Veecare Ltd

Sevington Mill

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection visit was carried out on 15 April 2015 and was unannounced. This was the first inspection carried out for this service since it was registered by the provider in October 2014.

Sevington Mill provides accommodation and personal care for up to 50 older people. There were 47 people in residence on the day of the inspection.

The service is run by a manager, who was present on the day of the inspection visit. The manager is not yet registered with the Care Quality Commission, but had commenced her application. The service has been without a registered manager since February 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 and associated Regulations about how the service is run.

People's health care needs were monitored, and changes were referred to their GP, district nurses and other health

Summary of findings

professionals. Some people required charts to record aspects of their care such as fluid charts for their hydration. These had not been properly completed, and showed only a few entries each day for people's fluid intake. Some were as low as two drinks in 24 hours. This did not confirm that people's health and hydration needs were being met.

Staff had friendly and caring attitudes, and spoke to people respectfully. A visitor commented that "Staff are always polite, courteous and very helpful". Two people raised concerns about items of clothing going missing from the laundry "On a regular basis", and being given the wrong clothes to wear. This compromised their dignity.

Records were stored confidentially. Some were up to date and fully completed, but others were in the process of change, and had not all been updated or were not complete. These included care plan files, consent forms, and staff supervision and appraisal records.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The manager understood when an application should be made and how to submit one to the local authority.

Staff had been trained in safeguarding adults, and discussions with them confirmed that they understood the different types of abuse, and knew the action to take in the event of any suspicion of abuse. Staff were aware of the service's whistle-blowing policy, and were confident they could raise any concerns with the registered manager, or with outside agencies if they needed to do so.

The service had systems in place for on-going monitoring of the environment and facilities. This included maintenance checks, and health and safety checks. The provider had identified areas of the building which required upgrading or refurbishing, and had commenced work in these areas, some of which had been completed.

Risk assessments had been implemented for each person living in the home, highlighting specific concerns which could affect their welfare and safety. This included a personal emergency evacuation plan, showing how each person would require assistance if evacuation was required. Other risk assessments included risk of falls, moving and handling risks, and risk of developing pressure sores. Action was taken to minimise the assessed risks. The manager monitored accidents and incidents to assess the frequency and location of these, and if they occurred more frequently at specific times of the day. She identified if there was action which could be taken to prevent future accidents.

People said they felt safe in the home, and thought there were sufficient numbers of staff. Staffing rotas and our observations showed that there were suitable numbers to meet people's care needs. People's call bells were answered in a satisfactory time frame, and staff ensured their call bells were within reach. Records for staff recruitment and induction training showed that there were robust recruitment procedures. Staff training programmes provided staff with on-going training for required subjects. Most of the care staff had completed formal qualifications in health and social care, such as diplomas. Staff told us that individual supervision and appraisal programmes had been implemented, and that staff had received individual supervision sessions or an appraisal in the last six months. However, records for these were not evident, and this could not be confirmed. Staff were encouraged to attend meetings, and to take their part in the development of the service.

The deputy manager and senior care staff managed and administered medicines for people following safe practices. People received their medicines on time.

Domestic staff were on duty throughout the day, and the service was clean, and did not have offensive odours. New cleaning programmes and additional hours for domestic staff had been commenced. Staff were trained in infection control, and good hand hygiene practices were observed. Staff wore personal protective equipment such as disposable aprons and gloves, and had their hair covered when serving food.

People said that the food was "Very good" and "Okay" and said they had sufficient choice. People said that the food was well presented, and they were given plenty of food. They knew that they could request a snack at any time. Mid-morning and mid-afternoon drinks were served with a selection of biscuits and fresh fruit, and drinks were actively offered to people throughout the day.

Summary of findings

Staff had been trained in understanding mental capacity, and demonstrated their knowledge of this by ensuring people were given choice, and by promoting their independence. They were aware of people's preferences to stay in their own rooms or to socialise with others. Staff were knowledgeable about people's different backgrounds and life styles, and knew their preferred activities and interests. An activities co-ordinator provided a wide range of activities and entertainment. An activities programme was displayed on notice boards in each sitting area, and people were given a copy to have in their own room. People were supported in going out of the home as they wished.

