Leamington Spa Nursing Home Limited

Royal Leamington Spa Nursing Home

Inspection report

14-16 Adelaide Road
Leamington Spa
Warwickshire
CV31 3PW

Tel: 01926426820

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 25 August 2016. It was an unannounced inspection.

Royal Leamington Spa Nursing Home is an older style property, divided into two houses and over three floors. The home consists of two buildings identified as houses '14' and '16'. The houses are connected by a corridor known as 'the link'. The home is registered to provide nursing or personal care for up to 46 older people. At the time of our inspection there were 39 people living in the home.

This service was last inspected on 23 April 2015 and we found two breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008. People were not always treated with dignity and respect and systems and processes were not established by the registered provider and operated effectively to assess, monitor and improve the quality, welfare and safety of the service. At this inspection we looked to see if the provider had responded to make the required improvements in the standard of care to meet the regulations. We found they had made improvements and they were no longer in breach of the regulations.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been in post since June 2016.

There were enough staff to keep people safe. Staff mostly understood people and were responsive to their care and support needs. However, new staff and agency staff did not always know people's needs which sometimes led to inconsistency of care and sometimes people had to wait for staff to respond to requests for assistance.

Safe and effective recruitment practices were followed to ensure that all staff were of good character and suitable for the roles they performed. Staff understood safeguarding procedures and knew what action to take if they believed people were at risk of abuse. Staff received training, supervision and support to meet people's needs effectively.

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed to take account of people's changing needs. People's care plans included risk management plans and control measures to reduce the identified risk. The provider had plans to ensure people were kept safe in the event of an emergency.

Medicines were managed safely and people received the medicines they required in the correct dosage at the correct time in accordance with their prescriptions.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they lacked the capacity to make decisions for themselves.

People were supported to eat and drink enough for their needs and to maintain a balanced diet. Staff had regular contact with visiting healthcare professionals to ensure people were able to access specialist advice and treatment when required.

Staff demonstrated an easy rapport in their interactions with people. Staff spoke with people in a kind tone of voice and used effective communication skills such as establishing eye contact with people before speaking with them. People were treated with dignity and respect and supported to be as independent as they wished. The registered manager regularly worked alongside staff to assure themselves that people received care and support from a staff team who were considerate and respectful in their interactions with people.

Care plans were written in an individual and person centred way and gave clear information about what people liked and did not like, and how they preferred their support to be provided. Staff were kept informed about people's health and wellbeing through handover meetings between shifts.

The provider had a complaints process and procedure that was accessible, but some relatives could not be sure informal concerns had been listened to or acted upon.

Staff felt supported by the management team and described the registered manager as 'open' and 'approachable'. The registered manager had made changes in response to staff feedback which had a positive impact on staff practice in the home.

There were effective quality assurance systems that monitored people's care. Where issues had been identified these were followed up and recorded when completed to improve the quality of care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe living at the home. Staff understood their responsibilities to protect people from harm. There were enough staff to care for people safely. Safe and effective recruitment practices were followed to ensure staff were of good character. People's care plans included risk management plans and control measures to reduce identified risks to their health and wellbeing. People's medicines were managed safely and in accordance with good practice.

Is the service effective?

Good

The service was effective.

Staff received training to maintain and develop their skills to deliver effective care. Staff had an understanding of the Mental Capacity Act 2005 and worked within the principles of the legislation. There were arrangements in place to ensure people had enough to eat and drink. People were able to access specialist advice and treatment when required.

Is the service caring?

Good

The service was caring.

Staff demonstrated an easy rapport in their interactions with people and used effective communication skills. People were treated with dignity and respect. People were supported to maintain relationships with those closest to them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Staff were mostly responsive to people's needs, but consistency of care was lacking when staff were unfamiliar with people's needs. People could not always be sure their concerns had been responded to.There were a variety of activities to promote people's social wellbeing. Care plans were written in an individual and person centred way and provided staff with

information about how people preferred to be supported.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the registered manager who took time to understand demands on their time and supported them at times of pressure. Staff could access help and support from the management team when they needed it. The registered manager was improving systems for people to share their views of the service.There were effective quality assurance systems that monitored people's care.

