Cherry Garden Properties Limited

Clare Hall Nursing Home

Inspection report

Ston Easton
Radstock
Somerset
BA3 4DE

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Clare Hall is a nursing home that provides personal and nursing care for up to 57 older people. Most people at the home have complex needs including dementia and as a result many of them had limited communication skills. On the day of inspection there were 32 people living at the home. Most people lived on the ground floor of the home in single bedrooms. There were communal lounges, a dining room and there were spacious grounds.

This inspection was unannounced and took place on 28 April and 4 May 2016.

The home has a registered manager who began working after the last inspection on 4 March 2015. 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.

At the previous inspection we found concerns because people were not always being listened to and they had a lack of activities. Both these areas had improved at this inspection.

People and relatives told us they felt safe but we found there were risks to their safety. We found problems with staff levels and recruitment. There were times people were not kept safe or had their needs met because there were not enough staff or they had not been deployed in the best way. People were at risk because the provider was not always keeping the appropriate records for staff members or completing the correct checks. Staff were supervised and did receive enough training to meet people's needs.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and had received training in safeguarding. Staff knew what action to take if they were concerned about the safety or welfare of an individual. They told us they would be confident reporting any concerns to a senior person in the home or the provider and they knew whom to contact externally. The registered manager understood when they were responsible for informing the local authority and CQC about safeguarding.

Most of the medication procedures in the home were safe but sometimes additional checks were not completed and there were missing signatures in the records. People who needed medicines as required and hidden had the correct procedures followed. Storage of medicines was done safely and in line with regulations.

Staff and the registered manager had some understanding about people who lacked capacity to make decisions for themselves. However, people were at risk of having their human rights breached when they lacked capacity because the Mental Capacity Act Code of Practice was not followed. Staff understood about Deprivation of Liberty Safeguards (DoLS) and the process to follow. One person had an authorised DoLS with no conditions and others had applications submitted correctly.

People were supported to see a wide range of health and social care professionals to help with their care needs. Staff supported and respected the choices made by people. People's differences were respected. People had a choice of meals, snacks and drinks, which they told us they enjoyed. When a special diet was required by a person it was provided. People and their relatives thought the staff were kind and caring and we observed positive interactions. The privacy and dignity of people was respected.

Staff had good knowledge about people's needs and their care plans were being revised to a new format. The needs of the people were reflected in their care plans.

There were quality assurance procedures in place to keep people safe. When shortfalls had been identified they rectified the issue. However, people were at risk of not being informed when changes occurred because they had not updated their statement of purpose or ensured their CQC ratings were available on their website; following the inspection these were rectified. There were good systems in place to manage the complaints and the registered manager demonstrated a good understanding of how to respond.

We made a recommendation the provider refers to national guidance about notifications which need to be made to CQC.

We found 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 the 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.

People were put at risk and their needs were not always met because there were not enough staff.

People were at risk because parts of the recruitment procedure were not effective.

People's medicines were managed safely but medicine records were not always correct.

Staff understood what to recognise and who to tell if they had concerns about a person's safety.

Is the service effective?

Requires Improvement

The home was not always effective.

People who lacked capacity did not always have the correct process followed by the provider to help with important decisions. The registered manager and staff demonstrated some understanding about making best interest decisions on behalf of someone who did not have capacity

People were supported by staff who had induction and training to meet their needs. However, some staff did not feel the induction was enough for those who had no experience of working in care.

Most people were supported appropriately to eat and drink. If they needed a special diet this was provided

Staff contacted relevant health and social care professionals to meet most people's health and social care needs.

Is the service caring?

Good

This service was caring.

People told us that they were well looked after and we saw that the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected.

People's religious needs were considered at all times.

Is the service responsive?

Good

The service was responsive

People's care plans were detailed and they covered all aspects of their care and needs.

People participated in activities and where possible the activities coordinator tailored them to meet individual needs.

