an e-learning provider. Training records indicated that fundamental training for all staff were up to date. For example, MCA, safeguarding, health and safety. Service specific training, such as end of life care, dementia, and diabetes had been undertaken by all staff. We saw care delivery for people who lived with dementia was more stimulating and person focused and people with specific health problems such as diabetes were appropriately supported.

Training schedules showed us that staff had received DoLS or MCA 2005 training. Care staff we spoke with had a basic understanding of mental capacity and informed us how they gained consent from people. One care staff told us, "We give them a choice of what they can wear, I hold it up for them and I look at their reaction." Another staff member said, "We get to know people really well and know what they want."

People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff recognised that people's health needs could change rapidly especially for people living with a deteriorating illness, such as Parkinson's disease. Staff demonstrated an awareness of people's changing health needs and were able to share with us how they secured advice and support from other health professionals. The clinical lead told us, "The surgery are very helpful and the GPs are approachable and will listen to us."

Is the service caring?

Our findings

At the last inspection in May 2015, the provider was in breach Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff had not always listened to and involved people in their care delivery or lifestyle choices and this had had a negative effect on people's individual needs and wellbeing. People had not always been treated with respect and had their dignity protected.

An action plan was submitted by the provider detailing how they would meet the legal requirements by 30 December 2015. Improvements had been made and the provider was now meeting the requirements of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection found that there was still some inconsistency in how people were cared for, supported and listened to. This was the result of staff changes and new ways of working that still needed time to be embedded. Overall staff seemed committed to improvement but still had some way to go to ensure person centred care. We observed people who found it difficult to initiate contact were still given very little time and attention throughout the day. People spoke positively of care staff, but staff admitted that it was difficult to give everyone the right attention because the communal areas were not used or enjoyed by all the people. One staff member said, "Some people are happy to stay in their room but this means we can't be everywhere, an extra quiet room would be good." The communal areas were not large enough for everyone to sit comfortably. Staff admitted to following routines and said, "We stick to routines because we have to get people up and washed by a certain time." We saw that people's everyday choices were dependent on which staff were on duty. Staff that had worked at St Pauls for a long time found changes to care delivery and care routines difficult to fully embrace. One staff member said, "It's quite difficult to remember to ask people if they want to go to the lounge or dining area because it wasn't something people wanted to do in the past." We spoke with person who on the second day of the inspection sat in the dining area. They said, "It's really nice to sit and eat at the table with other people." We noted that staff had to be reminded to offer people the choice of venue by the registered nurse. This was an area that requires improvement.

People told us they felt supported to be independent and make day to day decisions. One person said "They are good as they do my shopping, and support me very nicely." We were told that the activity person visited everybody in their room but care staff were not sure how often this happened. The records completed by the activity co-ordinator confirmed that people received one to one sessions, but as the activity co-ordinator said, "I want to increase my hours so that I can give everyone more time." This was being considered by the organisation. People we spoke with had varying opinions. One person said, "Don't see people to talk to, they pop in and then pop out just to check me, not really a conversation." Whilst another person said, "The staff come and sit down and chat." This is an area that requires improvement.

People's dignity was seen to be protected. We saw that people were dressed in the clothes of their choice which were clean and presentable. Footwear was well fitting and appropriate. People's preferences for personal care were recorded for each person. We looked at a sample of daily notes, which included documentation on when people received oral hygiene, bath or a shower. Documentation showed us that

people were receiving a bath or a shower as depicted in the care plan. The bath and shower facilities had been upgraded and were fully functioning.

We asked people and their relatives if they had been involved in the assessment of their needs. Some told us that they could not remember, but visitors told us they had been approached to discuss their loved one's care. One visitor said, "I have completed a social questionnaire which is good, it brings back some lovely memories." The care plans gave information about the person's family history, their preferences, relationships, family and key medical information. Since our last inspection care plans and care directives had been updated to reflect changes to peoples' health and their personal wishes.

Relatives told us, "I get told what's going on." Another relative said, "They are inviting us to meetings and telling us what is happening in the home."

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome.

Is the service responsive?

Our findings

At the last inspection in May 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not received person centred care that reflected their individual needs and preferences.

An action plan was submitted by the provider detailing how they would meet the legal requirements by 30 December 2015. Improvements had been made and the provider was now meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they were happy with the standard of care provided and that it met their individual needs. However our observations identified that staff still needed time to fully establish new practices of person centred care.