Royal Leamington Spa 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 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.

This inspection took place on 25 August 2016. The inspection was unannounced and was conducted by two inspectors, an expert by experience and a specialist advisor. An expert by experience is someone who has experience of caring for a person who uses this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

We reviewed information received about the service, for example, the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service. These are people who contract care and support services paid for by the local authority. They did not have any concerns about the service.

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. The PIR had been completed by the previous manager and was very brief. We therefore gave the new registered manager an opportunity to provide us with further information.

We spoke with ten people who lived at the home and three visitors or relatives. We spoke with the registered manager, deputy manager and 11 staff including nurses, care staff, the chef, maintenance man and activities co-ordinator.

We looked at a range of records about people's care including four care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the registered manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

People who lived at the home told us they felt safe and cared for because staff looked after them to ensure they remained safe. One person who chose to stay in their bedroom told us, "Oh yes I am perfectly safe. The staff look in on me." Another said, "I am more than safe I would say."

Staff had a good understanding of their responsibilities to protect people from harm. They told us they had received training in protecting people from the risk of abuse and understood their role in ensuring the safety of the people who lived in the home. Staff told us they would follow the provider's policies and procedures and report any concerns. One staff member told us, "I would go straight to the deputy manager, the manager or one of the senior carers if I was concerned. I would e-mail the owner if I thought things were not being dealt with."

The registered manager was confident that staff would protect people from possible abuse. They understood their role in safeguarding the people in their care and their responsibility with regard to reporting incidents at the home to the local authority and to CQC.

The registered manager told us staffing levels were based on people's dependency levels and staff rotas were completed to meet people's identified needs. They told us if occupancy levels within the home increased or people's needs increased, the staffing levels would be reviewed and levels adjusted to support the dependency needs of the people. For example, they had recently increased the number of care staff in the evening because of an identified need. The registered manager told us rotas also took into account the experience of staff and were planned to ensure there was an appropriate skill mix on each shift. We saw in the minutes of a recent staff meeting, staff had been asked not to change rotas, "because it is always done according to skill mix".

At our last inspection visit in April 2015 we found there were not always enough staff to care for people when they required help. At this visit people told us that the majority of time staff responded to their care and support needs, but sometimes they had to wait, especially if there were agency staff on duty. A typical response was, "They're probably not enough staff when the agency staff come in, they don't know what they are doing." When we asked if staff were quick to respond when people used their call bells, we received some mixed responses. One person told us, "I feel safe, if I press the buzzer you have never seen nurses move so fast." Whilst other comments included, "I ring the bell – sometimes they're busy and other times they come." Despite some people's reservations about the skills of agency staff, we judged there were enough staff to keep people safe and meet their needs.

Staff felt there were enough staff to support people safely and ensure they received the care they needed, but sometimes found it difficult to spend time with people. During our visit one person sitting in the lounge asked to return to their bedroom. Staff were busy and reassured the person two or three times that they would be with them soon, the person waited approximately 15 minutes before they were taken to their room. However, on other occasions staff were able to respond to people quickly.

The registered manager told us the provider had been reliant on using a high number of agency staff who had not always met the expected standards or had the necessary skills. Although staff numbers had been maintained, agency staff did not always know about people's needs and did not know the routine of the home which meant some shifts did not run as smoothly as others. The registered manager had taken action and recruited new permanent staff. The registered manager was confident that as new staff started work, people would receive more consistent support from staff who knew them well and understood their needs.

Safe and effective recruitment practices were followed to ensure that all staff were of good character and suitable for the roles they performed. Staff only commenced work in the home when all the required recruitment safety checks had been completed. Staff we spoke with and the recruitment records we looked at, confirmed that new staff members were not able to start work until the provider had received a copy of their criminal record check and satisfactory references.