People and their relatives were invited to take part in their care planning. Care plans reflected people's individual needs and were person-centred. Staff were in the process of putting care plans into a new format, which included different sections for each topic, so that specific information could be easily found. Some care plans had not been fully completed in the new formats, so both care files were needed. Consent forms were included, but had not all been signed in the new care plan files, so did not confirm that care plans and reviews had all been discussed with the person or their representative. Other charts confirming how personal care had been given were incomplete.

People felt that their concerns were listened to and were taken into account, and that changes would be made as a result. The complaints procedure was clearly displayed and was included in the service user's guide, which was given to people when they were admitted.

The manager had been in post for a few months and was in the process of applying to CQC for registration. She was supported by a deputy manager and senior care staff, who had been allocated with different areas of responsibility.

Staff meetings had been held since the new provider had commenced, and staff had been invited to share their views about proposed changes. Many staff had worked at the service for several years, and some said they had found it difficult to accept changes which included different hours of working, and different shift patterns. Other changes had been implemented such as commencing improved recording processes. Staff generally felt that morale was improving, and one said "Our views are taken into consideration". Staff surveys had been provided but only a small proportion of staff had completed these. Not all staff were sure about the vision and values put into place by the new provider.

The manager had an open door policy which was demonstrated on the day of the inspection. She was available and approachable to people, and several people and staff said they knew they could talk to her at any time. The manager assessed the quality of the service using a system of audits which had been commenced by the new provider. These contained a comprehensive assessment of each subject, and included infection control, accidents and incidents, and medicines' management. The audits had been thoroughly completed.

We found a number of 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Environmental and personal risk assessments were carried out, and were followed to provide a safe environment.

Robust staff recruitment procedures were carried out; and staffing levels were maintained to ensure people's needs were met.

Staff were trained in safeguarding and emergency procedures. Medicines were stored and administered safely. Infection control procedures were carried out effectively.

Is the service effective?

Requires improvement

The service was not consistently effective. Staff supervision and appraisal records were not available to provide evidence that all staff had received suitable individual supervision and appraisals. Processes were in place to keep staff training up to date, and additional relevant subjects were available for staff to further their knowledge and learning.

The manager and staff understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

The service provided a variety of food and drinks to provide people with a nutritious diet. However, accurate records were not maintained for people who needed their food and fluid intake monitored. Staff were knowledgeable about people's health needs and made referrals to other health professionals.

Is the service caring?

Requires improvement

The service was not consistently caring. Staff showed friendly, patient and helpful attitudes to people, and protected their privacy. People's dignity was sometimes compromised by losing their clothes or giving them other people's clothes to wear.

Staff encouraged people to retain their independence. People and their relatives were not always informed of changes to their care in a timely manner, and records did not demonstrate this.

Friends and family were able to visit at any time.

Is the service responsive?

Good

The service was responsive. People were involved in their care planning, and staff were committed to providing person-centred care.

People were supported in carrying out their preferred lifestyles and in taking part in activities of their choice.

Summary of findings

There were procedures in place to ensure that people's concerns or complaints were listened to, and were responded to appropriately. Learning from complaints was used to bring about on-going improvements to the service.

Is the service well-led?

Requires improvement 

The service was not consistently well-led. Staff were unsure about the vision and values of the service since a new provider had taken over.

The manager had been in post for a few months, and was working with the provider to bring about changes and improvements to the service. The manager was not formally registered with the Care Quality Commission.

New systems were in place to monitor the service's quality and progress, using audits and questionnaires.

Records were being re-evaluated and brought up to date, but some were incomplete.

Sevington Mill

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 28 April 2015 and was unannounced. It was carried out by a team of three people, comprising two inspectors, and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC) A notification is information about important events which the service is required to tell us about by law. We contacted two social care professionals for their views of the service before the inspection, and received feedback from one of them.

We asked the provider to complete a Provider Information Return (PIR) before the inspection. 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. The provider returned a PIR within the set time scale.