People received care and support in line with care plans and staff were familiar with the information in the care plans.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not always kept informed about changes in the home because the statement of purpose was not regularly reviewed and updated in line with changes which had occurred.

The service had quality assurance systems in place and when shortfalls were identified the registered manager and provider responded quickly. However, they did not identify all the shortfalls we found.

The registered manager kept their knowledge and skills up to date so they could provide the right support for people.

People were encouraged to participate with activities in the wider community and community links were being built.

Clare Hall Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 28 April and 4 May 2016 and was unannounced. It was carried out by one adult social care inspector and a specialist advisor nurse. The specialist advisor had a background and experience of managing care homes.

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 improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit.

We spoke with nine people that lived at the home in detail, four visitors and had informal conversations with other people at the home. We spoke with the registered manager and nine members of staff including the registered manager, operations manager, kitchen staff, nursing staff, activities coordinator and care staff. We 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 nine people's care records and observed care and support in communal areas. We looked at seven staff files, previous inspection reports, staff rotas, quality assurance audits, staff training records, the complaints and complements files, staff and resident meeting minutes, medication files, environmental files and a selection of the provider's policies.

Requires Improvement

Is the service safe?

Our findings

People were not supported by sufficient numbers of staff to meet their needs. A person said, "I don't know if there are enough staff". One relative said, "Maybe there could be more staff" and another told us, "Sometimes [person's name] has to wait a couple of hours or more if staff are busy with other residents". A staff member said, "Although they [the management] said there are enough staff – there never are". Other staff thought there were insufficient nurses, especially in the afternoon. They explained from their experience of being busy an extra carer was required for both the morning and afternoon shift. One member of staff told us there was one day recently where only four members of staff were on shift and the rota confirmed it. The staff member explained it was hard work but they managed to meet people's needs. The registered manager had told us there should be seven care staff in the morning and six care staff in the afternoon; in addition there were two nurses in the morning and one in the afternoon with a second nurse completing paperwork. They also said they had used up to two agency staff a day to meet these numbers in the last six weeks which the rota confirmed. Following the inspection, the provider told us they had identified their deployment of staff was wrong in the home but they had enough staff for each shift.

People were brought into the main lounge during the morning and we saw a person banging on the table to get staff attention because none were in the room for over ten-minutes. There was another occasion a person became distressed because they required support with personal care; no staff were in the room and some relatives became anxious for the person so went looking for staff. Personal care is when someone requires support to maintain personal functions such as washing and using the toilet. Another person who was at high risk of falls attempted to stand from their wheelchair on a number of occasions when in the lounge over a ten-minute period as there was no member of staff to support them. Therefore, there was a risk the person may fall and hurt themselves.

On the first day people had to wait for lunch to be served in the main dining room. One person said, "Oh come on where is the food" after waiting thirty minutes because there were no staff to serve food. The registered manager explained the activity coordinator was on training but usually supported people in the dining room. The registered manager confirmed once people had been helped in other parts of the home staff would come to the dining room. They also told us there were three new members of staff waiting to start work once the correct checks had been completed. Following the inspection the registered manager has reviewed the staffing dependency tool and adjusted the locations of staff in the home at times to keep people safe.

This is a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk of abuse because there was a not a robust recruitment procedure for new staff. All staff had Disclosure and Barring (DBS) checks. A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. However, four staff did not have proof of identity in their staff files and two members of staff did not have satisfactory evidence of conduct in previous employment. We spoke to the registered manager and operations manager who explained the

proof of identity had been seen at the time of employment but removed due to data protection rules. They explained some staff were contracted to the home so their full files were kept at their head office. Following the inspection the registered manager sent us further information about these staff. We were told by the registered manager and operations manager they would be reviewing the staff files and ensuring all paperwork was correct and in line with the regulations.