At our last visit we found risk assessments only contained basic information. At this visit we found that where potential risks to people's health, well-being or safety had been identified, they were assessed and reviewed to take account of their changing needs and circumstances. People's care plans included risk management plans and control measures to reduce the identified risk. These were personalised and provided staff with a clear description of the identified risk and specific guidance on how people should be supported in relation to the risk. These included assessments about moving around the home safely and nutritional risks. Two people whose care plans we looked at, had been assessed as being at high risk of skin damage. They were repositioned regularly to relieve pressure and staff applied cream to areas of skin most at risk. They both had air mattresses to reduce the risk of pressure on vulnerable areas of their body. Nursing staff reviewed risk assessments monthly or earlier if there was a change in people's circumstances. This was important to make sure that the information included in the assessment was based on the current needs of the person. One member of staff told us how they constantly monitored risks to people explaining, "On a day to day basis they have to be assessed because things change so quickly."

Nursing staff followed the provider's procedure for managing accidents or incidents in the home. Where accidents had occurred, they had been appropriately documented and investigated and action taken to mitigate the risks of a re-occurrence to the person involved. Nurses told us that learning from the events was fed back during staff and handover meetings. However, there was no analysis of accidents and incidents to identify any trends at service level, such as whether they occurred at a specific time of day. The registered manager had already identified this as an outstanding issue from our last inspection visit. They showed us a tool they planned to introduce to analyse accidents and incidents. The analysis will ensure trends or patterns in the causes are identified and mitigated by appropriate action.

People's medicines were managed safely and in accordance with good practice. Medicines were administered, recorded and disposed of safely. Accurate records were kept of medicines prescribed and given to people. Records showed that people who lived in the home received their medicines at the times they needed them. Medicines, including controlled drugs, were stored in accordance with the manufacturers' guidance to protect people and to ensure medicines were effective when used.

At lunch time, we saw people were given their medicines safely and as prescribed. Medicines were checked against the medicine administration records and people were identified before medicines were given to reduce the risk of medicines being given to the wrong person. Where necessary the nurse wore protective gloves and an apron and washed their hands to reduce the risk of infection. However, we observed one occasion when nurses signed to confirm the administration of a pain relief patch before it had actually been applied. Records should only be signed once medicines have been given and seen to be taken.

Any gaps or errors on the medicines administration records were listed on an audit sheet at the front of each medicines folder, together with a record of any action taken. These actions ensured people continued to receive their medicines safely and as prescribed.

We identified that some improvements needed to be made in respect of the stock control of some medicines. This included a liquid medicine that required extra checks because of the risk of inappropriate use. However, immediately following our inspection the registered manager introduced a system to record the level and volume of the medicine to ensure it was not being used inappropriately.

The provider had plans to ensure people were kept safe in the event of an emergency. Their plans included regular fire alarm testing and fire drills so staff knew how to evacuate the building. Emergency equipment was checked regularly to ensure it was in working order and properly maintained. The provider had responded to a recent Fire and Rescue Service inspection and taken appropriate action. They had implemented the recommended measures to ensure fire prevention and control measures were in line with the recommendations. Each person had a personal emergency evacuation plan that was accessible to staff and the emergency services and provided them with important information about people such as their mobility and any equipment or assistance they required when mobilising.

Maintenance staff carried out a range of physical checks and audits to ensure the environment was safe. A member of the maintenance team told us the provider was happy to send them on any necessary training to ensure they could carry out their role effectively. Staff had a list of emergency call-out numbers to contact suppliers for urgent maintenance matters out of hours. This ensured the building was kept safe for the people who lived there.

Good

Is the service effective?

Our findings

People who lived at the home told us they received care that was appropriate to their needs. One person told us, "Yes most of them are good – they have very good training sessions." A relative said, "On the whole some girls are absolutely brilliant."

At our previous inspection in April 2015 we found staff needed further training to meet the needs of the people who lived in the home. The registered manager told us when they took over management of the home in June 2016, they quickly identified there were gaps in the basic training care staff received. They had arranged for a trainer to come into the home to fill the identified gaps to ensure people received safe and effective care. The training had taken place over a six week period and care staff had now received the training the registered manager considered to be essential to meet the needs of people living in the home. The registered manager's updated training matrix showed there were very few gaps and that safeguarding adults and children, infection control and supporting people with dementia training had been added as essential for staff at this home. These areas of training had not previously been routinely offered to care staff. One staff member explained, "We all turn up to do our training because we need it. [Registered manager] has made an effort for all the staff to have the training."

