Care Quality Commission

Coate Water Care Company (Church View Nursing Home) Limited

Mockley Manor Care Home

Inspection report

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Ratings

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

Overall summary

We inspected this service on 30 November and 3 December 2015. Our inspection was unannounced.

Mockley Manor is registered to provide both nursing and personal care for a maximum of 52 older people. The home was set out over two floors and there was a separate unit for people living with dementia called Namaste. There were 39 people living in the home at the time of our visit.

There was a registered manager 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.

We last inspected the home in January 2015. After that inspection we asked the provider to take action to make

Summary of findings

improvements to ensure people's needs were met by sufficient numbers of appropriately skilled staff. At this inspection we found improvements had been made, but further improvements were still required.

Most people were happy with the staff, but acknowledged that staff were busy and they sometimes had to wait for assistance with personal care. Staff we spoke with said there were enough staff to support people safely and ensure they received the care they needed. Further improvements were needed in the allocation of staff to ensure there was oversight of communal areas at critical times.

People told us they felt well cared for and safe living at Mockley Manor. People told us staff were respectful and kind towards them and staff were committed to providing a caring environment. Staff protected people's privacy and dignity when they provided care to people and staff asked people for their consent before care was given. There was a programme of activities and entertainment to support people's social needs. Friends and family were welcomed into the home and encouraged to maintain a caring role in their relative's life.

Care plans contained information for staff to help them provide the individual care and treatment people required, however not all records supported people's changing needs. The management team had recognised this was an area for improvement and was taking action to address this.

Staff had a detailed handover between shifts when they were updated about people's care needs so they could respond appropriately. Records of care and treatment delivery did not demonstrate that plans to manage identified risks were being consistently followed.

Assessments had been completed to determine people's capacity to make certain decisions. The provider was meeting their requirements set out in the Deprivation of Liberty Safeguards (DoLS).

People were referred to other healthcare professionals and received their medicines as prescribed.

Care staff received training and support to meet the individual needs of people effectively. A newly recruited nursing team were being supported to ensure their competencies, but required a high level of clinical support to develop their confidence.

The registered manager was providing clinical and nursing support in the home which impacted on the effectiveness of their management of the service. Where checks, audits and feedback from people had identified issues, timely action had not always been taken to implement improvements. Following our inspection, the provider told us they were going to recruit two new clinical leads to the home to take over some of the registered manager's clinical responsibilities. This would enable the registered manager to concentrate on the management of the home. We will continue to monitor the service to ensure these improvements are implemented and maintained.

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?
The service was not consistently safe.

People told us they felt safe living at the home and with the staff who supported them. Staff understood their obligation to report any concerns about people's health and wellbeing. Improvements were required in how staff were allocated in the home to ensure communal areas were always monitored. Records of care and treatment delivery did not consistently demonstrate safe care and treatment of people. People received their medicines as prescribed.

Requires improvement 

Is the service effective?
The service was not consistently effective.

Staff had completed training to work with people in a safe way and meet their individual needs. Newly recruited nurses required further support to develop their confidence in carrying out their role and responsibilities. The service took appropriate action if they believed a person needed to be deprived of their liberty for their own safety. People were supported to access on-going healthcare support.

Requires improvement 

Is the service caring?
The service was caring.

Staff attended to people in a friendly manner, people were offered care choices, and people's choices were listened to. People were treated with respect, and staff were committed to providing a caring environment.

Good 

Is the service responsive?
The service was responsive.

Staff had a detailed handover between shifts. This gave them information which enabled them to provide the care and support people required and to respond to changes in their needs. There was a programme of activities and entertainment to keep people busy and meet their social needs.

Good 

Is the service well-led?
The service was not consistently well led.

The registered manager demonstrated a commitment to delivering a high quality of service. However, demands on their time to provide nursing and clinical support impacted on their managerial responsibilities. Action to improve standards had not always been taken in a timely manner. The provider only took action to provide rescources to support the registered manager following this inspection visit.

Requires improvement 

Mockley Manor Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 30 November and 3 December 2015. The first day of the inspection was unannounced. The inspection was undertaken by two inspectors, an inspection manager 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.

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. This was received prior to our visit. We used this information to plan our inspection.

We also reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 10 people who lived at the home and six relatives. We spoke with the registered manager, the clinical lead, one nurse, eight care staff, four non-care staff and a director of the provider company. We observed care and support being delivered in communal areas and we observed how people were supported at lunch time.