At our last inspection we found that communication and social well-being was an area of concern as people were isolated in their bedrooms and in the lounge areas with little interaction. This inspection found that an hourly well-being check list had been put into place for everyone in the home. This was completed but staff didn't always approach people and exchange any verbal interaction during those checks. It was just a check list. We noted at times during the morning and just after lunch when there were no staff in communal areas and people were left with little to do. The activity co-ordinator tried to multi-task but admitted that she could not be in the lounge and with people in their rooms. This was acknowledged by the management team as on-going and is an area that requires improvement.

This inspection found that care was personalised to the individual and included changes to their health. For example, one person had been identified as at risk from malnutrition and staff had immediately taken action when they noticed a lack of appetite and contacted the GP. They immediately started fortified food and drinks. We also saw that food and fluids were recorded and analysed on a daily basis. Staff therefore had been responsive to the changes in this person's care delivery and we were assured that the care delivered was reflective of their current needs.

We were told that when it was noted that people were not drinking it was highlighted to staff on handover and fluids encouraged. We saw on handover sheets that this had happened. We found some records indicated fluids only offered at certain key times and not in-between and so if a drink was refused they were not re-offered. This was an area that requires improvement.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. The care plans contained details of how to manage and provide specific care for people's individual needs. For example care plans for people living with diabetes contained information of how staff could identify hyperglycemia (high sugar levels) such as increased thirst or hypoglycemia (low sugar levels) such as lethargy and dizziness.

Wound care records for people were all up to date and contained detailed instructions to monitor and redress the wound as to the effectiveness of treatment. The clinical lead also had a whiteboard in the clinical

room that tracked peoples dressing changes and the status of wounds. We saw that this reflected the information in care plans and staff involved health professional as required.

The records viewed showed us that the activity co-ordinator spent time with people individually. We were also told she was very popular with people. It was acknowledged that increased hours were required to ensure that everybody had the opportunity to participate. We saw a notice board in the reception area that showed people enjoying visits from outside entertainers and pet visitors. We also saw that people's birthdays were celebrated. People told us that events were fun and they needed more of them.

A complaints procedure was in place and displayed in the reception area of the home. One person told us "I wouldn't hesitate to tell staff if I had a problem." Most people told us they felt confident in raising any concerns or making a complaint. A complaint folder was kept which contained information of timelines, letters sent on receipt of complaints and any correspondence relating to the investigation. Documentation confirmed complaints were investigated and feedback was given to the complainant.

Is the service well-led?

Our findings

At the last inspection in May 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were concerns identified within the quality assurance process, such as audits not being acted upon to drive improvement and identify shortfalls in care.

An action plan was submitted by the provider detailing how they would meet the legal requirements by 30 December 2015. Improvements had been made and the provider was now meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However there was still some improvements required to improve outcomes for people and embed good practice in to everyday care delivery.

People, friends and family described the staff of the home to be approachable, open and supportive. People told us; "Bless them they do okay here" and "Helpful." A relative said; "It's been a bit of a journey"

This inspection found that there was a registered manager in post. The registered manager was supported by a deputy manager and the area manager. The management team has recently been strengthened by a new clinical lead. Since the last inspection a number of registered nurses leaving and the organisation are recruiting to the vacant posts.

Quality assurance systems were in place, however we found some discrepancies in the medication audits, which will be investigated by the area manager and a report compiled. We still identified that the people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and staff deployment. Whilst this was acknowledged, it had not been progressed. We also found that people's meal time experience was variable due to on-going issues in the kitchen. Menus had been changed following discussions with people and with relatives but were not fully thought out and well-balanced. One person said the meals were boring and repetitive. This had been identified but not yet actioned. This is an area that requires further improvement.

The care plan audits had identified that people's specific health needs were not accurately reflected in their care plans, for example management of wound care, end of life and continence. Improvements in care documentation had been made and sustained.

This inspection found that the culture and values of the home whilst not fully embedded into every day care practice were improving with supervision and further support and training. Staff were able to tell us, "We can see where we need to improve, the new manager is very supportive." Staff we spoke with had an understanding of the vision of the home and were continuously striving to improve under new leadership. Staff spoke positively of how they all worked together as a team. They said some staff had gone but there was still a strong feeling of team work.

People, staff and visitors said that communication and leadership had improved within the home and the

atmosphere was pleasant. Staff and visitors had an awareness of the management team and felt that the morale of staff had improved.

The area manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at St Pauls Care home to share their thoughts, concerns and ideas with them in order to enhance their service. Friends and relatives meetings had been held and this had encouraged people to be involved and raise ideas that could be implemented into practice. One visitor said, "I think it has improved, it's nice to see dining tables."

Staff meetings had been held regularly over the past six months. The registered manager said, "We are getting a strong team, it's taken time and we know that there is more to do but I'm really proud of how far we have come." One staff member said that staff were embracing changes and felt it was all for the best."

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.