We viewed all areas of the service, and talked with 13 people who were receiving care. Conversations took place with individual people in their own rooms, and with people in the lounges. We also had conversations with four relatives and visitors, and ten members of staff as well as with the manager. Staff members we talked with included care staff, domestic staff, laundry staff, and the chef.

During the inspection visit, we reviewed a variety of documents. These included five care plans, three staff recruitment files, staff training records, staffing rotas for two weeks, medicine administration records, health and safety records, environmental risk assessments, activities records, quality assurance questionnaires, minutes for staff meetings, audits, the service users' guide, and some of the home's policies and procedures.

Good

Is the service safe?

Our findings

People said that they felt safe in the home and were happy living there. One person who had previously had falls at home said, “It is very pleasant here and I don't worry now about being on my own”. Other people said, “It feels safe here and I sleep well, everyone is very kind”, and “My room is very comfortable and I feel safe here”. A visitor said, “After my relative had several falls and was hospitalised, this is a good place for her to be. It feels very safe and I know my relative won't be so likely to fall”.

Staff training records showed that the staff had received training in safeguarding adults. Staff confirmed their understanding of the different types of abuse and what action to take if they suspected abuse might have taken place. They were also informed about the home’s whistleblowing policy, whereby staff should be able to report concerns about other staff members in a way that did not cause them discrimination. The manager was familiar with the processes to follow if any abuse was suspected in the home; and how to contact the local authority safeguarding team. There was a copy of the Kent and Medway safeguarding protocols in the staff office, so that it was easily accessible to staff.

Environmental risk assessments and emergency procedures were in place. A folder contained emergency details and contact numbers, and included a personal emergency evacuation procedure (PEEP) for each person. Fire emergency instructions were provided, and an arrangement had been made with a nearby care home to take people there if emergency evacuation was needed. Other emergency details included where the gas isolator valve was situated, and security locking up procedures.

People had individual risk assessments within their care plans. These included risks associated with using equipment in their bedrooms, such as ensuring there was sufficient space for the person to move about safely. Risk assessments included if people could access their call bell when needed, if window restrictors were in place, if flooring was suitable, and if their curtains closed correctly for protecting their dignity. Other risks were identified, including the risk of falls, risks with moving and handling, and risks of developing pressure ulcers. These contained information about how to minimise the risks. For example, one person’s moving and handling risk assessment showed that they could move independently with a four-wheeled walking trolley, but required assistance from care staff and the use of a bath hoist to get in and out of the bath.

An environmental assessment showed the provider’s programme for items which needed repair or refurbishment, and when these had been completed. The last few months had included re-carpeting of the stairs and all corridors on both floors; redecoration of corridors; shelves put up for storage in the laundry room, and bedrooms refurbished when they became vacant. Two bathrooms had been refitted with new tiles and new facilities, and had been redecorated; and a third bathroom was being refurbished during the inspection.

A range of equipment had been installed for people’s support, and included grab rails, raised toilet seats and surround rails, nurse call system, and mobile hoists. Contracts were in place for regular safety checks of fire equipment, emergency lighting, lift servicing, gas boiler checks, water temperatures and radiator thermostats. Mobile hoists and bath hoists were checked and serviced every six months. Electrical checks for portable appliance testing (‘PAT’ tests) were carried out yearly. Fire alarm tests were carried out weekly, and staff training records confirmed that staff were trained in fire safety and attended regular fire drills. Monthly bedroom assessments were carried out to check safety for items such as wear on carpets, window restrictors, and any trailing wires. Action was taken to remedy any items that were unsafe.

The manager monitored accidents and incidents and recorded a monthly summary of these so that any patterns could be detected. For example, if accidents occurred at the same times of day, or if the same staff were on duty. Action was taken to investigate and deal with any areas of concern.