Some of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We reviewed three people's care plans, the daily records for eight people and medicines records to see how people's care and treatment was planned and delivered. We checked whether staff were trained to deliver care and support appropriate to each person's needs. We reviewed the records of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires improvement

Is the service safe?

Our findings

Most people were happy with staffing levels, but acknowledged that staff were busy and they sometimes had to wait for assistance with personal care. A typical response was, "If I press my bell, more often than not, they are pretty good but I can wait 20 minutes." One relative told us, "Staff are superb; you could always do with more. Staff have told me they need more. I believe they are trying to get more, it is difficult because it is in the country and no transport."

When we last inspected Mockley Manor we found there were not always enough suitably qualified staff on duty to meet people's needs. At this inspection we found some improvements had been made, but further improvements were still required.

Our observations on the day showed care staff were busy, yet staff supported people and cared for people at the pace they required. However, we found some need for improvement in how staff were allocated. We noticed there were periods of time when there was not always a continual staff presence in the lounge in the Namaste unit where people could sometimes display behaviours that could cause distress to themselves or others. For a period during the afternoon, there was only one staff member on that unit whilst other staff took their breaks. This meant if someone needed personal care and a call bell rang in a bedroom, there was not a staff member to respond and to provide support in the lounge.

Staff told us they felt confident there were enough care staff to provide the care and support people required. Some staff told us staffing levels had been increased since our last visit. One member of care staff told us, "They have been pretty fair. They have increased staff and we have new staff." Another responded, "It has challenges when people become poorly, but I think at the moment it is okay." We were told that staff were allocated where people's needs were highest. One staff member told us, "Staffing is better than it was. It's better, I don't feel like I am struggling. Usually there are two staff to each area. We go to where help is needed." All the staff we spoke with said they supported people safely and people received the care they needed.

The provider's identified clinical staffing level in the home was two nurses on duty during the day or one nurse and a senior carer. Senior carers administered medication to support the nurse. When speaking with the registered manager and clinical lead, it was clear that some people in the home had complex medical needs. They both acknowledged that in the morning two nurses were required to ensure those needs were met safely and consistently. At weekends and when the GP carried out their clinic on Tuesdays, two nurses were always on the rota. On the other four days the registered manager who was a registered nurse, provided additional nursing cover as required. Whilst this ensured there were enough suitably qualified nurses to provide support, this impacted on the time the registered manager had to discharge their managerial responsibilities. On the day of our inspection, the registered manager was the only nurse on duty as they were covering for planned annual leave. Whilst rotas demonstrated this was not a regular occurrence, we were concerned it would have been a challenge for the registered manager as the only nurse on duty, to respond to any medical issues, especially during medication rounds.

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. Following our visit, we received written confirmation from the provider's operations manager that they planned to increase the support people received at key times. Staffing levels were to be increased to two nurses in the morning and an additional care staff member to cover afternoon shifts. These additional staff would help ensure people's clinical and caring needs continued to be met.

The registered manager told us they continued to use agency nurses to cover some of the shifts at night. The registered manager said they tried to use the same agency staff for continuity and because they knew they met the expected standards and had the necessary skills. We spoke to the agency nurse on duty on the second night of our inspection. They confirmed they regularly worked in the home and told us they would use the 24 hour on call system to contact the registered manager or clinical lead in the event of an emergency.

Requires improvement

Is the service safe?

The provider followed their policies and procedures and took effective action when staff failed to meet people's needs safely.The registered manager had taken disciplinary action against a staff member who had not supported people safely. The member of staff no longer worked at the home.

We asked people what being safe meant to them and whether they felt safe at Mockley Manor. People gave various responses about what made them feel personally safe, but all said they felt safe in the home. One person told us, "Yes, there is always somebody about. People can't get in unless they ring the bell and have got the code. They change the code every three weeks." Another said, "It's very safe here."

There were procedures to protect people from abuse. Staff were aware of safeguarding procedures and knew to report any concerns to the registered manager or a senior staff member. One staff member told us, "I would go straight to the manager or senior member of staff and explain what I had witnessed." Staff told us they would escalate any concerns if the registered manager did not take appropriate action. One told us, "I would report it to safeguarding and to you. I wouldn't turn a blind eye. I couldn't live with that." The registered manager was aware of their responsibilities and had reported safeguarding issues to us and the local authority as required.

