Rushcliffe Care Limited

Thorpe House Nursing 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out our inspection visit on 13 October 2016. The inspection was unannounced.

The service provided nursing care for up to 50 older people living with dementia and similar health conditions. At the time of our inspection there were 47 people using the service. Some of the people that used the service had advanced levels of dementia.

The service had a registered manager. 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.

People felt safe living at Thorpe House. The provider had systems in place for reporting and investigating accidents and incidents. Staff were aware of and practiced the provider's protocols of reporting incidents of concern. However, they demonstrated a varied understanding of what may constitute of abuse or avoidable harm to people.

There were not enough staff to meet people's needs. People that used the service, their relatives and the staff that supported them expressed concerns that the staffing levels did not meet people's needs. Following our visit, the registered manager informed us that they had reviewed their staffing levels and support people required and had increased the number of staff on duty during the day shifts.

People were supported to have their medicines as prescribed by their doctor. Trained nurses supported them with this task.

Staff had access to an induction and training programme to support them to gain the skills they required to fulfil their role. We found that staff had not all completed the training they required. Some staff did not feel they had the skills to support people with dementia. Following our visit, the registered manager informed us that they had arranged for staff to complete relevant training.

People's liberty was not deprived unlawfully. This was because the provider had made applications to the local authority for DoLS authorisation for people that required this. The staff we spoke with demonstrated a good understanding of Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People did not receive the support that they required to meet their nutritional needs. Staff were not deployed in a way that met their needs at mealtimes.

People received the support that they required to meet their health needs. They had prompt access to healthcare services when they needed them.

Staff were kind and compassionate to people. They maintained positive relationships with the people they supported and treated them with dignity and respect. They provided the support that people needed to be involved in decisions about their care.

People's care plans were comprehensive. Their relatives were involved in planning their care and support.

People were socially isolated. They were not supported to engage in meaningful activities. Following our visit, the registered manager informed us that they had appointed a member of staff to be responsible for supporting people with social activities and had advertised for an activity co-coordinator.

People had opportunities to provide feedback about the service they received. They told us that staff listened to them but some people felt they did not always use their feedback to bring about a better experience of care.

Staff felt supported by the registered manager to meet the standard expected of them. The registered manager was approachable and within easy access to staff and people.

You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staff did not always know what constituted abuse or how to whistle blow about unsafe practices of care.

There was not sufficient numbers of staff on duty to meet people's needs.

People felt safe when they received care from staff. Accidents and incidents were reported and investigated. People received the support they required to take their medicines.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had access to induction and training programme. However this was not always up to date. They did not always feel competent to meet the needs of people with dementia.

Staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They supported people to have prompt access to healthcare services.

People were not effectively supported with their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

Staff actively involved people in decision about their care and support. They made people feel like they mattered.

Staff respected and promoted people's dignity and human rights.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were socially isolated. They were not supported to engage in meaningful activities.

People had opportunities to provide feedback about the service. They did not always think their feedback was taken on board.

People's care plan was comprehensive and reflected their current needs.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People and their relatives did not feel their opinions were considered to improve the quality of care.

The registered manager was accessible to staff, relatives and people using the service. Staff had a clear understanding of the standards expected of them. They were supported by the registered manager to meet those standards.

The provider had procedures for monitoring and assessing the quality of the service. However, they were not effective to identify were improvements were required.

Thorpe House Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

We carried out our inspection visit on 13 October 2016. The inspection was unannounced. The inspection team consisted of two inspectors, a nurse specialist advisor and an expert by experience (ExE). An ExE is a person who has personal experience of using this type of service or caring for someone who uses this type of service.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law. We also reviewed the Provider Information Return (PIR). This is a form completed by the provider, where the provider gives key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority we were responsible for the funding of some people that used the service.

We spoke with two people who used the service, relatives of seven people who used the service, three care workers, three nurses, the cook and the registered manager. We looked at the care records of five people who used the service, medication records of nine people, staff training records, six staff recruitment and supervision records and the provider's quality assurance documentation. We observed staff and people's interactions, and how staff supported people. From our observations we could determine how staff interacted with people who use the service, and how people responded to the interactions. This was so that we could understand people's experiences.

Requires Improvement

Is the service safe?