Care staff spoke positively about the training they received and how this helped them to meet people's needs effectively. One staff member told us how training in how to support people with dementia had reminded them about best practice. They told us, "Whenever I greet someone with dementia it is with a smile and I always try to be patient. This is something I did anyway, but it was re-enforced on the training." During our visit we saw staff put their training into practice. For example, staff put on aprons and gloves appropriately to reduce the risk of spreading infection.

The registered manager explained how they planned to embed training and ensure changes were made to ensure best practice was consistently followed. They told us that nurses worked one care shift weekly to observe and assess the care staff. The nurses fed information back to the registered manager about what they observed, and this was linked into care staffs' one to one supervision meetings, where their competence was tested. Supervisions are meetings with a line manager which offer support, assurance and learning to help support workers develop in their role. Staff told us they had regular opportunities to meet with senior staff to talk about people, their own practice and to reflect on their work. One member of care staff commented, "We talk about how we can improve things, what training we might need and they also ask if we are happy."

Nurses received on-going training to maintain and develop their clinical skills in areas such as catheterisation, syringe driver management and wound care. Training was delivered through the local hospital or by specialist clinical staff and counted towards their continuing professional development.

Most nurses working at the home were registered general nurses (RGNs), two were registered mental health nurses (RMNs). One of the RGNs told us how beneficial it was having RMNs on the team to advise and support the rest of the team around mental health and emotional and psychological wellbeing. For

example, they had introduced ABC charts for some people with behaviours that could be challenging to themselves and others. The charts had helped to build up a record of behaviour patterns and enabled the nursing team to work out 'cause and effect' so they could provide more effective support.

The registered manager told us an induction supported new care and nursing staff in the home. The registered manager said the provider's induction included observation and assessment over a six week period to ensure the competence and skill of new staff in the work place. The registered manager told us they planned to implement the Care Certificate for all new care staff once they had successfully completed their first six weeks at the home. The Care Certificate is a benchmark for staff induction. It provides staff with a set of skills and knowledge that prepares them for their role as a care worker. This demonstrated the provider was acting according to nationally recognised guidance for effective induction procedures.

Care staff we spoke with confirmed they were supported through induction by senior staff who gave them the opportunity to work alongside experienced staff to observe how people preferred to be supported.

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 Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

We found that mental capacity assessments had been completed where it was believed that a person did not have the capacity to consent to a specific decision. Staff understood their responsibilities under the MCA and worked in line with the principles of the Act. This involved supporting people to make their own decisions and involving others when people had been assessed as not having capacity to make their own decisions. Staff confirmed that any decisions made on behalf of people who lacked capacity, were made in their best interests. One member of staff told us, "People here can often decide where they want to eat, what to wear, what to drink, but for bigger decisions we might need to involve family and other professionals."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At our previous inspection we found the need to apply for DoLS had not been assessed for people who met the criteria. At this inspection we found the registered manager understood their responsibilities under the legislation. They had identified people whose care plans contained some restrictions to their liberty and had submitted the appropriate applications to the authorising authority.

At our last visit we found people could not always access their drinks. At this visit people told us they were supported to eat and drink enough for their needs and to maintain a balanced diet. The main meal was served at lunch time and people had a choice of two or three main meals each day. Where people were unable to express a verbal choice, staff made choices on their behalf based on knowledge of their likes, dislikes and preferences. People were able to choose where they wanted to eat their meals. People spoke positively about the standard and choices of food available to them. One person said, "The meal I had yesterday was to die for. The weekend food is brilliant. The Sunday food is just like home-cooked food, all fresh. You get soup, a main meal, a sweet or a pudding and juice or water, whatever you want to drink with your meal. It is just like a hotel." Another person said, "If I am out I always get back for meals as the food is so good. I used to go out for lunch sometimes but I don't now." The chef explained that menus were based on people's preferences stating, "This is their home, this is where they live. If we can do something for them

then we will. I don't try and limit people to what they can and can't have to eat."