Staffing levels had been reviewed after the service was registered with a new provider, and provided suitable numbers to meet people’s needs. Numbers of care staff had been increased in the evenings and early morning which were busy periods. An additional care staff member had been added to night duties, with a sleep-in role overnight, so as to support night staff in any emergency. The manager and deputy manager had an on-call system for when they were not on duty. Care staff numbers included five care staff, and one senior from 8am to 8pm; and two care staff and one sleeping in from 8pm to 8am. An

Good

Is the service safe?

additional care staff was on duty during the evening from 4.30pm; and the sleep-in care staff worked during the evening and early mornings. The deputy manager worked five days per week, including a weekend day. The manager usually worked from Monday to Fridays, from 8am - 5.30pm, but varied her hours so that she could meet with other staff such as night staff. The deputy manager gave us examples of when staffing numbers had been increased in response to increased dependency, such as when a person had been admitted with two broken arms, and needed additional staff support.

Domestic staff hours had changed so that domestic staff were on duty throughout each day, and not just in the mornings as previously. Two domestic staff were on duty in the mornings, and two in the afternoons. They said that this impacted on cleaning everyone's bedrooms in the mornings, as it was "Too rushed"; and communal areas were not fully cleaned until the afternoons. Domestic staff told us that they concentrated on cleaning the bedrooms in the mornings, as some people liked to rest back in their rooms in the afternoons..

The premises were visibly clean and did not have offensive odours. Communal areas were cleaned during the mornings and afternoons, and we observed staff cleaning surfaces and vacuuming throughout the day. Carpets were deep cleaned as needed, and bedrooms were deep cleaned on a rolling programme, and when vacant. Domestic staff used colour-co-ordinated cleaning equipment for different areas. Bathrooms and toilets were equipped with liquid soap, paper towels, pedal bins and antibacterial gel. A system of using red alginate bags was in place in the laundry for dealing with soiled items. A robust infection control audit was carried out monthly, and assessed all aspects of infection control, including management, staff training, policies and procedures, hand-washing, laundry and sluice areas. New records had been implemented for cleaning schedules, which showed when different areas had been cleaned, and which staff were responsible. Signed records showed when each area had been cleaned. We observed that some communal areas, including stairways, did not look clean in the morning, but had been thoroughly cleaned during the afternoon.

Staff recruitment procedures included required checks, such as checking the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. A record was kept of the interview process. All staff followed a detailed induction programme and shadowed other staff until they were assessed as competent to work on their own.

Medicines were stored in locked cupboards and medicine trolleys, which were kept locked to the wall when not in use. Arrangements were in place to store trolleys in a less centralised area. Room and drugs fridge temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures. There were suitable procedures for checking medicines in from the pharmacy, and for recording any unused medicines for return.

Only senior care staff who had received suitable training administered medicines to people. Some people were assessed as able to administer their own topical creams or inhalers, and had a locked cupboard in their rooms for safe storage. People said that they received their medicines on time. Each person had a medicines administration record (MAR chart) which included their photograph for identification purposes, and a record of any allergies. There were clear guidelines in place for consistency for staff to give 'as necessary' medicines, for example for pain relief, or constipation. MAR charts had been accurately completed.

Requires improvement

Is the service effective?

Our findings

People spoke positively about the staff and said they were kind and helpful. Staff greeted people or stopped to talk with them as they went by. One person said "The care is better here than it used to be", but did not give any further explanation. Another person said they were aware that staff "Had lots of training".

Staff were knowledgeable about people's different care needs, and demonstrated an understanding of people's different mental capacity. Most staff had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff training records showed that all staff received required training in subjects such as moving and handling, infection control, health and safety, fire safety, food hygiene, first aid and safeguarding adults. Other relevant topics included dementia care, person-centred care, medicines management and diabetes. The majority of care staff had completed formal training in health and social care with National Vocational Qualifications (NVQ) or diplomas, to levels 2 or 3. (NVQs are work based awards that are achieved through assessment and training. To achieve an NVQ, candidates must prove that they have the ability to carry out their job to the required standard). All of the staff that we spoke with said that the training they had received had been useful. Training was provided in house by a certified trainer. Staff described the trainer as knowledgeable and said they presented information in a way that staff could understand and relate to the setting and the people they cared for. Group training enabled staff to discuss their training together, and the trainer ensured that staff understood their training and knew how to apply it.

Two staff were behind in required training updates, and the manager was aware of this and had addressed it. These staff were booked into training updates, and if they failed to complete them, would not be allowed to work until the training was completed.