Our findings

People felt safe when they received services at Thorpe House. One person told us, "I feel safe now … everything is very safe in here." Another person told us, "Oh yes, we're fine and feel safe." Their relatives also told us that they were confident that their loved ones were safe. One relative told us, "I've no worries that [person]'s safe." Another relative said, "[Person]'s safe in their room and can't go anywhere." Another relative told us about an incident that involved their loved one. They said, "Oh yes they safe. They [staff] put appropriate safeguards to manage that."

Staff that we spoke with knew how they would put into practice the provider's protocols of responding to and reporting incidents of abuse. However, staff demonstrated a varied understanding of what may constitute of abuse or avoidable harm to people. A care worker that we spoke with told us that they had not received training in safeguarding. One care worker told us, "If I thought something was wrong I would report it straightaway." They went on to tell us that they did not know what were the potential signs of abuse to look out for and did not know how to whistle blow if they witnessed any unsafe practices. Another care worked told us that they understood abuse to be, "If someone is not themselves, or not happy or if they are worried. We learnt about the signs. (Of abuse). I would tell the manager and the nurse in charge. They should take the lead. I have heard of whistleblowing. You can go to CQC (Care Quality Commission)."

The provider had systems in place for reporting and investigating accidents and incidents. Records showed that when accidents or incidents occurred, that staff took appropriate actions to develop people's support in a way that minimised the risks of a reoccurrence of the accident or incident. The registered manager or registered nurses investigated incidents and took relevant actions. For example, they made changes to the environment and care people received to minimize the occurrence of falls. Staff assessed risks to people's care and put appropriate measures to minimise risks in areas such as falls, pressure care and managing people's mobility needs.

The provider had arrangements to respond to, and manage emergencies. People using the service had an emergency evacuation plan. Each person that used the service had a coloured dot on their door indicating the level of support that they required in the event of emergency evacuation of the building. Staff also had a master list displayed within the home for referencing the support that people required during emergency situations.

The provider had safe recruitment practices. They completed relevant pre-employment checks before staff commenced their employment. These included Disclosure and Barring Service (DBS) Check. DBS checks were completed before staff commenced their employment and again every three years. This assured them that staff remained safely suitable to work with people who used care services. Where staff had been employed through the overseas nursing programme, we saw that the provider also completed relevant police checks from the home country.

There were not enough staff to meet people's needs. All the people we spoke with expressed concerns about the staffing levels. They told us that issues of staff shortage were more apparent at lunchtime,

weekends and in the evening. One person told us, "There's not many at the moment – the number has dropped. Weekends I notice it and around bedtime. People are sat on their own for ages – I'll stay up and keep them company and help staff out." Another person told us, "I think there's enough but they seem stretched at weekends." A relative said, "There's not enough on – lunchtimes and early evening are the worst. I see them left alone in the lounge (1st floor) in the evening, no staff around." Another relative told us, "They're always short – just not enough for the needs. There's never any staff on the corridor and I've witnessed violent incidents and we've had to go find staff. It takes two staff about 40 minutes to hoist and toilet [person] and wait, but they have to serve lunch too" and "We make sure one of us is here at lunch and tea to feed her – a vote of no confidence in enough staff to feed them. Food goes cold in their rooms in no time while they wait." Another relative expressed concerns that the needs of their loved one was not met due to insufficient staffing levels. They said, "There is not enough staff. I don't blame staff, they are lovely, there just aren't enough to care for these highly dependent people. I worry about meal times and at weekends. I'm going to my car now to have a good cry."
The registered manager told us that they put additional staff on duty to support people with appointments, events or to settle new people into the home. They told us that they did not use agency staff to cover absences as agency staff "did not know the residents." They told us that they covered absences from the provider's pool of temporary staff. We reviewed the staffing rota for a two week period which showed that staffing levels were mostly met up to and exceeding the agreed levels of staff required on duty by the provider but this did not meet people's needs. We spent time observing the care that people received. We saw that there was not enough staff to support people especially at meal times.

Care staff also expressed concerns about the staffing levels. They told us that there was not enough staff on duty to meet people's needs. A care worker told us, "There are not enough staff. Yesterday we only had three staff on upstairs. The people upstairs … You have to watch them all the time. Someone had to come and help yesterday. If someone is off sick there are problems." A senior care worker told us, "The worst times are mealtimes. A lot of people to feed in bed. Then the dining room people get up and wander round or need the toilet. It can be hard." A care worker told us, "There is an issue with staffing. There is one person who has 'one to one care'. If there are only four [staff] on the floor it can be difficult. More staff would be good. We could improve staffing levels. If there were more staff it would be a better service. Sometimes when we are short if someone should have a bath it would be cancelled. They would still have a wash but not their bath." These issues constituted a breach of Regulation 18 (1) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

Following our visit, they informed us that they had reviewed their staffing levels and support people required and had increased the number of staff on duty during the day shifts.