Risk assessments identified where people were potentially at risk and actions were identified to manage or reduce those risks. However, during the day we identified occasions when staff did not always follow risk management plans. For example, one person was at risk of skin breakdown and was unable to move themselves in bed. Their care plan stated they needed to be turned every two to three hours, but on the day of our visit records demonstrated they had been lying on their back for 11 hours. There was no record to confirm that another person had been repositioned in accordance with their risk management plan. Daily records had not been checked to ensure staff were delivering the care people required. Another person had been identified as being at high risk of falls. Their care plan stated they should sit on a sensor mat to alert staff if they attempted to stand unaided. We checked when they were in the lounge and found they were not sitting on a sensor mat. There was no staff presence in the lounge at the time. This meant that risks to people's health and wellbeing were not consistently managed.

We checked the administration of medicines to see if they were managed safely. We found medicines had been stored safely and in line with manufacturer's guidance. Arrangements were in place to obtain, administer and record people's medicines. Medicines were available and Medicine Administration Records (MARs) had been signed to confirm administration, or a reason documented to explain why a medicine had not been given. We observed the clinical lead giving people their medicines and saw they followed best practice. For example, they did not sign the MAR to confirm a medicine had been given until they had observed the person take it. Where people were on a variable dose, the amount they had been given was recorded to ensure they were not given too many. Where it was important to ensure specific time periods were maintained between doses, the actual times the medicines were given were recorded. One person was on a 'time critical' medicine. There was an effective process to ensure they received their medicines at the right time.

We looked at the MAR for a person who was given their medicines by 'covert administration'. This is where a person lacks capacity to understand the importance of taking their medication and medicines are usually given hidden in food or drink. The GP had been consulted to ensure it was in the person's best interests and information on how the medicines were to be given was documented on the person's medicine records.

Another person was given their medicine in their tea to make it easier for them to take. There had been no checks with the doctor or pharmacy to check if putting the medicine in hot drinks would affect its effectiveness. Contact was made with the pharmacist during our visit who confirmed the medicine would remain effective if the drink was not too hot.

During our checks we found that one person who had diabetes was not having their blood sugar levels monitored consistently. Although this person was identified as being at low risk, it is important this is done to ensure they receive the correct dosage of medicine to manage their condition.

A system of medicine checks was in place. We looked at a recent audit and found some areas had been identified as requiring improvement to ensure the risks around

Requires improvement

Is the service safe?

medicines were managed. For example, there was no system to identify medicines that needed to be taken before or after food. Action still needed to be taken to manage this risk at the time of our visit.

The registered manager told us they encouraged an open culture of reporting medicine problems. They explained that where errors had occurred, they were discussed with the staff member involved and there was also shared learning with the rest of the staff to ensure the error did not happen again.

There were processes to keep people safe in the event of an emergency. Each person had an evacuation plan which detailed what support they needed to evacuate the home safely. There was a continuity plan should people be unable to return to the home immediately.

Requires improvement

Is the service effective?

Our findings

People told us they thought staff understood their roles and knew what they were doing. One person told us, "Staff know what they are doing, they know how to help me." A relative said, "The staff are well trained, you can see from the care they provide."

New care staff undertook an induction to the home when they started working there. This included training in areas considered essential to meeting the needs of people effectively and a period of shadowing more experienced staff. One member of staff who had been working in the home for under a year told us, "I like it here. I had an induction. I shadowed for two weeks until I felt comfortable. I had moving and handling training, safeguarding, Mental Capacity Act, dementia and end of life care. It's good." Another member of staff who was still being inducted into the home said, "The carers I worked with, including the manager, were all very informative and asked what help I required." The Care Certificate was introduced nationally in April 2015 to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care. New staff were working towards obtaining the Care Certificate.

Staff skills and knowledge was refreshed. Regular training was organised to ensure care staff were following best practice. One staff member told us, "There is plenty on offer and you can put your name down for it. Some training is mandatory." Another told us, "It is not too bad. They have a training board and you just put your name down for it. It is better now because we get paid for doing it." However, during our visit we found some staff did not always demonstrate a good understanding of dealing with challenging behaviours or of supporting people who could be defensive in their responses. The registered manager had recently completed 'train the trainer' in meeting the needs of people living with dementia and managing actual and potential aggression (MAPA). It was planned they would deliver this training so staff had a better understanding of how to support people who could present challenging behaviour such as when they declined personal care.