Staff supervision programmes had been implemented, and each staff member had a named person to give them individual supervision. Staff told us they had had one or two individual supervision sessions in the last six months, and/or an appraisal, but said that supervision had been irregular and infrequent. This meant that staff did not generally feel supported and some were unsure about sharing their views. Records for the supervision programme were not evidenced, as a staff supervision planner had not yet been prepared.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People said that staff explained things to them, and gave them the support they needed. They were encouraged to retain their independence and to carry out their preferred lifestyles. Staff obtained verbal consent from people before assisting them with personal care tasks. People were asked for written consent to show that their care plans had been discussed with them, and to show they agreed with them. Care plans contained forms for written consent for taking photographs for identity purposes, for documenting wound care, and for recording social occasions. Some had been signed and some forms in new care plan formats had not been signed. However, the care plans were being changed from one format to another, and it was evident that people had previously signed consent in their original care plans. A staff member had been designated to bring all the information together in the new care plan files.

Staff were able to talk about how they supported people who lacked mental capacity. The Mental Capacity Act 2005 sets out how to act to support people who do not have capacity to make a specific decision. Some people had fluctuating capacity, and were able to make decisions more easily at some times than at others. Some were able to make everyday decisions about their food preferences, and the clothes they wanted to wear, but could not understand or retain information about their health needs. This was recorded in their care plans. Staff ensured that people who lacked mental capacity had mental capacity assessments completed, and were supported by their next of kin or representative, and by health and social care professionals, to make difficult decisions on their behalf and in their best interests. No one was deprived of their liberty for their own safety, and no DoLS applications had been made. The manager was reviewing people with symptoms of confusion or dementia and who needed support to go out of the premises, to assess if DoLS applications were needed.

People were given daily choices for their food and drink. The menus provided a range of foods to promote a nutritious diet. People were able to have a cooked breakfast if they wished, and were offered mid-morning,

mid-afternoon and evening drinks and snacks. Some people enjoyed several biscuits or fresh fruit with their drinks. Lunch was served in two dining room areas, or in people's own rooms if they preferred. Staff encouraged people to sit together at meal times so as to prevent social isolation, but some people preferred to eat alone. People were supported to position themselves so that they could eat comfortable and safely. The menus were displayed on noticeboards in different areas, and people knew they could ask for alternatives if they did not wish to have the dishes on the menu. People ate independently at lunch. One person ate with their fingers, but was left by staff to do this and retain their independence. People were asked if they had had enough to eat, and were offered more.

The kitchen was clean and uncluttered, and storage areas held a wide range of stocks of fresh foods as well as other groceries.

People said the food was good and they enjoyed it. One person said she was happy that she could have something different if she didn't like what was on the menu and said she enjoyed a good breakfast. Another person said, "The food is very good, every day I have bacon and eggs for breakfast." Other people said, "The food is mostly ok and there is a choice, the salads are very fresh and nice"; and ,"The food is very good".

Some people had food or fluid charts if they were at risk of poor nutrition or dehydration. Records of people's fluid intake were poorly completed, with only two or three entries for people's hydration in some 24 hour periods. Amounts over 24 hours had not been added up, and it was not easy to assess if people had improved their hydration or if it had deteriorated.

This did not confirm satisfactory care in regards to nutrition and hydration. This was a breach of Regulation 14 (4) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care plans included their medical histories and health assessments. These included falls risks, moving and handling assessments, nutrition assessments, and skin integrity assessments. Care plans had been written in line with people's specific health needs, and contained comprehensive information. Body maps were used to show where people had bruises, injuries or wounds, and district nurses were contacted if people needed dressings or pressure relief assessments. Some people had pressure-relieving equipment such as pressure relieving mattresses or cushions. People's weights were recorded each month, and significant rises or falls were reported to the manager and deputy manager. Referrals were made to the GP and dietician if required. A chiropodist visited at regular intervals, but records in some care plans had not been completed for these visits. This meant that staff were unable to clarify how long the gap was between chiropody visits.

People thought that their health needs were met, and said "The staff get the doctor for me if I need him". Another person was delighted with the improvement in their health care, as they told us they had had severely swollen feet and ankles at the time of admission, but these were now healed.