Some people who used the service are not able to use their call bells due to the level of their needs. Their relatives told us that that staff responded in a timely manner when they have used the call bell alarms to request staff attention. One relative told us, "I've used it before and they come quite quickly." Another relative said, "We've rung a few times to get help – it's a longer wait at weekends, up to 25 minutes." Other comments included, "They respond very well." and "I've used it at times to get help and they come very quickly."

People told us that they received the support that they required to take their medicines. One person told us, "They always wait with me. I can ask for paracetamol if I need it and I'm aching." Another person told us, "It's always supervised." Relatives agreed that people were supported with their medicines. One relative told us, "It seems well managed and they [staff] supervise them." Another relative said, "[Person] has liquid medicine now – they stay with him to help."

People medicines were stored safely following current guidelines. However, we saw that staff did not always follow guidance of rotating the stock of medicines people required which would have ensured that medicines were administered before they became unsafe for people's use. We saw that this did not have any impact on people's safety because none of the medicines available had become unsafe for use. Staff also did not always follow the provider's guidance to record storage temperatures twice daily. However, records showed that medicines storage temperatures remained within safe limits. This meant that there was no risk that people's medicines may have become unsafe for their use.

We reviewed people's medication administration records (MAR) charts. We saw that staff completed these as stated in the provider's guidance. Where medicines were prescribed on an 'as required' [PRN] basis there was a clear protocol for when it should be used and the frequency of use. Following our inspection visit, the registered manager sent us further information to support that people had protocols to for all medicines given as PRN.

Nursing staff who had received relevant training administered people's medicines. They told us that the registered manager regularly supported their competency with this task through supervision and competency assessments.

Requires Improvement

Is the service effective?

Our findings

People that used the service and their relatives told us that staff had the skills and experience required to support them. One person told us, "They [staff] seem very good." A relative told us, "There's been training lately and it has improved. But common sense can be lacking when they're too busy." Another relative commented, "They do try more than other places we've been. They've a good routine going and work bloody hard."

Staff received a comprehensive induction before they supported people. A nurse told us, "Induction was quite good, one full week held at headquarters then one full week practical with Home Manager and Senior Nurse." A care staff told us, "I found the induction useful. We were shown how to check the rooms and make sure everything was ok." Another care worker said, "I did an induction. It included moving and handling, the basics of caring. We did training about respect and dignity. It was very useful." Staff told us that following their induction that they received further training where required. A care staff told us, "I have done training since then [induction]. I have done moving and handling and food safety. I haven't done safeguarding. I am not sure about MCA." Another said, "I have done training since then. I have just done food handling. I have not done safeguarding…I have done MCA."

Staff told us that they did not feel competent to support people with dementia and similar conditions. They told us that they required training to support people when they displayed behaviours that may challenge others. A nurse told us, "I feel we need more training dealing with residents who may challenge. Some we manage with distraction." They went on to tell us how they required this to support a person who did not always comply with staff when administrating their medicines. Another nurse told us, "I would like to have more training to manage challenging behaviour but have not yet asked for this."

We reviewed staff training records and found that some relevant training that staff required had not been completed or were due for refreshers. The registered manager told us that some training such as first aid training was currently being taking and not been updated on their training records. Following our visit, the registered manager informed us that they had arranged for staff to complete training in safeguarding, mental capacity, dementia and managing 'challenging behaviours'.

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA 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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Most people who used that service required a DoLS. We saw that the provider had made applications to the local authority for DoLS authorisation for people that required it. This meant that people's liberty was not deprived unlawfully. Staff we spoke with demonstrated a good understanding of MCA and DoLS. A nurse told us, "MCA is the ability of one person to decide for herself; if not able to make decisions we do Best Interests Decisions. It's not for us to say if their decision is right or wrong."