People were assessed to determine whether they were at risk of malnutrition and where risks were identified, care plans were put in place to assist staff in meeting their needs. Information was shared with the chef to ensure staff met people's individual needs, such as who required a diabetic diet or their food softened or pureed of if they had any allergies. Where people were at risk of losing weight, their food was fortified with extra calories.

Staff had regular contact with visiting healthcare professionals to ensure people were able to access specialist advice and treatment when required. The registered manager had arranged for a GP to visit once a week to ensure people were referred to healthcare professionals promptly. The outcome of healthcare professional visits were recorded in detail to ensure people received appropriate care to manage their medical and healthcare needs. A visiting healthcare professional described good communication and team work with the nursing and care staff in the home.

Good

Is the service caring?

Our findings

At our last inspection in April 2015 we found that people were not always treated with dignity and respect when care and treatment was provided. At this inspection we found improvements had been made. Staff had an easy rapport in their interactions with people which demonstrated trusting relationships based on respect and person centred care. Nobody we spoke with shared any concerns about the attitude of staff when they provided care and support, but it was clear from speaking with people that they found it easier to build caring relationships with permanent staff who knew them well. Comments included: "The staff are very good and friendly." "The majority are good, but there's one or two staff who I'm not enamoured with." "Yes on the whole, they are caring."

People were treated with dignity and respect. When our inspectors were introduced to people, staff knocked on doors and checked it was alright for us to go in. Staff checked whether people wanted to adjust their dress or hair before we entered. Staff were discrete when carrying out any personal care or nursing interventions. They closed doors and curtains to ensure people's privacy and dignity was maintained. A member of staff explained, "If people want their door closed we make sure it stays closed. Before we go in we knock on the door and ask if it is okay to help them." People confirmed that staff carried out personal care in a way that respected their privacy. Comments included: "They shut the curtains and cover me with a towel," and "They always cover me with a towel depending on what they're doing."

Staff told us they enjoyed working at the home and developing positive relationships with the people they cared for. For example, a member of staff whose relative was in the armed forces made time to have regular conversations with a person who used to be in the forces. They spoke with this person about family and their travels and experiences based on their mutual interests. Another member of staff explained, "I love working with older people. They get our full attention. We are always there if people need something.....We love to engage people in conversation to make sure they are okay."

Staff did not rush people and took time to talk with them as they went about their work. Staff spoke with people in a kind tone of voice and used effective communication skills, such as establishing eye contact with people before speaking with them. For example, when people were given their medicines, interactions between the nurse, people and family members were professional and caring. The nurse made eye contact with people and took time to explain what they were about to do, such as mouth care or putting eye drops in.

One nurse spoke some French to a person who was French and in Italian to another person. Another person was not able to communicate verbally, but was able to respond to conversations using facial expressions and nods. When giving this person their medicine, the nurse interacted with them in a relaxed manner, talking to the person, asking them questions and giving them time to respond. The nurse asked the person how they were feeling, and as they appeared a little emotional, the nurse offered to go back and have a quiet chat with them after they had completed their medicine round. The person responded positively to this suggestion and there was an easy and comfortable rapport between them and the nurse.

Staff knew people well and always used their names when speaking with them to give them a sense of identity. Staff greeted people as they moved around the home with comments such as, "Hello [name], how lovely to see you." Staff knelt down when talking to people in their chairs and gave verbal and tactile reassurance when people displayed signs of anxiety or confusion.

Some people openly praised staff and spoke highly of the home and the care they received. One person told us they had chosen their bedroom and said they had been told to, "Treat it like you own home - so I do." This person told us they liked art and described how staff had helped them create a "messy corner in the room for my arts and crafts." Other people's rooms were personalised and decorated with their own pictures, bedding, small items of furniture and photos of family members on the wall. Staff spoke of the importance of providing people with a homely environment. The maintenance man explained, "When someone is moving into the home I make sure I give the room a lick of paint so people feel someone has taken the time to care."