End of life care instructions were provided in some care plans, but others had not been completed. These provided an opportunity to ask people for any specific wishes, such as if they would prefer to stay in the home rather than go to hospital if they were seriously unwell. Some people had 'Do not attempt resuscitation' (DNAR) orders in their care plans and these were signed by their doctor or consultant, and related only to a resuscitation attempt in the event of a sudden collapse, and not to end of life care. The DNAR forms had been appropriately discussed with the person concerned and their next of kin where this was applicable.

The premises provided a range of communal areas for people to relax in, including lounge and dining areas, and a smaller quiet lounge on the first floor. This room was cluttered with equipment during the morning, which included a number of walking frames and wheelchairs. The manager explained that these items had been put into the room together temporarily as they were being removed the next day. People usually preferred to spend their time in the communal rooms on the ground floor. Doors opened from the lounges to the garden which was attractive and well maintained. People said that they liked to sit in the garden in good weather.

The premises were generally well maintained, and the provider ensured that a planned programme of maintenance and refurbishing was being followed. Plans included altering an existing bathroom into a wet room, as the service did not have a wet room. This would provide people with more choice of a bath or shower.

Requires improvement

Is the service caring?

Our findings

People said their privacy and dignity were "Always respected". Comments in recent questionnaires to obtain people's and relatives' views included, "Staff are always polite, courteous and very helpful, nothing is too much trouble"; and "People appear happy and content, and their dignity is maintained at all times". Monthly bedroom checks included checking that people's curtains closed properly, so as to protect their privacy. However, several people and relatives expressed concern that their laundry items went missing "On a regular basis". One relative said that three new items of clothing had gone missing, even though they were named, and had spoken to the manager about this. Another relative said "They are sometimes wearing other people's clothes". The manager said that this was being addressed.

Wearing other people's clothes did not protect people's dignity. This was a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they liked their bedrooms and several said they had "A very comfortable bed". One person said, "It is very pleasant here. My room is very comfortable and I was given a new mattress when I came here so I sleep very well". Some of the rooms contained lots of personal items, and people were able to bring in their own possessions and have their rooms as they preferred. Bedrooms were provided with a lockable facility for people's use.

People confirmed that they were able to get up and go to bed as they wished, and could sit or walk where they chose. One person told us, "I will go to my room after lunch and have a sleep" and this took place. Another said, "I go to bed when I like and watch television in my room". People said "The staff are caring" and a visitor said, "I am very impressed with this place, it is very welcoming, and the staff are helpful". Other people said, "The 'girls' stop and chat to me when they can"; and

"It's ok here, the people are nice." A family member commented on a questionnaire, "My relative is much better since being in here. Staff all seem to be very caring".

Care staff and domestic staff stopped briefly to speak to people as they went past their rooms. One person said, "It makes my day when they stop and chat with me". People said they enjoyed activities and entertainment, and the activities co-ordinator spent time with people individually as well as in groups. People told us they were reminded about different activities each day, and had a copy of the activities programme in their rooms as well as on noticeboards.

People said that staff communicated with them well, and asked them where they wanted to go and what they wanted to do, and did not presume they had a set programme every day. One person told us they liked to go to the local pub sometimes or out to the shops, and this made "A nice change". People said that they had been informed about the change of manager and provider, and knew that staffing shift times had been changed. One person said, "It is better for care. There are more there when we need them". Staff knew the people who preferred to stay quietly in their own rooms. People said, "I am happy with my privacy and do not want to go out, although I do sometimes have visitors"; and, "I like my own company, I don't want to join in things, so I stay in my room and I am fine".

People were called by their preferred name, and this was recorded in their care plans. Staff were informed about ensuring people were able to make their own choices. For example, one person asked for breakfast at 10am, having forgotten that they had already had breakfast earlier. A staff member reassured them saying, "That's all right. You can have what you like. If you're still hungry we will get what you want". The person asked for a piece of toast and this was provided. Another person said they felt like a bath, and staff arranged for them to have one during the morning.