People told us that staff sought their consent before they provided their care and support. A relative told us, "We hear them ask [person] – and so polite to them too." Another relative said, "They say a big hello and get on with it." A care worker told us, "I always ask for consent. If the person says no and they have capacity to do this then I respect their decision. I would see if they were willing to be assisted. If they didn't have capacity – it depends. If they have a DoLS we need to consider that. You can't leave people wet." During our observations, we saw that staff did not always ask for people's consent before supporting them. For example, we saw that a care worker tried to check if a person required support with their personal hygiene without any form of communication or interaction with them.

People did not receive the support that they required to meet their nutritional needs. People described their meals are being basic. One person said, "It could be a bit better – it's quite basic. I'll have a jacket potato or sandwiches if not. I'd like to see more to drink after tea. We used to have a suppertime sandwich and hot drink but not now. Now we have to ask and staff can be too busy." Another person said, "It's good food – I just accept what comes." A relative commented, "[Person]'s on a puree diet – we feed him lunch and tea in his room. Sometimes they'll ask us if we want them to do it. The food at tea isn't maybe researched enough – tomato soup then chopped tinned tomatoes to follow. I've a drawer full of pudding pots and cakes here, as extras." Another commented, "…They [staff] never ask us what [person]'d like – they blend whatever's blendable on the menu. We've a supply of yoghurts in the mini fridge to give extra if [person]'ll eat, but staff don't often use them."

Staff told us that people had chosen their meals the previous day. We saw that a member of staff asked people about the meals they had just eaten. This showed that staff had a limited understanding of the advanced level of dementia.

All the relatives we spoke with told us that they visited Thorpe House daily to support their loved ones with their meals because there were not enough staff to provide this support. We observed the support that people received in the dining room at lunch time. We found that the meal time experience was erratic. People did not receive support they required. Some people had long waits of up to one hour before their meal was served. People were not forewarned that their plates were warm. We saw some people grimaced when they touch their plate. Staff did not encourage people who require prompting and encouragement to eat their meals. We saw several instances where people who required support from staff to eat their meal did not receive this support, when this was offered it was not offered in a timely manner. This meant that some people had very little to eat. For example, we observed a visiting relative came to support a person who they noticed had been trying to get staff attention. This person requested support to eat their meal. We brought to the attention of staff that another person had not eaten any of their meal during lunchtime before staff provided them the support they required. We observed a care worker leave the person they were supporting in order to answer a telephone call. This was done without any explanation or interaction to the person before or after the care worker returned to them.

These issues and those related to activities in the later part of this report constitute breach of Regulation 9, (3) (b) of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

People received the support that they required to meet their health needs. Staff promptly referred them to

health care service when they required this. One person told us, "I'm going to be getting the dentist coming in." A relative told us, "They're very quick to get the doctor in if needed. [Person] has an NHS chiropodist. He's seen the optician and dentist here though." Another relative said, "The doctor makes the rounds every Friday. He came straight away recently when [person] had a urine infection. They've just had the chiropodist too." Staff we spoke with knew the provider's protocols for reporting and referring any changes to people's health and wellbeing. A care staff member told us, "If needs change we check vital signs and past medical history, look to see if any infection or behavioural changes. We observe physically and refer to GP or Community Mental Health Team and liaise with family." Another staff member told us how they had referred a person to the dietician due to weight loss. People records also showed that staff referred people to health care professionals and followed any instructions as recommended by health professionals.

Good

Is the service caring?

Our findings

People complimented the caring attitude of the staff that supported them. They told us that staff were kind to them. One person told us, "I can't praise them enough." A relative told us, "All are lovely – another reason we chose this place. I've never heard a raised voice." Another relative commented, "They seem very 'compassionable'." Other comments included, "I never see any cruelty with people – they're very good staff." And "The carers are really nice and kind people."

People told us that they had good relationships with the staff and felt like they mattered to them. One person told us, "They were very good settling me in – and treat me like family now. I feel ever so safe with them." They went on to say, "I really do feel happy with them. I have a laugh!" A relative told us, "They're like friends some of them. I think they're very good." We observed that staff mainly appeared focused on task rather than the person they were supporting. However we observed that they were caring towards people such as getting to people's eyelevel when they talked to them.

Where possible, staff encouraged people to be as independent as they chose to be. People told us that staff respected their choices and supported them to remain as independent as possible. One person told us, "They leave me to my own devices as they know what I can do. I can come and go as I want to, decide on my bedtimes and what I fancy wearing tomorrow." Another person said, "I've no restrictions on me and where I go." People's care records included details of how staff could support them to maintain their independence.