This is a breach in Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people's care plans contained some risks assessments and where in place measures were considered to reduce the risks. For example, a person who was at risks of falls and other health issues had some measures in place to reduce risks to them. Their care plan said "[Name of person] has a mat next to their bed so that they don't slip if the floor gets wet". There were considerations about the environment and where their call bell was placed. The registered manager had ordered some specialist equipment to try and protect the person further. However, a second person had no risk assessment for eating in bed. A member of staff said, "[Person's name] nearly choked because they lay down whilst eating". On the second day of the inspection this person was lying in bed at lunchtime and their food was left on the table next to them. The registered manager said the person does eat in bed but sitting up. Another person had bed rails being used on their bed to prevent them from falling out, but there was no risk assessment in place.

People were not always protected from a risk of errors with their medicine administration. Medicines entering the home from the pharmacy were recorded when received and when administered or refused. However, there was not consistent double checking of drug disposal which meant although there was an audit trail and they knew what medicines were on the premises it had not been verified. This meant medicine being disposed was not checked by a second member of staff to ensure it was physically removed from the home. We found on one day a person had 14 medicines not signed for in their Medicine Administration Record (MAR) chart by the same staff member on two separate occasions. Another person had seven medicines not signed for on one occasion. Stock levels matched the quantity which was left if they had been administered. The registered manager immediately investigated the situation and confirmed the medicines had been given but the staff member had not signed for them on the MAR chart. Once we alerted the registered manager they contacted the member of staff and rectified the situation and put a plan in place to support this member of staff.

People told us they felt safe at the home and with the staff who supported them. Many of them had difficulty communicating this to us because of their medical diagnosis. Some people responded to us when we asked them if they were safe by saying "Yes". Another person said, "This is a very nice place and I feel safe, too right I do". One relative explained they felt the home kept the person they visited safe. They continued by saying, "I can sleep at night" meaning they were not worried. When a staff member was asked about whether people were safe said, "All safe, 100 percent".

People's medicines were administered by nurses who had received medicine management training. Whilst administering medicines the registered staff wore a red 'do not disturb' tabards which is best practice in order to reduce disturbances. People and staff did not interrupt them whilst they were wearing these tabards. People's identities were checked during the medicine round and the member of staff explained to the person what medicines they were giving. They did not rush the person to take the medicine and the medicine trolley was locked between uses. There were suitable secure storage facilities for medicines which included secure storage for medicines which required refrigeration. Spare oxygen cylinders were stored in the clinical room and secured to the wall to prevent potential risk of them falling.

Some people were prescribed medicines on an 'as required' basis and one person received covert medication. Covert medicine is when someone refuses to take medicine it will be hidden in a drink or food in their best interest to make sure their health needs are maintained. Each as required medicine had guidelines in place so staff knew when to administer them. The GP had authorised the as required and covert medicine. The staff confirmed this decision with the pharmacist to ensure it would not be damaged by being hidden in drink or food.

Staff told us, and records seen confirmed, staff received training in how to recognise and report abuse. They understood what may constitute abuse and how to report it. A member of staff told us about a specific example where they had made sure someone was safe. Another member of staff told us some signs to look for, such as bruising and the person shying away. All were confident any concerns reported would be fully investigated and action would be taken to make sure people were safe. Most of them said they would go higher up in the company or to an external body like CQC if they needed to. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with relevant authorities to make sure issues were fully investigated and people were protected.

Requires Improvement

Is the service effective?

Our findings

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

We checked whether the service was working within the principles of the MCA. People were at risk of having their human rights breached because the principles of the MCA were not always being followed. Staff did have some understanding of the MCA and how to complete decisions in people's best interest. A member of staff explained a situation where someone's best interest had to be considered. Within a carers meeting there was mention of some MCA training which had occurred. People were always asked for their consent before staff assisted them with any tasks. However, there were some people who had MCA assessments and best interest decisions but these were not decision specific in line with the Code of Practice. For example, on one person's form in the decision box it said "Whether [person's name] understands and can make decisions about their care needs – personal care, medical care, nursing needs" rather than showing that decisions around these things should each be considered separately in their own right. In the corresponding best interest decision there was no record anyone else had been consulted other than the member of staff completing the form.

