N Notaro Homes Limited

La Fontana

Inspection report

Fold Hill Lane,
Martock TA12 6PQ
Tel: 01935 829900
Website: www.notarohomes.co.uk

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on16 and 22 July 2015 and was unannounced.

The home is registered to provide accommodation with nursing or personal care for up to 76 older people with a dementia or with other mental and physical disabilities. At the time of the inspection there were 73 people living at the home. People had complex nursing care and support needs and many of the people found it difficult to engage in meaningful conversations because of their health needs. The home was purpose built and is situated in a rural setting with modern well maintained premises and grounds.

Most of the people in the home were living with a dementia and this limited the number of people we could have conversations with. To help us gain more information about people's experiences of the service we also spoke with visiting relatives and observed the care and support practices in the home.

People and relatives told us they felt safe but we found areas that required improvement. For example, the service did not always have enough suitable staff to consistently meet people's needs in a timely way. The staffing structure was clear but improvements were needed in the supervision and support provided to staff at all levels.

Summary of findings

People had a choice of meals from a four week rolling menu. Alternatives were available if requested. The quality and quantity of food served was satisfactory but people were not always given appropriate support to eat their meals. Staff attitudes, at times, during lunchtime were not always caring.

There were inconsistencies and inaccuracies in people's care records. This meant people may not have received the care they required. The provider's quality assurance system had not operated effectively in identifying and making changes without delay when improvements were needed.

Although we identified areas where the service needed to improve, feedback from people and their relatives was generally complimentary. One visiting relative said "The best thing in the home is the friendly staff. There is no point in having a lovely home if the staff are not nice. They all seem to work as a team".

In the provider's annual satisfaction survey of people and their relatives the quality of service and buildings were rated as excellent overall; food and activities were rated as good. We were shown numerous compliment cards and letters from relatives referring to the excellent care people had received at the home, particularly those people approaching the end of their lives.

Relatives told us they were always made to feel very welcome and the management and staff actively encouraged their involvement in care planning and service developments.

People received their medicines safely and were protected from the risk of infection. The home was clean and tidy throughout and all areas were well maintained.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not always enough staff to meet people's needs in a timely manner.

People were generally protected from abuse and avoidable harm. However, some staff were unclear about the appropriate procedure for managing aggressive behaviours. This presented a potential risk to people who lived in the home and to the staff.

People received their medicines safely from registered nurses and were protected from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People had their nutritional needs assessed but they did not always receive the support they needed at mealtimes or have their reasonable meal preferences met.

People received care from staff who did not always fully understand or demonstrate the behaviours and practices required to meet people's needs effectively.

The provider generally acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who respected people's privacy and dignity.

People with the mental capacity to do so were able to choose where they spent their time and were involved in decisions about their daily care and support.

People were encouraged and supported to maintain family relationships.

People received compassionate care at the end of their lives.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care records were not always accurate or complete. It was difficult to judge if the care people received was always appropriate to their needs or took account of their preferences.

Summary of findings

People were able to engage in a range of social activities but the engagement of people who were most dependent on staff for support could be improved.

People, relatives and staff were able to express their views and the service responded appropriately to feedback or complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The leadership and supervision arrangements for staff did not always ensure staff were fully supported.

The provider's quality assurance system had not operated effectively in identifying and making changes without delay to address areas for improvement.

People and their relatives told us the management and staff were open and approachable and they were generally complimentary about the service.

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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 16 and 22 July 2015 and was unannounced. It was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was as a carer for a member of their family who was living with dementia.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries and information we hold about the service. At the last inspection on 13 August 2013 they were meeting all of the quality and safety standards reviewed and no concerns were identified. However, more recently, we had received information of concern from a relative of a person who used to live at the home and from a member of staff who used to work at the home.

During this inspection we spoke with seven people who lived in the home, six visiting relatives and 12 members of staff. Most of the people who lived in the home were unable to fully express themselves due to their dementia and other health care needs. We therefore spent time observing the care and support practices in the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We also looked at records which related to people's individual care and the running of the home. These included 10 care plans, 10 food and fluid intake charts, four staff recruitment files, six medication records and some of the provider's quality assurance records including complaint and incident files.

Requires Improvement

Is the service safe?