The provider had recently recruited newly qualified nurses from Spain. To support the nurses, the provider had a preceptorship programme which lasted six months. We were told the aim of the programme was for the nurses to 'demonstrate confidence and competence safely within their role'. Areas covered under the programme included assessing, planning, implementation and evaluation of care and clinical practice. The registered manager and clinical lead were mentoring the nurses under the preceptorship and told us they were not signed off until they were competent to carry out their role safely. Through talking with the registered manager and clinical lead, it was clear the nurses still needed support to develop their confidence in discharging their responsibilities independently. For example, we were told of an issue the previous week when one nurse had waited until the clinical lead attended the home before calling an ambulance when someone's health deteriorated. The clinical lead also recognised that further work was required to improve the new nurses' documentation skills. This was clearly evidenced in care plans which lacked the level of professionalism the registered manager was eager to demonstrate.

The management team had a good understanding of the individual strengths of the care staff in the home. They also recognised where staff needed more development and support. Whilst staff's individual training needs were discussed during supervision, the management team agreed that with further support some care staff could take on additional responsibilities. This would support the nursing team and give care staff an opportunity to develop their careers.

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. 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.

Capacity assessments indicated where people were able to make their own decisions, where they needed support to make decisions and when decisions had to be made in

Is the service effective?

their best interests. The registered manager understood people's capacity could fluctuate depending on the complexity of the decision and explained, "Some people can make basic decisions but can't understand risk."

Care staff told us they had received training in the MCA, but were not always able to demonstrate an understanding of the legislation. One staff member told us, "I think that was in our mandatory training, but I can't remember much about it." Another staff member was able to explain, "This is about dementia and to understand when people can't make decisions. We work around it by always giving people choices. If a service user lacks capacity, it's usually confusion or they are upset. I explain, talk, say what I am doing and what's going to happen."

However, staff understood the importance of gaining people's consent before providing care and support and we saw this demonstrated during the day. For example, we saw staff asking if people were ready for their dinner or whether they could remove their newspaper so they could eat. One staff member said, "If they are not happy, I give them more time. Hopefully they understand better. If they keep saying no, I seek advice. I wouldn't force them."

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).The manager understood their responsibilities under the legislation. They had identified that some people needed restrictions to their liberty and had submitted the appropriate applications to the authorising authority. However, care staff we spoke with were not always aware when people's liberty was being restricted. We asked one member of staff whether any applications had been made under the DoLS. They responded, "I don't know."

People spoke positively about the food in the home and the choices available. One person told us, "Very good with great variety every day. If you don't like either choices you can ask for something else." Another said, "The food is quite nice. I get a choice, I don't know what it is today, you are usually asked."

Catering staff were aware of people's nutritional needs and had information about people's preferences, allergies and how they needed their food preparing. People who were at risk of poor nutrition had their food fortified and received food supplements if needed. Some people needed soft food. Each food item was presented separately so people could continue to enjoy the different food tastes.

We observed lunch in the dining room and in the main lounge. In the lounge two people required the support of staff to assist them to eat. Staff sat with them and helped them at a pace that suited the person. They explained what was on the person's plate and what was on each forkful. It was used as a time to engage with the person. However, the meal time was not such a pleasant experience for a person who was in bed in their room. Their meal had been placed on the table over their bed, but the spoon had been placed out of their reach. We felt the plate which was cold and there was no heat coming from the meal. The clinical lead confirmed this person's ability to eat independently fluctuated and they sometimes required assistance. After ten minutes a member of staff went into the room and asked if the person wanted their meal. The person lives with dementia and reacted defensively. The meal was taken away without considering whether re-heating the meal may have made it more appetising or whether another member of staff could have persuaded the person to eat.

When we were walking around the home, we saw most people had drinks within reach when sitting in their bedrooms or in communal areas. One person told us they always had a drink and said, "They (staff) always pick up my cup and check how much there is and will always fill it up." Another person said, "I get plenty to drink, they look after me."

Some people were having their food and fluid monitored and recorded because they were at risk of not eating or drinking enough. We looked at a sample of charts used and found that fluids had been recorded but were not being totalled up to identify when people needed prompting to drink. The recording of food eaten also needed to be improved. For example, staff had recorded that people had eaten 100% of cooked breakfast or 100% of pudding but it was not clear what the cooked breakfast or pudding consisted of. This information would assist health professionals in ensuring person's nutritional needs were met.