Another person had a range of decisions on their form which ranged from visiting the GP, having invasive tests through to taking photographs. No one had been consulted as part of the best interest decision. This person had recently had a pressure mat put at the side of their bed because they were at risk of falls. There was no specific capacity assessment and best interest decision related to this. Therefore, staff were not considering decisions separately and respecting people who could have fluctuating capacity or the ability to make a decision about one thing but not another. The registered manager said all staff had recently had training. After showing the registered manager the capacity assessments they agreed there should be one for each decision.

This is a breach in Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether conditions on authorisations to deprive a person of their liberty were being met. Where the registered manager had identified people were being restricted which could result in a deprivation on the liberty they had made the appropriate applications to the local authority. One person had an authorised DoLS in place with no conditions the home had to follow.

People's nutritional needs were usually assessed to make sure they received a diet in line with their needs

and wishes. One person said, "There is always two meal choices and you can always get something else". The chef reported to us they, "Knew most residents. Nurses gave the kitchen staff information regarding residents". They continued to tell us they invited comments from the residents and relatives about the food. A relative told us the chef had found out their loved one like stilton cheese so they now received it. In the kitchen there was a poster with people's photographs and descriptions of different food textures. People made choices a day in advance but there was no opportunity for them to choose from pictures or actual plated meals. The chef manager was reviewing this by holding meetings with residents and relatives.

However, during our lunchtime observations one person struggled to eat their pudding because they were using a dinner knife rather than a spoon. Prior to this they had difficulty eating their main meal with a spoon as the pieces were large or they became distant and forgot to eat. A number of staff had been near them but did not notice the person struggling. Their care plan showed they had a medical condition which should be controlled by their diet and an assessment in relation to eating said "Manages unaided". We spoke with the registered manager and a nurse who explained this person had medical issues which caused them to fluctuate in their ability day by day. They told us they would review this person's care needs. Another person had lost weight according to their care plan but no referrals to a dietician had been made. We spoke to the registered manager who explained if they noticed a gradual weight loss it was monitored before contacting the GP.

People were supported by staff who had undergone an induction programme which gave them basic skills and information to care for them safely. The registered manager was in the process of identifying how to incorporate the Care Certificate into their induction. The Care Certificate has been developed by Skills for Care and is a set of standards that social care and health workers follow in their daily working life. It is the minimum standard which should be covered as part of induction training of new care workers. However, some staff felt the current induction was not sufficient for new staff especially if they were new to working in care. One member of staff said, "Induction should be longer" and explained this was because some recently employed staff were new to care so needed to learn the basics such as using the hoists safely. Staff did receive moving and handling training prior to using the hoists.

There were always qualified nurses on duty to make sure people's clinical needs were monitored and met. However, we were told by members of staff there should be more in the afternoon. We spoke with the registered manager who explained recently, they had changed the nursing staff from two in the afternoon to one. They told us the second nurse was meant to complete paperwork and not be on the floor of the house because it was not necessary. We found there needs to be more staff in the home to meet people's needs and keep them safe. Following the inspection, the provider and registered manager told us the second nurse in the afternoon was always available for additional support.

People received care and support from staff that had the skills and knowledge to meet their needs. The registered manager explained they had ensured all staff had received up to date training. On the second day some staff had refresher training for some of the techniques they would regularly be expected to use. Staff had mixed feelings about recent training they had attended. A member of staff told us about the MCA and DoLS training they had completed. Another member of staff said, "There was good e-learning training" and continued to tell us about end-of-life training delivered at the local hospice. The registered manager was supporting the qualified nurses with their continuing professional development.

The home arranged for most people to see health care professionals according to their individual needs but had not recognised when a person required a dietician. Two people identified at increased risk of falls during the registered manager's monthly audits had been referred to other Health and Social Care professionals and specialist equipment had been sought. Staff demonstrated their willingness to contact

other professionals when a person showed they were upset about their temporary placement. During the inspection the staff and registered manager tried to arrange for this person to see their social worker. A third person with complex health needs had records of multidisciplinary involvement in their care; this included the person seeing a dentist, physiotherapist, occupational therapist and specialist nurse for one of their medical conditions.