Our findings

Most of the people who lived in the home had a form of dementia. This meant we were only able to have meaningful conversations with a limited number of people. To help us gain more information about people's experiences of the service we also spoke with visiting relatives. Although people and relatives said they felt safe, we found some aspects of the service required improvement. This included the deployment of enough suitable staff to consistently meet people's needs and further staff training for managing more challenging behaviours.

Although management were actively trying to recruit new staff, the service had difficulties ensuring there were enough suitable staff to meet people's needs at all times. A relative, who visited the home most days, said they felt their relative was safe and well cared for. However, they said there were times when the home was short staffed and people had to wait some time to be assisted. Nursing and care staff said there were usually one or two shifts each week, particularly at weekends, when staff called in sick and this made it much harder to meet people's needs. They told us they always ensured people's essential care and support needs were met but "it was a bonus" if they had time to engage people in conversations or recreational activities.

We reviewed the staffing rotas for the past four weeks with the registered manager. He agreed that on average around two to three shifts per week were below the agreed establishment staffing levels. This was mainly due to short notice sickness absences. He said they were trying hard to reduce the incidence of short notice absences but progress was difficult and slow. They had a policy for managing sickness absence and used an external human resources contractor to advise them on complex staffing matters.

The registered manager said they currently had their full establishment of registered nurses but had vacancies for four care staff. Staff overtime or agency staff were used to cover holidays and other absences provided there was sufficient notice to arrange this. The registered manager said they were able to cover all nurse absences through use of agency staff or by the deputy manager (who was a registered nurse) covering some of the nursing shifts.

However the processes for managing and replacing care staff at short notice had not ensured there was enough staff on duty at all times. This meant, at times, people's needs were not being met in a timely way.

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

The home was organised into three blocks with 24 to 25 bedrooms in each block. Each block was staffed by five care staff and a registered nurse. The ratio was one care staff member for every five residents. Additional staff were deployed to support three people on a one to one basis because they had high dependency needs. The registered manager said the staffing level was agreed with the continuing healthcare and social care teams who commissioned their services.

Their difficulty was recruiting and retaining sufficient care staff. The provider had a continuous recruitment programme and used a variety of different job sites and recruitment methods. They had recently been successful in recruiting a number of new care staff but some had decided this was not the right job for them and had left after a short time in post. Some experienced care staff had left for jobs in the NHS offering more attractive benefits.

The registered manager said he had approval to recruit over and above his staff establishment but it was currently very difficult to recruit and retain sufficient numbers of suitable care staff. Recruitment of overseas staff had been considered but this was limited by language considerations as staff needed good communication skills to support people with dementia and other complex needs. He said he needed to carefully consider any new referrals to the home until a full complement of care staff was in place.

Although people and relatives said they felt safe, we found some examples where people were potentially at risk. A relative said "My [relative] feels safe living here. I have previous experience of care homes so I know this is a good home". Another relative told us the staff were "accessible and forthcoming" and they felt that the home was a safe place for their relative to be now they were not able to be at home on their own. However, during our inspection a person who lived in the home pointed to another person and told us "Don't sit next to them as they will grab you or bash you. They're not a nice person".

Requires Improvement

Is the service safe?

We observed two of the relatively new members of staff were unsure how to manage a person who displayed aggressive behaviours. They told us they did not feel safe working in the unit due to the behaviour of this person. The behaviours of the person in question had become more challenging over time and they were about to be moved to another care setting more suitable to their current needs. When we returned for the second day of our inspection the move had taken place.

Although records showed these staff had received training in safeguarding and in challenging behaviours they were not confident about who to go to or how to handle this type of situation. Other care staff confirmed they had received training in challenging behaviours but not in the use of any physical restraint techniques. The registered manager said their policy was not to use physical intervention. We were told the dementia awareness training covered non-physical interventions such as distraction and calming techniques. The provider's Physical Intervention and Restraint Policy stated "Physical intervention is only to be used as a last resort by trained and skilled staff" and "This includes the use of medicines to control violence or aggression….only if it is prescribed for the condition causing the challenging behaviour".

The registered manager said aggressive situations were unusual but further action would be taken to address this. The registered manager said when a person's behaviours changed they informed the community psychiatric nurse who carried out an assessment and, if needed, referred the person for a psychiatric appointment. One to one staff support was also put in place where required. They said further staff training in managing challenging behaviours was planned and they would ensure this clarified the appropriate staff procedure for dealing with more aggressive situations.