Relatives expressed different views on how staff communicated changes in people's care to them. One said "I only find out when I visit. I wish they would phone me". However, another had commented on a questionnaire that "What I need to know I am informed about". Communication sheets for discussions with family members were not evident in all the care plans viewed, and three forms were completely blank. Some people preferred family members to act on their behalf for decisions about their care. No-one needed advocacy services, but the manager had details available for anyone who might require these in the future.

Good

Is the service responsive?

Our findings

People knew about their care plans and the plans were written with clear directions to show people's individual needs and preferences. People said that they had been visited by the manager before they were admitted to the service, to discuss their care and what they needed. Pre-admission assessments showed that all aspects of people's care were discussed, to ensure that the service could meet their needs. People's family members were involved in their care planning if the person wanted this. Care plans had monthly reviews to assess any changes.

Care plans contained information to show how people liked things to be done, and their usual lifestyle choices. This included what they liked to eat, what they liked to wear, how personal care was delivered, when to get up, when to go to bed and how to spend their time. Staff showed their understanding of people's individual decisions with comments such as, "If they always did something one way at home, why should it be any different here?" The new care plan format provided separate sections so that it was easy to access the information. The plans contained information about people's personal care needs, mobility, nutrition, continence, sleeping and social interests and activities. They provided specific directions such as "Has varied mobility. If not weight-bearing, use hoist and medium sling. Two staff for all transfers". And "Goes to bed at 8.30-9pm. Likes milky coffee before bed, curtains drawn, light off, door shut". Staff spoke about how important it was that people were supported to mobilise in a way that respected their dignity and reduced the risk of harm to the staff helping them to move.

Care plans were written for different aspects of personal care, including skin care, foot care, mouth care, speech, hearing and sight. They identified if people usually preferred a bath or a shower; how much support they needed; if they could brush their own teeth or needed help with cleaning dentures; if they required help shaving; and if they had hearing-aids or glasses. Separate charts were in place to show the care and support that had been given. Some of the charts did not show if baths/showers had been given; and did not show when the chiropodist or optician had visited. This meant that staff could not clarify how often these events had taken place. However, it was clear from talking to people and staff that this care was being given, but had not always been recorded.

People's care plans reflected their individual interests. They included people's life histories, and information about their family members, lifestyles, and previous occupation. The activities co-ordinator was building on these to find out people's preferred activities and hobbies. Some people liked to spend most of the time in their own rooms, but enjoyed having time to chat, or to have their hands massaged or nails manicured. Some people liked to join in occasionally with group activities, and a recent activity that people enjoyed was a memory game just before lunch was served. Games such as snakes and ladders, and skittles were played together, and people enjoyed bingo with prizes. Other people enjoyed quizzes, and there was a topical "Guess the weight of the royal baby" competition with a prize for the winner. The activities co-ordinator arranged a variety of classes, including an exercise class, art classes, and crafts. Examples of some people's artistic talents were displayed on the walls in the lounges.

Events were arranged for people's enjoyment, and included afternoon teas, parties, and visiting singers and entertainers. People were able to go out as they wished, and some went out with relatives and some with staff. People visited local shops and the town which was nearby, and went to pubs or out for walks. One person told us that they planned their trips out with staff and enjoyed their company when going out.

A church service with communion was sometimes arranged for people who wished to join in. People were asked at admission if they wished to have visits from church leaders or ministers, and this was arranged as requested, to meet people's spiritual needs.

The complaints procedure was displayed in the reception area, and was included in the service user's guide given to each person on admission. People were informed about how to raise concerns and complaints, and said they knew they could raise any concerns with any of the staff. The reception area also included a suggestions box, and people sometimes used this to make their comments. A complaints log showed that there had been one written complaint during the last year. The details of the complaint had been taken into consideration, had been investigated, and had been responded to appropriately.

People were able to raise concerns at residents' meetings and through quality assurance questionnaires. Records showed they were appropriately addressed. For example they had raised some issues about the food that had been

Good

Is the service responsive?

addressed. People and relatives told us they knew they could “Ask any of the staff anything”. And they were confident that if they spoke to the manager their concerns would be listened to, and changes would be made if needed.

Requires improvement

Is the service well-led?