People were happy with the way their health needs were managed. People were referred to other healthcare professionals such as a dietician or speech and language

Requires improvement

Is the service effective?

therapist when a change in their health was identified. The service worked in partnership with a local GP surgery and the GP provided a clinic in the home every Tuesday. A list of people who needed to be seen at the clinic was faxed through to the GP surgery so the GP was aware of who needed to be seen. One person told us, "The GP comes every Tuesday. If you don't feel well they put your name on the board." The person went on to speak positively about the time the GP spent talking with them. The registered manager told us that people were given the option of retaining their own GP, but most people who lived in the home permanently chose to register with the local GP.

Good

Is the service caring?

Our findings

People were positive about the compassionate nature of the staff and felt cared for. One person told us, “The girls are lovely.” Another said, “They are angels.”

The registered manager told us they spent time on the floor and felt that staff were caring in their approach and took pride in meeting people’s needs. They explained, “I think the staff are passionate about what they do. The staff do genuinely care and go that extra mile. They want to make a difference.”

Staff told us they felt there was a commitment by the staff team to provide a friendly environment. One staff member told us, “When I first came for my interview, I felt everyone was close. Everyone knows the residents well and has a good relationship with them. It felt homely.” When asked if staff were caring another responded, “When I’m on I can be giving care but I will be looking around at what the others are doing, and they are caring.”

During our visit we found people were listened to and staff understood people’s preferences, for example, where they preferred to sit and by calling people by their preferred names. Staff gave people choices about what they wanted to do and where they wanted to be. One person told us, “They know what I like and let me do what I can.” Another said, “Oh yes, they are the best, always ask what I prefer.”

We observed respectful interactions from staff. People were spoken with politely and courteously and staff knocked on people’s doors before they entered. One relative told us, “They make sure [person’s] privacy and dignity is maintained.” Staff gave examples of how they respected people’s dignity by closing doors when they carried out personal care and speaking with people confidentially about their personal care. One staff member told us, “If I take them to the toilet, I don’t let the whole room know. I ask them but let them do things for themselves. Helping them be as independent as possible helps promote their privacy and dignity.” However, during lunch we saw staff emptied plates of food scraps into a bin which was right next to one person’s head. The person was still eating and it was neither dignified nor caring. We also saw another person sitting with their underwear exposed. Staff covered the person up when we drew this to their attention.

People were encouraged to maintain relationships with those who were important to them. Throughout our inspection we saw relatives coming to the home to visit their family members. Visitors were able to choose whether to see people in private or sit with them in the communal areas. There were no restrictions on people visiting. Some relatives were particularly pleased to still be seen as an important part in their family member’s life and involved in their care. One relative told us how they visited every day and enjoyed assisting their family member with their meal. Another relative supported their family member with their medicines.

The registered manager understood the pressures on staff and the need to make staff feel cared for themselves. They explained, “It is acknowledging what they do.” They told us about an incident in the home that had been emotionally demanding for them and the rest of the staff team. Following the incident they had a meeting with staff to discuss it and share their experiences. The manager told us, “They know I am human.” We asked staff whether they felt cared for. A typical comment was, “She [registered manager] cares about everyone and she really makes an effort to talk to everyone.” Some staff told us they felt particularly supported when they had experienced problems outside work. One told us, “She (registered manager) has been supportive 110% of the way.”

Good

Is the service responsive?

Our findings

Everyone we spoke with was very positive about the enthusiasm and energy of the activities co-ordinator. Activities were arranged and organised by the activities co-ordinator in discussion with the people who lived there. There was an activities timetable in the entrance hall which informed people and their visitors of the planned activities for the week which included exercise, drawing, skittles and one to one time.

On the morning of our visit the activities co-ordinator was helping people make crafts in the lounge on the Namaste unit. In the afternoon they arranged a skittles match in the main lounge. There were around fifteen people sitting in the lounge and the activities co-ordinator encouraged everyone to be involved. Most people chose to join in, but some were content to watch. People with limited physical strength and movement were encouraged to participate and given time and reassurance. One person sometimes displayed behaviour that could challenge and declined to engage with staff. We saw that with gentle persuasion they were encouraged to become involved. The game was an opportunity for engagement on an individual basis, but to also to encourage people to interact with each other as a group. One person told us, "[Activities co-ordinator] is very nice. I love playing skittles."