The provider sought to protect people from the risk of abuse through appropriate policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff received training in safeguarding and whistle-blowing procedures and said they would report any concerns to the nurse in charge or to management.

Incident records showed the service followed local safeguarding protocols for reporting potential abuse. Other significant incidents were recorded on an incident and accident form and were notified to the relevant statutory authorities where required.

The risk of abuse was reduced because there was a robust recruitment procedure for new staff. This included carrying out checks to make sure they were safe to work with vulnerable adults. Staff records showed all staff underwent an interview process and were only appointed once written references, evidence of qualifications and safety checks had been received.

Care plans included risk assessments which outlined measures to ensure people received care safely. This included equipment and staffing support. Risk assessments covered mobility and pressure sore risk, falls, use of bedrails, malnutrition screening, personal hygiene, and medication.

People received medicines safely from staff who had been trained and assessed as competent to administer medicines. We observed one of the registered nurses carrying out a medicines round. People were given their medicines in a safe, considerate and respectful way. Medicine administration records (MAR) were accurate and up to date. A GP visited the home twice a week and reviewed people's prescriptions, including 'as required' medicines, to ensure they were up to date and appropriate.

Medicines were kept securely in locked medicine trolleys which were stored in locked treatment rooms when not in use. There were suitable arrangements for medicines which needed additional security or required refrigeration. The provider had an appropriate medicines policy and procedures.

People were protected from the risk of infection. The home was well maintained and appeared clean and tidy throughout. There were clear housekeeping schedules and we observed regular cleaning of the premises during our inspection. There were sufficient supplies of personal protective equipment (PPE) for staff located around the premises.

Requires Improvement

Is the service effective?

Our findings

People's reasonable food preferences were not adequately met and people were not always given appropriate support to eat their meals.

People's nutritional needs were assessed to provide a diet in line with their needs. The service had a four week rolling menu with choices each day for each meal. The menu was discussed at the Residents and Relatives Meeting and the choices people liked were included. Alternatives, such as omelette, baked potato and sandwiches were available if requested. Special diets were prepared when requested for people with diabetes or gluten free diets.

We observed people having their lunchtime meal. There were two meal choices available and we were told staff decided for people who were unable to express a choice. We observed staff decided meal choices for the majority of people. We did not see any alternatives offered during the inspection. One member of care staff told us "After a while you remember people's choices".

During the lunchtime we over heard a person say to a member of staff they didn't want the meal being served. The member of staff replied "well there's nothing else you'll just have to eat it". The staff member left the meal on the table and walked away. The person was clearly not happy and said to other people at the table they did not want the meal but nevertheless started to eat it as they were hungry.

Some of the people needed staff assistance with their meal. Some staff were friendly and supportive and were effective in encouraging people to eat their meals. However, we observed other staff provided little support or encouragement to people sitting at their table. For example, one member of staff who was assisting one person failed to react to two other people at the same table who were struggling to coordinate their cutlery and eat their meals. One of the people had started to eat with their fingers and the other person was only able to scoop up a small amount of their meal with a spoon. They received no assistance from the member of staff at their table or from any other staff.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Meeting nutritional and hydration needs.

Some people were prescribed food supplement drinks and other people required their food or drink at a specific consistency to assist with swallowing. One person received their nutritional needs through a PEG feed tube administered by the registered nurses. PEG is short for percutaneous endoscopic gastrostomy. When a person is unable to swallow, nutrition can be given through a PEG tube directly into their stomach.

We spoke with staff about the training they received to provide effective care and support for people in the home. A senior member of care staff and other experienced staff told us they received refresher training to keep their skills and knowledge up to date. They said new staff received a one week induction training programme in a range of relevant subjects. These included dementia awareness, safeguarding, whistle blower procedures, care plans, personal care, moving and handling, infection control and other health and safety subjects. New staff shadowed a senior member of staff for at least three shifts or longer if needed. The training provided was evidenced by the provider's staff training matrix and staff induction checklists.

We received mixed messages from care staff about the level of supervision and support they received. One new member of staff said "The team are very caring. The senior carers are really good and very supportive". However, two other new staff said they felt they lacked the skills and knowledge to meet the needs of people who became anxious or distressed. Also, in our discussions they displayed little knowledge or understanding of people's care plans or their risk assessments. This indicated improvements were needed to the induction process and the supervision and support provided to new staff.