Good

Is the service caring?

Our findings

At the last inspection people said they were not always supported by staff who listened to them. During this inspection we found there had been improvements in the way staff interacted with people. People now said they were supported by kind and caring staff. One person said, "Staff look after us" and continued to say they were "As kind as they can be". Another person told us "[The staff] look after you well" and continued to say they were "All nice people [meaning the staff]". A third person said, "I am getting wonderful care".

People and visitors were treated politely and with respect. They were spoken to kindly and most people were relaxed throughout the inspection. If they showed signed of distress staff were quick to come over and reassure them if they were in the room. The home was calm and peaceful. One member of staff sat next to a person and said "You look nice today, you look really lovely". Another person had a positive conversation with the chef when they came in the room during the morning.

People told us they were able to have visitors at any time. Each person who lived at the home had a single room where they were able to see personal or professional visitors in private. During the inspection there were visitors in people's bedrooms and others in the main communal spaces. One person explained they would like to speak with us another time as they had so many visitors during the first day of the inspection. We did arrange to speak with them. A relative explained the staff always greeted you when they arrived.

People's privacy was respected and all personal care was provided in private. Staff were able to tell us how they protected people's dignity during personal care. One staff member explained they would keep people covered with a towel. Another staff member explained they would respect whether the person wanted a male or female to help them. A person became distressed and was at risk of exposing themselves in a communal room; once a member of staff and the registered manager were in the room they acted quickly to find a blanket and take the person somewhere private. Staff knocked on bedroom doors before entering them.

People made choices about where they wished to spend their time. Some people preferred not to socialise in the lounge areas and spent time in their rooms. People were able to choose if they had their own or shared bedroom. We checked they were in agreement with this arrangement. One of them told us "They [meaning their partner] like to be in their own room at night. They have always been like that". Members of staff helped one of them move to the other bedroom during the day so they could be together. Another person wanted to go downstairs so they could participate in the activities. The registered manager found a member of staff to support the person with this choice.

There were ways for people to express their views about their care. A person told us "I am involved as much as I want to be in my care". Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and view their opinions. People who lacked capacity to make care choices had information to show relatives were involved. For example, one person had their relative sign various decisions to show they had been included in the discussions. A third person explained they "See the manager regularly and attends regular meetings" when asked about their care. There was an

annual person and relative survey completed by the provider. The last results were positive and actions had been taken with any concerns raised.

Staff were aware of issues of confidentiality and did not speak about people in front of other people. A member of staff said "I shouldn't be blabbing around the building" when a person tells you something confidential. When they discussed people's care needs with us they did so in a respectful and compassionate way. During a discussion with the registered manager they chose to close the door of the room to maintain confidentiality. Staff elected to speak quietly with us to maintain a person's privacy.

People's cultural and religious differences were respected by staff. The registered manager explained they were considering recruiting a chaplain with the provider's support. However, this had been put on hold because there was not enough interest. People had access to a communion once every three weeks at the home. A member of staff told us they read the Bible for someone regularly.

Good

Is the service responsive?

Our findings

At the previous inspection there were concerns not enough activities were available for people. Also, people who required more physical support to meet their needs felt they had fewer choices. There was now an activities coordinator in post who involved as many people as possible even if this was just taking them a sample of what had been made. This meant the activities coordinator would make extras such as wind chimes or models which were then given to people in their bedrooms who had not participated in the activity. A person who required greater support with their physical needs explained they wanted to get downstairs because they enjoyed the activities; later they were fully participating in the activity to make wind chimes. One relative said "Activities are quite good and that is down to [new registered manager's name]". A member of staff said, "The activity lady is fantastic with the residents". Another one said "Lovely girl [name of activity's coordinator]. They are a breath of fresh air. They do so many activities".