Another person told us they had a large number of paintings, but there was not enough room in their bedroom to hang them all. The provider had agreed that some of the paintings could be hung in communal areas so the person could continue to enjoy them as they moved around the home.

People were supported to be as independent as they wished. Staff recognised that it was important to support people to do things for themselves, such as washing, dressing and making their own day to day choices. One member of staff told us, "We try to encourage people to wash their own face for example. We encourage people to do as much as they can for themselves. With drinks, we encourage people to hold their own beaker if they can." One person confirmed they maintained their independence. They told us, "I am one of the residents that can come and go as I like. I can go out any time without a carer."

People were supported to maintain relationships with those closest to them. People told us their family could visit whenever they wished. One person told us that a family member had visited them at breakfast one day and another at 9.00pm at night. Another person assured us, "My family can come when they like, they come at all hours." Relatives confirmed they could visit at any time and were always made to feel welcome.

We asked the registered manager how they assured themselves that staff respected people's choices and supported people in a caring and dignified way. They told us they were regularly on the floor observing staff and they used this time to see how staff conducted themselves with people and relatives. They explained, "I work on the floor myself at least once a week, normally the early shift. I see that as part of my managerial responsibility. During that time I am able to observe staff as they interact with residents." Their observations assured them that people received care and support from a staff team who were considerate and respectful in their interactions with people.

Requires Improvement

Is the service responsive?

Our findings

Staff mostly understood people and were responsive to their care and support needs. For example, one person liked cold drinks and had been given a thermos flask with ice cubes to chill their drinks. However, new staff and agency staff did not always know people's care needs.

At our last inspection visit in April 2015 we found people did not always feel staff were responsive to their needs. At this visit we found some improvements had been made but further improvements were still required. Relatives told us they felt that attention to detail and consistency of care was lacking when staff who were unfamiliar with people provided care. One relative told us new staff were not aware of the reasons for their family member's agitation and frequently provided care in a way that increased that agitation. They explained that routines that were important to the person to help them understand what time of day it was, were not understood by agency staff. They told us, "It is just attention to detail he needs."

During our visit we saw there were sometimes delays in staff responding to people's requests. For example, at lunch time we saw there was a significant delay of around 45 minutes in some people receiving their lunch. Some people started to become agitated at having to wait so long for their meals, although they told us they did not normally have to wait so long. A member of staff told us the meal had been delayed because of the number of agency staff on duty who were not familiar with people's needs and how meals were delivered in the home.

People were offered activities to meet their social needs. The activities co-ordinator told us that when people moved to the home, they were asked about their interests and hobbies. Each person had an individual record of activities, interests and hobbies that they might enjoy. Each activity people participated in was evaluated to ensure it met people's social needs and was fulfilling for the people who participated. During our visit the activities co-ordinators ran a bingo session. People who chose to play the game appeared to be enjoying the activity and were joining in. There was singing and people were offered a selection of drinks and popcorn to enhance their enjoyment.

The activities co-ordinator told us they tried to make activities interesting and stimulating by inviting external people into the home. For example, a singer visited the home regularly and a group brought animals into the home for people to stroke and feed. Relatives were invited to attend events such as cake sales and quiz nights. An organised trip to a local museum had recently taken place.

For people were unable to leave their rooms, or who chose not to, the activities co-ordinator arranged one to one activities. The activities co-ordinator explained, "Some people like hand massages, some like poems. One person enjoys writing letters to family and friends so we help with that." Staff told us of another person who liked animals, particularly cats, but was unable to join in with group activities. The activities co-ordinator had made a scrapbook of cat related pictures the person could look at in their room. We saw the activities co-ordinator singing along with another person who was cared for in bed. The person was engaged with the singing and afterwards talked enthusiastically about musical instruments they used to play.