The registered manager supervised the deputy manager, the deputy manager supervised the nurses and the nurses supervised the care staff. Records showed staff received formal one to one supervisions every three to four months, except in cases where there was long term sickness absence or maternity leave. The registered manager said the timeliness of supervisions was something they wanted to improve on now they had their full establishment of nurses in post.

Staff received training in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff said they always asked people's permission before delivering care or support and respected

Is the service effective?

people's decisions. We observed staff asking people's permission before providing personal care or support during the inspection. The service followed the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. Care records showed where people were assessed as lacking the mental capacity to make certain decisions a best interest decision was made on their behalf. Where appropriate, people who knew the person well (including their relatives or relevant professionals) were involved in the best interest decision making processes.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. With the exception of one person, a DoLS application had been submitted for all of the people who lived in the home. The home specialised in caring for people living with dementia and the majority of people in the home needed certain restrictions to help keep them safe. This included the use of key pads to unlock external doors and 'as required' medicines for a small number of people who sometimes became very anxious and distressed. Two DoLS authorisations were now in place but a decision was still awaited on the rest of the applications.

People were supported to access a range of external healthcare services to help them maintain good health. Care plans contained records of hospital, GP, dentist, audiology, optician and chiropodist appointments. Specialist advice was sought as and when needed. For example, a community psychiatric nurse regularly visited the home and made referrals for a psychiatric assessment when people's mental health needs changed. The provider contracted with a local GP to visit the home twice a week and carry out a 'ward round' including reviews of people's medicines. One of the nurses in the home said "Generally I think we meet people's physical and mental health needs pretty well".

We observed the premises had been designed and adapted to meet people's specific care needs. The accommodation and grounds were maintained to a high standard and provided a pleasant environment. People's rooms were all on the ground floor and opened out onto secure gardens with pathways covered in a soft surface to help protect people if they fell. Doors leading to different areas of the home had large signs with descriptions and pictures to help people understand each area of the home. People's bedrooms were individually numbered and had 'memory boxes' on the wall outside each room to help people identify their own room. All bedrooms had ensuite bathrooms.

The newest block included a 'memory room' with simulated sun light settings, a number of shop window displays to stimulate people's memories and an ice cream stall where people could obtain a free ice cream on request. We were told this area was accessible to anyone who lived in the home.

People's relatives told us the well maintained gardens and grounds were not used by everyone due to the lack of available staff to support people. They said the outside areas were mainly used by people with visiting relatives who took them outside and by a few people receiving one to one staff support.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were kind and caring and treated them with respect. Although staff were busy most of them displayed a friendly, kind and caring approach toward people in the home. A person who lived in the home said "I moved here in April, I like it here and the staff are really wonderful". A visiting relative said "I come in here three times a week to visit my [relative]. I have never known any of the staff to be unkind".

We observed most of the staff displayed a caring approach. For example, staff knelt down to be on the same level as people in their chairs when they spoke with them. We over-heard one member of care staff ask a person how they were feeling and said to them "Relax your legs for a bit. Later tonight we'll have a cup of tea and cake together". Another member of staff fetched a cup of tea for someone who appeared to be a little disorientated. The staff member said to the person "If it is too hot for you I can get some more milk or if you prefer you can leave it to cool down for a while". The registered manager told us when a person receiving one to one staff support went into hospital they let the member of staff go with them. This was to reassure and comfort the person and assist the hospital staff in understanding their needs.

We heard staff consulting people about their daily routines and preferences. A member of staff said "We always ask people if they want to get up. If they don't we let them stay in bed. Similarly we respect people's decisions whether they want to have a bath or not. No one is made to do anything they don't want to".

Care plans described people's individual communication needs, decision making capabilities and things they enjoyed or disliked. People were encouraged to express their views and preferences to the extent they were able. Where people had limited communication skills the views of close relatives or other people who knew them well were taken into consideration.

People's rooms were personalised to reflect aspects of their previous home life. Every person had a 'memory box' on the wall outside their room to help them remember and identify their own room. Staff provided personal care in people's rooms to help protect their privacy and dignity. We observed staff respected people's privacy by knocking on people's doors before entering their room. When they discussed people's care needs with us they did so in a respectful and compassionate way.