However, the activities coordinator explained during the morning they were left on their own running activities in the main lounge; on the inspection we saw this had happened. They had a call bell to get support from other staff should it be required. This distracted them from running the activities because one person with a history of falls tried to stand in their wheel chair and another person was calling out for help. We spoke to the registered manager and operations manager about this. Following the inspection the registered manager informed us in the morning a member of care staff would now be designated to the communal area. They were hoping this would meet people's needs and keep people safe.

The activity coordinator explained it was a relatively new role for them and they had clinical qualifications. People were being supported to create their own sensory garden as part of their activities. So far they had been involved in planting and making wind chimes and there were plans to make flower pot people, a water feature and a wall of fragranced flowers. The variety of activities for people to choose from had increased including reminiscent activities, painting, collaging, bingo and singing sessions. There was now a visiting Pet as Therapy dog and a pottery class had started. A relative confirmed they had seen an increase in activities including singers coming into the home and regular music. This meant people now had more choices and opportunities whilst living at the home.

People's care plans were in the process of being updated and personalised further to assist staff to provide care following people's needs and wishes. Even during this transitional period staff knew the needs of people and demonstrated in depth knowledge of specific individuals. The registered manager explained they were in the process of rewriting and updating all people's care plans so they were consistent. We found different versions of care plans which demonstrated this process. New care plans were clearly set out and included key information. For example, one person had a nursing assessment which included information about their history of falls and measures in place to reduce the likelihood. There were sections for expressing a person's sexuality, spiritual fulfilment, proactive measures around wound care and an end of life plan. Historical documents were kept so staff could refer back to them. Another person had goals defined in their care plan; one was for promoting health eating. This meant staff had the information they needed to meet people's needs.

Each person had their needs assessed before they moved into the home. This was to make sure the home was appropriate to meet the person's needs and expectations. The assessments included nursing information so specific needs such as mobility and health needs could be met. There was information about other professionals who had been involved in the person's care. One person who had recently moved in for respite had a care plan in place which covered all their needs and wishes. Respite is when a person comes to the home for a short stay from where they usually live. It is designed to provide additional support to the person and the people who usually support them.

The registered manager sought people's feedback and took action to address issues raised with the support of the staff. For example, some people expressed they did not want to receive support with personal care from staff of the opposite gender. Some members of staff had worked on reviewing people's preferences. The home, where possible, now respected these preferences and the registered manager tried to incorporate them in the rota.

There was a large collection of compliments kept about the home. This included a selection of cards from families thanking staff for the care of their relative. Comments such as "It is a great comfort to us to know that they were so well looked after" and "I recommend the care home. I will always be grateful". Amongst the compliments we saw a newspaper cutting about a flower arranging activity which had occurred. There was a comment saying there was a "Wonderful selection of flowers".

Each person received a copy of the complaints policy when they moved into the home. They had a copy in a folder in their bedroom. Since the current registered manager had been in charge there had been seven formal complaints. In each case the registered manager had recorded the date, nature of the complaint and the response. Where relevant, internal investigations had been completed. When it was possible, the complainant was asked to sign the complaint off with a note of their satisfaction or otherwise. If they were unavailable for this a record of their comments was recorded. All complaints had been managed in an efficient and timely manner in line with the company's policy.

Requires Improvement

Is the service well-led?

Our findings

Providers have a responsibility to produce a statement of purpose during the registration process. This is a document which advises people of specific information about the service including the name of the registered manager, the legal status of the provider, the aims and objectives of the provider and the kinds of services provided. It is then the duty of the provider to ensure this document is updated when there are changes and notify CQC of these within 28-days of the changes. There was a statement of purpose in the entrance to the home which had the wrong registered manager recorded. The provider had a duty to regularly review the statement of purpose and had failed to update it or notify CQC of changes. By not updating the information people may not know who the registered manager was and who to contact should they have concerns.

We recommend the provider refers to national guidance about notifications which need to be made to CQC.