Care plans were written in an individual and person centred way and gave clear information about what the person liked and did not like, and how they preferred their support to be provided. Each person had an 'All About Me' document which included information about their past and what was important to them. The document gave a good picture of each individual's life. Care plans were easy to follow and included regular monthly updates. We spoke with one person whose care plans we looked at. The care plans accurately reflected the person's own description of their identified care needs and their understanding of the management of their medical condition. The care plans contained clear information about the person's priorities in respect of the care they wished to receive as their condition progressed. Staff told us that care records were kept up to date, easy to read and provided them with the information they needed to support people effectively.

For people who were at risk of not drinking enough, staff had started to keep a record of their fluid intake. However, the fluid charts we looked at were not consistently completed or totalled, which meant it was difficult to determine how much each person had drunk and whether additional drinks should be offered. This meant there was a risk of staff not responding to the risks of dehydration by taking reasonable measures to minimise the risk. Following our inspection visit, the provider sent us a copy of a new form they planned to introduce to ensure staff consistently recorded people's fluid intake.

Staff were kept informed about people's health and wellbeing through handover meetings between shifts. The handover at lunchtime was carried out in the link area between the two houses. Information shared at handover was detailed and person centred. It included information about care delivered or required and any risks to people's health. This ensured staff had the information they needed to respond to changes in people's needs. However, as the handover took place in an open area, the information was not shared in a completely confidential way.

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home. Staff told us how they supported people to make a complaint. One care staff member said, "If someone wanted to make a complaint I would get a senior member of staff to come and talk with them and make sure they knew it was okay." In the complaints log we saw that complaints since our last inspection visit had been investigated and responded to in a timely way and to the complainants' satisfaction.

At our last visit we found people did not always feel they could complain and if they did, the response they received varied. At this visit some relatives told us they had raised concerns informally but were not sure they had been listened to or acted upon. For example, some relatives expressed concerns that their family members spent a lot of time in their room and were at risk of social isolation. One relative explained, "I do get frustrated because I don't see her in the lounge. I don't know whether they've asked her if she wants to go there." There were no records to assure relatives that staff had acted on the concerns they had raised.

Good

Is the service well-led?

Our findings

People and relatives were happy overall with the quality of the service. One person told us, "Most of the time everybody seems reasonably happy." Some people had recorded their thoughts in thank you cards with comments which included: "Thank you for your care and kindness" and "You have all done a great job, Dad seemed very happy and said how lovely everyone was and how he was looked after."

At our last inspection in April 2015 we found that systems and processes were not established by the registered provider and operated effectively to assess, monitor and improve the quality of the service. At this inspection we found improvements had been made and action was being taken to ensure staff felt valued and supported.

The registered manager had been in post since June 2016 and had been registered with CQC since August 2016. The registered manager was supported by a deputy manager who had been in post for five years. The deputy manager worked as a nurse, but had protected time to carry out their managerial responsibilities and ensure they were completed.

Staff spoke positively about the new registered manager and their open approach. They told us the registered manager was a significant presence in the home, took time to understand the demands on their time and supported them at times of pressure. One member of care staff told us, "The manager's door is always open. They work on the floor sometimes. This reduces the workload and means they understand what is happening with people." Other comments included: "The registered manager is very approachable which is very nice. They have been pleasant since the first day we met them. They are very easy to talk to." "[Registered manager] is very hands on, they do the breakfast and the dinners and will help on the floor." The registered manager told us it was important that they were visible and involved as it provided them with an opportunity to see staff deliver care and get to know the people who lived in the home.

We saw evidence of the positive impact the registered manager had on the quality of the service in the short time they had been at the home. The registered manager told us that one of the first issues they had identified on starting work at the home was staffing levels and the high use of agency staff. They explained that some of the agency staff did not always exhibit the standards they wanted to promote so they had started using a new agency to ensure they used staff who promoted high standards in their work. However, they wanted to get their own consistent staff team in place to ensure people received a service that was always responsive to their needs and had recently recruited nine new staff. Three staff had already started working in the home and six others were going through their recruitment checks. They had increased staffing levels during the evening and introduced 'return to work' interviews to find out what support staff needed to reduce the high level of sickness absence in the home. Staff confirmed the registered manager had recruited more staff and had kept them informed of the progress of this and their plans to maintain staffing levels in the future. One staff member told us, "Staffing has been much better. [Registered manager] has done some recruitment and we have been allowed to have more staff in. We are starting to have six in the evening now which means we can manage."