People with the physical and mental capacity to do so were able to choose where to spend their time. They were free to walk around the communal areas of the home, spend time in the company of others, or return to the privacy of their own rooms as they pleased.

People's relatives told us they were made to feel very welcome when they visited the home and were encouraged to be involved in their relative's care planning. Relatives said they could visit at times convenient to them, there were no set visiting times or unreasonable restrictions.

The home provided compassionate care to support people approaching the end of their lives. We were shown numerous letters and compliment cards from families who had expressed their gratitude for the way their relative had been supported at the end of their lives. There was a remembrance book for deceased residents in the main reception area. With the family's consent, this contained photographs of their deceased relative with loving sentiments expressed by family and friends.

Systems were in place which ensured people's wishes and preferences were respected during their final days and following death. The service had achieved the National Gold Standard Framework (GSF) accreditation in September 2014. GSF provides a comprehensive training and quality assurance system to enable care homes to provide quality care for people nearing the end of their life. Providers have to apply for re-accreditation every three years. One of the nurses said "End of life care is very good here, everyone really cares".

Information about people's end of life preferences and any spiritual or religious beliefs was included in their care plans. The service supported people to practice their spiritual and religious beliefs where this was important to them. For example, local clergy from different denominations visited the home to conduct services and provide pastoral care for people who requested it. We were told the home had particularly strong links with a local church. Some of the church members volunteered to visit people in the home and provided them with additional social contact and support.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were assessed but we found inconsistencies between the personal care records and the detailed care plans and the frequency of care plan reviews. It was difficult to determine whether this was purely a case of inaccurate recording or whether people did not always receive the care detailed in their care plans. From our observations of care practices and discussions with staff it was clear they relied mainly on verbal communications about people's needs and preferences rather than documented records. This increased the potential for errors and omissions when providing people's care and support.

For example, we found inconsistencies between the entries on people's bath and shower forms and the entries on their daily personal care records. The provider told us they planned to discontinue the use of the bath and shower chart to avoid any confusion. A senior member of care staff said people's preferences should be recorded in their care plan but this was not always the case. They said care staff "got to know" people's preferences and tended to pass this on to each other verbally.

Where people were assessed as at risk of malnutrition or dehydration their food and fluid intake was recorded by staff. We found the quantities provided each day were not totalled on any of the food and fluid charts we reviewed. This meant staff could not easily see whether the person had received sufficient amounts. Out of 10 food and fluid charts reviewed only two showed an entry for food and fluid after 5pm in the evening. This meant either food or fluids were not provided to these people after 5pm or staff were not completing the records accurately when food or fluid was offered.

We found inconsistencies between people's medicine administration records (MAR) which recorded supplements had been administered but these were not recorded on the person's food and fluid intake chart. The inconsistency in recording meant nursing staff could not be sure the person's nutritional needs were being met. There were also examples where the review dates stated in people's care plans were delayed or overdue. This included overdue review dates for weight monitoring, malnutrition screening assessments, and skin integrity assessments. At best, this showed people's care records were not always accurate or complete. At worst, it showed the service did not always respond to people's identified care needs.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

People's relatives told us their relative's personal care needs were met. One visiting relative said their relative was always clean and nicely dressed. They said staff always changed their relative's clothes after a meal if their relative had spilled anything down them. They added this was not just reserved for their relative as they had seen staff doing the same for other people in the home. However, during the inspection we noticed one person had 'an accident' and clearly required personal care and a change of clothes. This was very obvious but we observed three different members of care staff pass by without offering any assistance. A member of the inspection team had to ask care staff to come and assist the person. We brought this to the attention of the registered manager.

People's care needs were assessed by the registered manager before they moved to the home to check whether the service was appropriate to their needs and expectations. Relatives told us they had been fully involved in the initial assessment visits to people in their own homes prior to moving to La Fontana. Following the move, a six week review took place involving the home's management, social services and family members where appropriate. Relatives said the communications between the family and management were good.

After the initial assessment, a detailed care plan was drawn up identifying the person's background, preferences, and support needs. The detailed care plans were stored in the nurse's station on each block and each person's key nurse was responsible for reviewing and updating the care plan. Each person also had a personal care file in their own room. This provided a summary of the person's needs including communications, decision making, sleep pattern, pressure risks and repositioning. Care staff were responsible for recording each time they provided any care or support. In addition to the care plans and personal care files, nursing staff noted key facts about people's health and well-being and any changes to people's care requirements in a shift handover book. This was used to brief staff at each morning and evening shift handover meeting.