People were not always being informed about the most recent inspection from CQC on the provider's website. The provider had failed to include the ratings on their website in line with regulations. We spoke with the registered manager and operations director. They showed us a website they thought the ratings were displayed but it was not the correct one. Following the inspection the provider responded promptly to address the shortfall and it is now displayed along with a link to the CQC report. When the provider and registered manager were alerted to this shortfall they responded in a timely manner to rectify the situation. There was a hard copy of the report was available in reception and the required poster was on display.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. Audits and checks were in place to monitor safety and quality of care. The registered manager ensured audits were completed for care plans, medication, skin integrity, infection control and the home environment. Where shortfalls in the service had been identified action had been taken to improve practice. The provider completed visits to check the audits. They had identified the concerns around staffing and there was an entry on the service improvement plan with some basic actions. However, on occasions a shortfall had been missed. For example, the statement of purpose was not correct but on two quarterly quality audits produced by the registered manager it stated the document was current.

The registered manager was a registered nurse they and kept their skills and knowledge up to date by on-going training and reading. They had organised for all the nurses to attend revalidation training. Revalidation is the new process that all nurses and midwives in the UK need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). This is to ensure all nurses are following the code of practice to maintain high standards and safe care. However, they were not receiving clinical supervision because their supervisor was not clinically trained. Clinical supervision is an activity which brings skilled supervisors and practitioners together in order to reflect upon their practice. The registered manager was positive about the support they were receiving from the provider and said the operations manager was always at the end of a telephone.

People and relatives were positive about the registered manager. When interacting with the manager

people smiled and enjoyed the interaction. For example, the registered manager helped a person to identify whether their newspaper was from the right day. A relative said, "[The registered manager's name] is a manager. They have their finger on the pulse" and continued to say "[The registered manager's name] is the best". The staff had mixed opinions of the registered manager. Staff said, "The [registered manager's name] was approachable" and told us they got on well with the registered manager. Another staff member said, "There was too much pressure from the manager" referring to the staff levels.

There was a staffing structure in the home which provided clear lines of accountability and responsibility. The registered manager was supported by a Head of Care and Clinical Lead; both shared responsibility for supervising the nurses and care staff. Information was shared between senior staff at Heads of Department meetings three times a week. This allowed the registered manager to be informed of any concerns or developments in the home. The operations manager and registered manager explained there were plans to recruit a deputy manager to provide further support.

The registered manager had a clear vision for the home and the mission statement was shared with members of staff during their induction. Their vision and values were communicated to staff through staff meetings and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. A member of staff said they had supervision every three months. Records seen showed staff had received supervisions recently. The registered manager told us they wanted to have more frequent staff meetings.

All accidents and incidents which occurred in the home were recorded and analysed. When patterns emerged action was taken by the registered manager to reduce the risk of reoccurrence. For example, if a person had a number of falls in a short space of time referrals were made to relevant health and social care professionals. Two people had recently had falls so were waiting for additional specialist equipment. The registered manager notified important individuals to each person and kept them updated.

People were being protected by monitoring from external agencies. The home had notified the Care Quality Commission of significant events which occurred in line with their legal responsibilities. In addition, the local authority or other health and social care professionals were informed. For example, when medication errors had occurred the registered manager had liaised with the local authority safeguarding team. This was to identify whether there was a risk of harm from the mistakes.

The provider tried to ensure people had opportunities to be involved in the wider community. The activities coordinator and registered manager were working together to hold a garden party to celebrate the Queen's 90th birthday. They were attending a meeting with the Parish Council to organise this. Other links were being made with a local choir, gardeners club and the Women's Institute. There were plans to link with local colleges to encourage students to have work experience at the home. Recently, there had been a joint significant birthday and wedding anniversary party of two people living at the home; their family and friends had all been invited into the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People did not have their human rights protected when they were unable to give consent because the correct procedures were not followed. Regulation 11 (1) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures did not ensure specific information for each member of staff was available. Regulation 19 (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported by a sufficient number of staff to meet their needs and keep them safe. Regulation 18 (1)