People, their relatives and other professionals were involved in planning their care. People's care plan included information which showed their involvement and agreement to the care and support plan. A relative told us, "We get regular meetings and I feel involved with her care, being here a lot." People also had access to advocacy service. The provider displayed information of independent advocacy services to people and their relatives should they require this. Advocates support people to make their views and choices known, and to protect their rights.

People told us that staff treated them with dignity and respect. Relatives told us that they observed staff show regard for people's privacy. They gave us examples of how staff did this. A relative told us, "They always knock – they never step over the threshold without knocking, even if the door's open. We leave the room so she's got some dignity when they're changing her." Another relative said, "They always knock even if it's open, and always shut the curtains when they're changing him." We received other similar comments. A care worker told us, "I always try and promote dignity. I will knock on the doors, shut the door, make sure people are properly dressed and have their hair brushed. It is important to respect what they want, including their religion."

The home had three dignity champions. Dignity champions are staff who support other staff to promote the delivery of care in a manner that protects people's dignity. The provider also had a 'dignity tree' which they used to encourage people to contribute to and consider ways in which they could promote people's dignity.

People's family and friends visited them without undue restrictions. We observed that relatives visited freely on the day of our inspection. A relative told us, "We come any time and have been told we can stay overnight if we need to." Another relative said, "I can come anytime – they ask between 10am-8pm ideally." Other comments included, "Yes, you can visit whenever. [Registered manager] told us we can visit whenever even supper time. I would say if it's after 8pm they would perhaps ask you to ring them so that they are expecting you."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives were involved in planning their care and support. One person told us, "They don't talk about it with me. My boys do all the forms." Another told us, "My daughter tends to do it and then tells me, so we both feel involved." Relatives' comments about their involvement included, "Yes we are [involved]. My sister and I went through [person]'s care plan. We highlighted areas that needs to be updated." And "They explained it all to us when she came in and we told them all about her. She's got DNR now too."

People's care plans were comprehensive and included information about the level of support that people required for various aspects of the daily living. They also included information about people's history, likes and preference. This information support staff to provide support in a way that meet people's individual needs.

People's relatives told us that the support people received met their individual needs. One relative said, "[Person] definitely gets care the way they need it." Another relative told us, "They do their best for him." Another commented, "The basics are done well."

People's bedrooms were personalised. We saw that the home was decorated with the view of the needs of people living with dementia. Each person's door had their pictures on it. There were picture and items to aid people's orientation of their space and support them to navigate their home.

The provider operated a keyworker system. This meant each person had a key member of staff who ensured that their needs were met and would report any change in person's need to a senior member of staff for follow up and further action. We received mixed response about the keyworker system. One person told us, "I've no idea if I have one." A relative told us, "[Person]'s got a main carer and named nurse – the nurse updates me, so I find it reassuring." Other responses included, "[Person] has a named nurse and carer but there's no contact with us. The photo in the room is a new thing." And "I know both her named carers – we have a chat. I'll raise any concerns with them first."

People were not supported to engage in meaningful activities and to avoid social isolation. One person told us, "There's not a great deal going on. I sit and people-watch or have a natter if someone has time. I chat to other patients. They do a church service now and then but it's a bit babyish." Another person told us, "The activities are ok. I used to sew a lot but don't get the chance now." Relatives told us that people had limited opportunities to have social interaction. One relative said, "Nothing happens in her room by [in terms of] Activities. But one day the PAT dog lady came in and Mum touched the dog and she remembered it the next day, so it really meant something." Another relative told us, "Nothing is offered to her. Activities downstairs are pathetic – there's no music movement or stimulating things." Another commented, "No-one comes for him if there's something on… They don't do anything special for birthdays – families can bring in a cake. We'll bring in our own things – it's his birthday tomorrow. They don't even know it's his birthday and no fuss is made of them."

Relatives went on to tell us that staff did not have the time to spend engaging with people which contributed to their isolation. One relative said, "I've never seen them sit with her – there's that many people, they can't do it." Another commented, "It's just us he sees." A person who used the service told us, "I'd like it if we had a computer to use. I want to be more involved too, to help staff out"

The registered manager told us that they employed a full time activity coordinator who was absent on the day of our inspection. Following our visit, they informed us in the absence of the activity coordinator that they had appointed a member of staff to be responsible for supporting people with social activities and had advertised for an activity co-coordinator.