People in the home received varying amounts of staff engagement and social stimulation. Some people enjoyed a good degree of social and recreational activity whereas

Requires Improvement

Is the service responsive?

others were less fortunate. The service employed three dedicated activity co-ordinators. We observed weekly activity schedules were pinned on the entrance doors to each block giving details of the daily activities for the week. A relative said "[Their relative] goes out with staff regularly. Today they are going out to see the baby lamas". One of the nurses said "People do quite well, there is always something going on every day". This included trips out to the garden centre or cinema, visits from local musicians, the donkey sanctuary and captive birds of prey, as well as visiting volunteers from a local church.

On the morning and afternoon of the inspection we observed group activity sessions taking place in parts of the home. For example, one activity involved six people in a circle with staff throwing a ball to them and the people throwing it back. This provided social interaction and fun as well as a degree of exercise. Most of the people in the lounge area at the time participated but around half of the people on the unit remained in their rooms. We were told one of the activity co-ordinators organised the home's 'farm in the barn' which housed a collection of pet animals. Sometimes the pet rabbits were brought into the home but more often people were encouraged to visit the 'farm'.

Relatives told us people with visiting friends and family, and those receiving one to one staff support, were able to access the home's gardens and the 'farm' on a regular basis. However, they said other people remained inside the home because there were not usually enough staff to support them to go out. One relative said "The activity co-ordinators do their best but there was only so much they could do" and "Often it was the more vocal people who received the most staff attention".

This was reinforced by some of our own observations. We observed several people sitting quietly in the same chairs throughout the inspection with little staff interaction other than to offer them their meal at lunchtime. When care staff did engage with people they seemed to appreciate it a great deal. Unfortunately these social interactions were few and far between and were only for brief periods of time. For example, we saw a member of staff ask a person sitting on a dining chair if they would like their nails painted. The person nodded enthusiastically but once their nails had been painted they were left alone again. They fell asleep in the chair where they remained for the rest of the day. Social interaction with people who were most dependent on staff support was an area that could be improved further.

People and their relatives told us they were able to raise issues or concerns with the management and staff. One relative said "The manager was not around much but was available if they needed him. However, the deputy was always around and very approachable". Similarly, another relative said "[Deputy manager's name] is on the floor a lot. If I had to complain I would speak to her, but I have never had need to complain".

There was an appropriate complaints policy and procedure. This gave people information about how to make a complaint and the timescales they could expect a response. People and their relatives said they would not hesitate to make a complaint and they were confident any concerns would be addressed. However, they told us none of their issues had escalated into formal complaints as the staff on the unit had sorted their problems out.

The service had not received any formal complaints in the last 12 months. The registered manager said a complex complaint from a relative of a deceased resident was currently with the Ombudsman. However, this had not been raised via the provider's complaints process. We were already aware of this complaint.

Requires Improvement

Is the service well-led?

Our findings

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. The registered manager told us the service philosophy was to provide a high standard of care, meet people's needs and provide a safe environment. People were to be treated with respect and dignity and offered choice. He wanted a happy working environment for staff and to involve people's families and other professionals as part of their care team. The registered manager said staff training and development was aimed at promoting these service values. It was also reinforced through staff meetings, shift handover meetings and one to one staff supervision sessions.

Whilst the staffing structure was clear improvements were needed in the supervision and support provided to staff. The nurses' role was to lead the shifts but they did not appear to have the necessary time, experience, understanding or training to do this effectively. One nurse could not tell us the names of the care staff they supervised or even how many staff they supervised. From our conversations with staff and observations of care practices, our overall impression was there was a lack of visual leadership. Most care staff told us it was the deputy manager rather than the nurses who provided day to day leadership. However, the deputy manager had many other duties and could not reasonably be expected to effectively manage the nurses and every member of care staff.

The registered manager said his role was the general running of the home, finances and pre-admission assessments. The deputy manager was responsible for the clinical aspects of the service including supervision of the nurses and care staff. The registered nurses were responsible for managing the care staff on each block with support from a senior care worker on some shifts. The registered manager said "We all work as a team and sort things out together". An experienced member of care staff told us "Management are fair and reasonable. If we request something they accept it where possible". Other staff said they could talk with the managers and they felt listened to.