The home benefited from access to wide open countryside. People were encouraged to take an interest in their surroundings and follow interests outside the home. For example, there were chickens in the grounds and visitors to the home could purchase the eggs they produced. People participated in autumn and spring watch and enjoyed watching local wild life that visited the grounds.

There was a range of entertainments available. Planned entertainment for the weeks following our visit included a country music show and an old time music show. The activities co-ordinator explained how they used events to encourage people from the wider community to visit the home and engage with the people who lived there. For example, the day before our visit there had been a Christmas fete to which people from the local villages had been invited. One person from the local community had recently visited the home to provide some entertainment and education around Diwali. Many of the entertainments were based on seasonal celebrations such as the local Wassail event and celebrating May Day with the traditional maypole dance. The activities co-ordinator explained, "It is education but it also marks the time of year. It is easy for people to lose track of the year."

We asked how the activities co-ordinator engaged with people who were either cared for in bed or who chose to remain in their room. They responded, "I've taken over the menu. I go up and talk to individuals about the menu and take them their newspapers. I just go around the rooms and chat and tell them what is happening."

Care plans and assessments contained information that supported staff to meet people's needs. There were plans to support staff to meet people's specific health needs, for example, catheter care. However, we found some of the care plans lacked detail and others had not been reviewed in a timely way when people's needs had changed. For example, one person's care plan stated they were able to shave themselves and were able to eat without assistance. It was confirmed that the person's health had deteriorated and they were now no longer able to do these things independently. The management team were aware that improvements were required and were in the process of reviewing the care plans of everyone in the home.

Staff understood people's health and care needs. Staff told us they received all the information they needed to respond to changes in people's needs through the handover between shifts. One staff member told us, "We go through their care plans and we are told in handover. They are very good handovers." Another told us, "They (handovers) are informative. We are told what the residents have experienced that day, what to look for, who needs foods and fluids pushed, any anxiety or moods." We observed a staff handover. The handover was clear and detailed and staff showed a good knowledge of people and their needs. Every person was discussed in a personalised and sensitive way. For example, one person was described as 'tearful' and staff discussed the possible impact of a change in their medication.

People told us they would feel confident to raise any concerns. One person told us, "I can speak my mind. I would speak to the seniors." Another said, "I have never complained - yes I have seen the information." We asked one member of staff how they would respond if someone raised a concern with them. They told us, "I would ask if

Good

Is the service responsive?

they wanted to speak to me about it and ask if they wanted an appointment to see [registered manager] or for [registered manager] to come and see them and take it from there."

There was a copy of the provider's complaints policy and procedure in the hallway for people to read. There was also information about external organisations people could approach if they were not happy with how their complaint had been responded to, although some of the details needed updating. We looked at the complaints file maintained by the registered manager. Only one complaint had been recorded since our last visit and this had been responded to promptly and in accordance with the complaints policy.

Requires improvement

Is the service well-led?

Our findings

The registered manager had been in post for over five years and was a visible and known presence to staff, people and relatives. People told us they had confidence in the registered manager. One relative told us if they had any concerns, "I can go to Rachael, she is very good." Another person told us, "If I had a concern about something I would go to the boss, have a little moan and she will sort it out."

A clinical lead had been appointed in May 2015 and was due to become deputy manager of the home on 1 December 2015. The registered manager and clinical lead had established a good working partnership in the five months they had been working together. They were confident that each understood their role and shared the same values. The registered manager described the clinical lead as a "breath of fresh air" and went on to say, "She is clinically excellent and very much a hands on nurse and will walk around the home. We work well as a team and she is a great support to me." The clinical lead when speaking of the registered manager told us, "Rachael is one of the best people, very caring but she is in charge. She amazes me with her observation." They went on to say, "We want the same things……Everything Rachael expects is exactly how I have been trained."

Talking with the registered manager and clinical lead it was clear they knew people well and had an in-depth understanding of people's medical and emotional needs. They were committed to providing good quality nursing care, but required time to translate this commitment into practice.

The service had been through a challenging time as nurses had left the home which meant the provider had been reliant on agency staff to provide nursing cover. A new nursing team had been recruited from Spain and they were settling into their roles at the time of our visit. We found the clinical lead and registered manager were distracted by their need to provide clinical oversight until the new nurses were confident in carrying out their responsibilities. This clinical oversight impacted on the time they had to complete some aspects of their managerial role. The clinical lead told us, "It is difficult to discuss management issues. I have six supernumerary hours per week. That was planned three weeks ago. I don't get time. I haven't had them yet."