People and their relatives knew how to raise a complaint about the care people received. They told us that staff listened to them but some people felt they did not always use their feedback to bring about a better experience of care. One relative told us, "We've complained about so much –We're just placated, as they won't spend the pennies. Matron keeps saying "Rushcliffe won't allow it". They went on to say, "I get lots of smiles and platitudes but nothing ever happens." Another relative said, "I complained about staffing in the evenings and people left in the lounge alone for 20 minutes or more while others are being put to bed. It got mentioned by several other families too. It changed for a while but has slipped back again." They said, "I think they listen ok but things don't always happen." Another relative told us that they have not needed to make a complaint. They said, "Yes, they listen. I asked if he could get up a bit more during the day, and they did action it."

Requires Improvement

Is the service well-led?

Our findings

The service had an experienced registered manager. It is condition of registration that the service has a registered manager in order to provide regulated activities to people. The registered manager understood their responsibilities to report events such as accidents and incidents to the Care Quality Commission. They promptly sent notifications to the Care Quality Commission when required. The registered manager was supported in their role by a deputy manager. They carried out thorough investigations of incidents that staff reported, and worked with the local authority where required to investigate such incidents.

People knew who the registered manager was and they spoke highly of them. One person said, "She's often around. She's nice." Relatives' comments included, "She's lovely. We always see her around" and "We only see her if she's passing his room. She seems very nice."

The registered manager was supported in their role by a clinical advisor and a team of nurses. They told us that the provider was supportive in enabling them to carry out their role within the home. They told us that they had been involved in a research which was effective in reducing the number of falls people experienced with the home. They said that they were commencing another research project which may support them in reducing the occurrence of urinary tract infections in the home. They said the provider had fully supported these researches and was sharing the knowledge within the wider organisation.

Staff felt supported by the registered manager to meet the standard expected of them. They received support through opportunities to participate in team meetings, training and supervision. Their supervision included observational supervision where a senior member of staff observed staff practice when they offered people support. We reviewed records which showed that staff received feedback following their supervision. For example, a staff member received feedback and support to improve their recording of the care that people received. A care worker told us, "We can have supervision anytime." Another care worker told us, "You have an individual nurse who supervises you when doing things such as hoisting. They make sure you are using the right method."

Staff told us that they could easily approach the registered manager to seek support and guidance when needed. A care worker told us, "[Registered manager] is open. We can talk whenever.
If you have any worries you can talk to a manager. They will listen. They appreciate me in my job." Another care worker said, "I could go and talk to someone if I think something needed to be done. I feel listened to." We saw that the registered manager was readily available to support staff in caring for the people that used the service. The registered manager told us that they held a weekly 'staff surgery' where staff could meet with them to discuss any concerns. A care worker told us, "The manager is kind. I like her. She is fine."

People had opportunities to contribute to the development of the service. Most people did not think that their contributions were taken on board to bring about improvements in the service. One person told us, "I've been to a few meetings but not much happens." A relative told us, "I go to them all – and the same things get said and nothing gets done. There was actually a Rushcliffe rep at the last one who made lots of notes – and says they're re-designing the kitchen and a few minor changes elsewhere." Another relative said,

"I've been to a couple but nothing gets done straight away, then it fizzles out." Staff told us that they also contribute to service development and that their feedback was sometimes taken on board. A care worker told us, "I have been to a staff meeting. You can raise concerns. Sometimes changes happen. We had a problem with a hoist – it was manual It was still working but it was old. We told them and have a new one now. It has a remote control it is much better." The registered manager told us that they compiled people's responses and used this to improve the service. They displayed the changes they had made following feedback from meeting on their 'You said, We did' notice board.

The provider had systems and procedures in place for assessing and monitoring that the quality of care they provided. These included quality assurance audits of people's care and support and the general maintenance of the building and equipment. Another way they monitored the quality of care was through questionnaires and survey to people that used the service and their relatives. One relative told us, "There's a comment card system here and we get an occasional postal one." Other relatives we spoke with told us that they had not received a survey. The provider's quality assurance systems had not identified the issues we saw in relation to staffing, people's meal time experience and delivery individualised care and support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not receive the support that they needed especially at meal times and to engage in meaningful activities.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure they deployed enough staff to meet people's needs.