All the staff we spoke with said they enjoyed working at the home. They said teamwork was good and the registered manager and deputy manager were available when they needed help or support. The deputy manager described an 'open door policy' for staff and said, "Staff are very good at coming to us if they need advice." The registered manager and deputy manager operated an on-call system which meant there was managerial support available to staff 24 hours a day seven days a week.

Staff were given the opportunity to share their views and concerns at regular staff meetings. Records showed that staff meetings were an opportunity for managers to discuss the aims and objectives of the service and share information about roles, responsibilities and training. Meetings included an open forum where staff could raise any topics of concern they wished to discuss. One staff member told us, "We get the chance to say what we want to say. We do feel able to raise things." They told us staff had raised concerns previously about the attitude of some staff within the home. They told us these concerns had been listened to and dealt with and as a result, the service people received was much better.

Records showed that staff also felt confident to raise their concerns in writing. For example, we saw one staff member had written to the registered manager about a concern regarding staffing levels one weekend because agency staff had failed to turn up. The registered manager had responded in detail and thanked the staff member for bringing their concerns to his attention so action could be taken.

Staff told us the registered manager had made positive changes in response to staff feedback. For example, they told us daily reports had been changed so they were simpler to complete, less time consuming and more informative. One member of care staff said, "I think it is getting there. We have just changed the daily case book which we are finding easier, but it is still recording what we need to record."

The registered manager and staff shared the provider's values and aims, to provide person centred care. Some staff told us morale had improved and there had been positive changes in staff practice since our last inspection visit. One member of staff explained, "We have got a good team and we are very protective. Most of us are here for the residents and we are all here for the same purpose. We do work as a team, we are sharing the load."

Staff told us they could speak to the provider because the provider visited and stayed at the home regularly. They told us the provider was good at responding to queries via email or telephone. A member of non-care staff told us, "[Provider] is here every six or seven weeks, he is a nice person and he listens. There is never a problem if something is needed. He never says no." One member of care staff said, "It is a happy family run business. Everyone is friendly. We all get on and we are here to care for people like they are members of our own family."

At our last inspection in April 2015 we found some people and their relatives felt they were not always listened to and concerns were not dealt with. The registered manager was keen to nurture an open culture and was developing the keyworker system so people had an opportunity to talk to a named member of staff and share any concerns or raise any issues. The registered manager explained, "I'm a believer in the keyworker system where staff have one to ones with residents. The resident will have a known person they can talk to and confide in. The keyworker will also be a link with people's families and with the manager." The registered manager was confident the system would provide people with a process to share their views or concerns about the service and discuss any changes they would like in the care they received.

People were asked for their views about the service, to make sure care was focused on their individual needs and preferences. Satisfaction surveys were issued annually for people and their relatives to complete. We looked at the results of the last survey and found 93 per cent of people were satisfied or very satisfied with

the care they received. However, it was not clear what action the provider had taken in respect of the 7 per cent who were not happy with some aspects of the service. The registered manager told us this was an area they needed to address.

There were effective quality assurance systems that monitored people's care. We saw records of audits and checks which monitored safety and the quality of care people received. These checks included care planning, medication, health and safety, training and food safety checks. Where issues had been identified these were followed up and recorded as 'action taken' to ensure people's safety. For example the training audit in June 2016 had identified that only 39 per cent of staff training was up to date. Action had been taken and a subsequent audit on 30 July 2016 confirmed that 97 per cent of staff training was up to date and relevant to the needs of people living in the home.

The registered manager told us they understood their legal responsibility for submitting statutory notifications to us, such as safeguarding referrals or incidents that affected the service. This is so we are aware of information about the service that affects the safety of people using it, to enable us to monitor changes or concerns effectively. However, we identified that the registered manager had not informed us about approved Deprivation of Liberty applications as required. The registered manager acknowledged this oversight and subsequently submitted all the necessary notifications in accordance with their statutory responsibilities.