During the week when there was only one nurse on the rota, the registered manager had a "hands on" approach and provided nursing cover when a need was identified. They also provided nursing cover during absence or annual leave. For example, on the first day of our inspection due to annual leave the registered manager was the only nurse working in the home. The clinical lead was called in so the registered manager could support our visit. Whilst working on the floor enabled the registered manager to have a good working knowledge of the challenges faced by staff during a working day, this again impacted on the time available to carry out their managerial responsibilities.

Following our visit the operations manager confirmed they were recruiting two new clinical leads who would work alternating shifts to monitor and mentor nursing staff, care staff and systems. We will continue to monitor the service to ensure these improvements are implemented and sustained.

All staff spoken with told us they felt supported by the management team and the registered manager in particular. One staff member told us, "Very much so, Rachel is very approachable. Rachel is 100% there if I have a problem and very much has an open door policy." Another said, "She is lovely, she is really nice and I do find her really approachable." A member of non-care staff told us, "You can't get a better one (manager), she is very hands on."

Meetings were held with staff to focus on consistency and quality issues and discussion included reminders about good practice. We looked at the minutes of a recent meeting with the nurses. We saw there had been detailed discussion around best practice in medicines management and how this should be implemented within the home. Nurses had been given the opportunity to feedback any worries or concerns. During the meeting, the nurses attended a person who had fallen. Once the matter had been dealt with, it was used as a training opportunity for discussing the appropriate action to take in emergency situations. The minutes of the meeting had been translated into Spanish to ensure the nurses had a correct understanding of what had been discussed.

We asked staff what communication was like within the home. It was clear from the responses that there had been some communication issues with the foreign nurses. Whilst, there was an understanding these issues had not been fully resolved, staff told us there had been improvements. One member of staff said, "At first it was a

Requires improvement

Is the service well-led?

bit challenging but that was just communication but they are fluent in English now. They are good, really enthusiastic." Another said, "It is a lot better. One or two struggled a bit, but the communication is alright." The clinical lead acknowledged that communication, and particularly written communication, was an area where further improvements were required.

We spoke with staff about what they would do if they witnessed poor practices. A typical response was, "Tell them to stop, explain why it was wrong and report it to the nurse or manager." When we asked if staff would feel confident to follow the whistleblowing policy we received the following response from one staff member, "I am not aware of a whistleblowing policy." Another staff member told us there was one, but was not clear about it. When we asked if they knew where to find a copy they replied, "I don't know to be honest." Improvements were needed of staff understanding of their role in the whistleblowing process.

People and relatives were encouraged to provide feedback about the quality of care in the home through meetings and questionnaires. We saw that one of the recurring issues was around staff numbers. One person had responded, "Staff are kind, gentle and understanding. However, through no fault of their own, they can be difficult to find." Another had responded, "Shortage of staff in communal areas." We found improvements were needed in responding to people's views as these concerns were only addressed following our inspection visit.

Arrangements were in place to assess and monitor the quality of service provided, but action was not always taken to resolve issues that were identified. Each month the registered manager completed a report which recorded any incidents, accidents and falls. This also recorded information about people with weight loss and infections. This was analysed by the operations manager to identify any trends or patterns so action could be taken where necessary. The monthly management report for October 2015 referred to a complaint received in October about staffing levels. This complaint had not been recorded in the complaints folder. The report also referred to the need for a constant staff presence in communal areas, particularly because one person was at high risk of falls. The constant staff presence was not being consistently maintained at the time of our visit.

Where audits and checks had identified areas where improvements were needed, they had not always been actioned due to the lack of managerial time. For example, improvements identified during medication checks had not been implemented and care plan reviews remained outstanding. The registered manager had not been able to deliver training in dementia care and managing behaviours that challenged due to other commitments on their time.

We found improvements were needed to assess, monitor and mitigate the risks relating to people's health, safety and welfare. The provider needed to ensure the registered manager had the resources and time to carry out their managerial role. The registered manager told us they were confident that once the new clinical leads were in post, they would be able to delegate some of their responsibilities so they could concentrate on this aspect of their role and improving the quality of care provision. They explained, "I do not want this home to fail. I want to deliver care to a high standard."

Providers have an obligation to display the ratings from previous inspections. The ratings from our last inspection visit were not initially displayed. However, the registered manager ensured they were prominently displayed before the conclusion of this inspection.