Most of the nursing and care staff appeared motivated and dedicated to meeting people's needs. The individual roles and responsibilities of the nurses and the care staff were generally understood but were not well co-ordinated. For example, food supplements were prepared by the nursing staff but were given to people by the care staff. Their respective records did not always tally. One member of care staff said "Supervisions are infrequent and not very helpful. The nurses spend 90% of their time in the treatment rooms and very little time on the floor". Some of the newer staff told us they were unsure how to deal with challenging behaviours or who to turn to for support and advice.

The provider had a quality assurance system but this had not operated effectively in identifying and making appropriate changes without delay to address the areas for improvement we found during our inspection. Many of these areas were directly or indirectly attributable to the staffing and recruitment issues identified earlier in this report. Although the provider had taken action to try to address this, the action to-date had not proven to be fully effective.

The provider's quality assurance system included regular monthly audits of key aspects of the service. Audits included medicines, nutrition, wound management, and the environment. The provider's Quality and Performance Manager carried out a service review of the home every couple of months. The home owner also visited periodically. The registered manager was responsible for drawing up and implementing an action plan to address any issues, for example staff recruitment, and this was followed up at the next service review. However, these audits and quality monitoring systems had not identified a number of the areas for improvement found during our inspection. Where areas for improvement had already been identified, appropriate changes had not always been made without delay to address these.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

The registered manager was not visible on the floor of the home when we inspected. He said this was because he did not want to "interfere" with the inspection process. However, he was available in the office whenever we wished to speak with him. People's relatives told us the registered manager was available, if needed, and the deputy manager was very accessible and visible around the home. The registered manager said he normally walked around the home several times each day and spoke informally with people and staff. He had daily conversations with the deputy manager and nursing staff

Requires Improvement

Is the service well-led?

about issues concerning people and the staff. He chaired the staff meetings every two months. He said members of staff often came to him for help and advice, for example to discuss flexible working arrangements during and after pregnancy. We found evidence of agreed flexible working agreements in our discussions with staff and the staff files.

Quality monitoring included reviewing significant incidents. The registered manager carried out a monthly audit of significant incidents and action was taken where lessons could be learned to improve the service. For example, a movement alarm and regular supervision checks were introduced for a person who was prone to falls during the night. In response to another incident, one to one staffing was put in place for a person who was found eating foreign objects and a referral was made to the community psychiatric nurse.

Although the inspection identified areas where the service needed to improve, the feedback from people and their relatives was generally complimentary about the service. One visiting relative said "The best thing in the home is the friendly staff. There is no point in having a lovely home if the staff are not nice, they all seem to work as a team". People and their relatives told us they could express their views directly to management and staff and also through the provider's annual satisfaction survey.

The results of the last survey showed the home had received good or excellent overall ratings from people and their relatives. The quality of service and buildings were rated as excellent overall; food and activities were rated as good. We were shown numerous compliment cards and letters referring to the excellent care people had received at the home. Relatives told us they were always made to feel very welcome when they visited and management and staff actively encouraged their involvement in care planning and service developments.

The registered manager participated in a number of forums for exchanging information and ideas about care practices. This included meetings of home managers in the group, multi-agency meetings, conferences and seminars. They also accessed online resources and other training materials from service related organisations. The service had achieved the National Gold Standard Framework (GSF) accreditation for caring for people at the end of their lives.

People who lived in the home were supported to get involved with the local community. Staff and relatives supported people to go out into the community on a regular basis. Local church volunteers regularly visited the home to chat to people and support them with other social activities. Pupils from a local school visited the home and performed seasonal events, such as Christmas carol singing. Local musicians visited two or three times a month to entertain people. The registered manager said they used local butchers and local produce whenever possible and also sponsored other local events in the community.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs How the regulation was not being met: People's reasonable food preferences were not adequately met and people were not always given appropriate support to eat their meals. Regulation 14 (4) (c) and (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider failed to maintain an accurate, complete and contemporaneous record in respect of each service user. Regulation 17 (2) (c). The system to assess, monitor and improve the quality and safety of the service was not operating effectively. Regulation 17 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to meet the needs of people using the service at all times. Regulation 18 (1).