Our findings

People said that the manager and staff were approachable and were aware that the manager had an open door policy and they could talk to her at any time. The provider and manager had held meetings for people and the staff to inform them of the changes in the ownership of the service. The provider visited the service on a regular basis, and people said they had spoken to him.

The manager had been in post since February 2015, but was not registered with the Care Quality Commission. She was in the process of a formal application to CQC for registration. She worked closely with the deputy manager and senior care staff. Staff had different areas of responsibility so that they could be accountable for these. For example, the deputy manager oversaw the medicines management. The manager and deputy manager were visible in their management of the service and the running of the shift. Staff had been allocated people to care for. They were organised, and confident in going about their duties.

Changes had been made to recording processes, so as to have clearer information provided in care plans and records of personal care. People told us they were well cared for, but this was not reflected in all their records. Care staff wrote daily records of each person's care. Some of these contained suitable details, but some records were very generalised and did not provide a clear picture of the person's day, their moods, their health care and their activities. Fluid charts were poorly maintained, with only two or three entries per day for some people. Daily charts were in place to show how people's personal care needs were met. Some of these were incomplete, and only showed when people had been assisted to wash and dress, and did not show if they had been supported with a bath, a shave, or had their fingernails cut and cleaned. There were spaces to complete for chiropody visits and hairdresser visits, but most charts did not include this information. Some care plans lacked communication records for discussions or phone calls with people's next of kin or representative. Some did not have completed consent forms. Staff supervision and appraisal records were not in place.

This was a breach of Regulation 17 (2), (c,e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other records had been newly implemented, such as records of cleaning programmes and audits, and these records were comprehensive and properly completed.

Staff meeting minutes showed that different staff meetings had been held for people's different job roles, and at different times of day. These had included meetings for senior care staff, evening and night staff, and day staff. Staff were invited to put items on the agenda, or could put suggested items in the suggestions box anonymously if they wished to do so. Agenda items had included changes of shift times, changes in records, and changes in medicines management. Staff had been invited to complete questionnaires, but only six had been returned out of 47 staff. Many staff had worked at the home for a number of years, and it was evident that some were unhappy with changes being made, especially the shift patterns. Some told us they did not like the changes to shifts, but had not voiced their concerns to the manager or completed staff surveys, even though they had been given the opportunity to do so. Others said they had voiced their opinion of the changes. One staff member said, "They do take our views into consideration", and a staff member alongside agreed with this. Staff were not clear about the vision and values of the new provider, although meetings had taken place.

Meetings had been organised with people using the service. The minutes showed that people had been consulted with and informed about the day to day operation of the home. Examples included the changes in shift patterns, menu planning, cleaning schedules, range of activities provided and overall levels of satisfaction. The manager said that she aimed to hold a meeting with people at least once a month. The manager was in the process of implementing a key worker system. She said that this would address the issues of care staff's responsibilities in maintaining records correctly, and enable staff to get to know some of the people and their relatives more thoroughly so as to support them more effectively.

The manager had put new auditing systems in place. These included a monthly infection control audit, a catering audit, a medicines audit and an accident audit. These contained comprehensive details of each subject and if each part of the audit was being met in accordance with requirements. For example, the catering audit included the state of stock rooms and store rooms, the cooker's

Requires improvement

Is the service well-led?

cleanliness, the state of crockery and cutlery, food safety, waste management and the food service. Each section identified any concerns, and produced a score, which led into an overall percentage for each month's compliance.

Any concerns identified how these should be addressed, and who was responsible, and were followed up the next month. This enabled the service to make continuous improvements.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 (4) (a) HSCA 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: People who use services were not protected from the risks of inadequate hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 (1) HSCA 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: People who use services were not always treated with dignity and respect in regards to the care and management of their clothes.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (2) (a) HSCA 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: Staff were not receiving appropriate support through individual supervision and appraisals.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (2) (c, e) HSCA 2008 (Regulated Activities) Regulations 2014 How the regulation was not being met: Records were not all complete, accurate, and up to date. This included: care plans, daily records, charts for personal care needs, communication records, consent forms; and staff supervision and appraisal records.