Brendoncare Foundation(The)

Brendoncare The Old Parsonage

Inspection report

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Date of inspection visit: 9 and 10 June 2015
Date of publication: 24/07/2015

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

The inspection took place on 9 and 10 June 2015 and was unannounced.

Brendoncare The Old Parsonage provides accommodation and nursing care for up to 28 older people, some of whom may also be living with dementia or have a physical disability. The home is situated in the village of Otterbourne and is a period house which has been altered and extended for use as a nursing home. There is access to landscaped gardens and grounds.

Brendoncare The Old Parsonage did not have a registered manager in post at the time of our inspection. The registered manager left shortly before our inspection and

Summary of findings

there were plans in place to transfer a registered manager from another Brendoncare home. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

A range of tools were being used to assess and review people's risk of poor nutrition or skin damage, however we found that the provider did not always link risk assessments to care plans in order to address the identified risk.

Staffing levels for care workers were sufficient on the day of the inspection, however there were not enough nurses on duty in the afternoons to meet everyone's needs.

Medicines were not always stored safely, as some medicines were stored in unlocked cupboards in the clinical room and the door to the clinical room was not always locked. There was a risk that unauthorised persons could access medicines. There were no protocols in place to determine when and how often 'as required' medicines should be administered. There was a risk that 'as required' medicines may not be administered appropriately. All staff had received training in medicines administration and had been assessed as competent. This included care workers who were not primarily responsible for administering medicines.

The lack of proper storage in the home meant that some equipment was not stored appropriately. For example wheelchairs, hoists and trolleys were left in corridors. This was unsafe for people with reduced mobility or who were at risk of falls.

Food and fluid monitoring charts were used to monitor people's fluid and food intake. However some charts were not detailed enough and some did not give an accurate record of the food and fluid offered to the person. Fluid charts did not include a daily intake target and there was no evidence they were actively monitored to ensure adequate intake of fluid. This meant some people were at risk of dehydration. Most people were supported to have sufficient to eat and maintain a balanced diet.

People were protected from abuse as staff had received safeguarding training and knew how to report any concerns.

Staff had received appropriate training to meet people's needs. Nurses had completed clinical training. A training programme was available for the large team of volunteers who helped in the home and on outings. Staff understood the meaning of person centred care and this was practised in the home.

Most people had capacity to make decisions about their care. Paperwork relating to assessing people's mental capacity required improvement although the principles of the Mental Capacity Act 2005 (MCA) was followed.

People were supported to maintain good health through access to on-going health support. A GP surgery was held in the home once a week and access to other health professionals was evident from records, such as a speech and language therapist (SALT) and a psychiatrist when required.

Staff showed they had good relationships with people, speaking about them warmly indicating they held them in high regard. Staff had a good knowledge of people as individuals and knew what their likes and dislikes were. There was a family atmosphere amongst people living in the home which was encouraged by staff. People 'looked out' for each other and kindness and understanding was demonstrated across all staff groups.

People's dignity was respected. People were involved in decisions about their care where they wanted to be, and families were involved if the person wanted this.

Care plans were in place for each person although they did not always address all identified risks or include all the relevant details, for example in relation to pressure care. There was a risk that people may not have received appropriate care.

The service was responsive to concerns and complaints from people and staff. People and staff were encouraged to provide feedback about the service through regular meetings and annual surveys.

People were supported to take part in social activities. There was an activities co-ordinator on shift on the day of our inspection. A trip to Furzey gardens, including a picnic lunch had been arranged. Craft activities and quizzes were available and outside entertainers visited the home. A total of 23 local volunteers supported the home.

Summary of findings

There was a positive and open culture within the home. Staff said they felt able to raise concerns and there was good morale amongst staff. The provider and registered manager had shown openness and honesty, submitting relevant notifications to the CQC.

Staff told us they understood their role and responsibilities. The provider had a statement of purpose for the home. A statement of purpose is a statement about the provider's core purpose and focus. Staff told us they understood their role in relation to the statement of purpose, in relation to providing care.

There was a clear vision for the future of the service. The provider had developed a business plan for 2015-16.

The provider had a plan of audits which should take place on a regular basis, in order to drive improvements. This plan was not yet underway, due to recent changes in management.

During our inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the full version of the 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 always safe.

People's identified health risks had not always been addressed in their plan of care.

Nurse staffing levels were not sufficient to meet people's needs in a timely way to ensure their safety, especially in the afternoons.

Medicines were not always stored safely. There were no protocols for medicines which were administered as required, which meant there was a risk they would not be administered appropriately. Medicines which were administered on a regular basis were appropriately given and accurately recorded.

People told us they felt safe. Staff had received safeguarding training and knew how to recognise the signs of abuse.

Is the service effective?

Requires improvement

The service was not always effective.

Some people did not receive sufficient fluids and nutrition because records were not always accurate and were not actively monitored.

The principles of the Mental Capacity Act 2005 (MCA) had been followed although records did not always reflect best interest decisions taken. No one in the home was subject to a Deprivation of Liberty Safeguards (DoLS).

All staff received appropriate training to carry out their roles and responsibilities effectively.

Is the service caring?

Good

The staff were caring.

Staff treated people in a kind and compassionate way. They made sure that people were safe and comfortable and felt included in conversations.

Staff were able to describe how they respected people's privacy and dignity whilst caring for them.

People were complimentary about the care they received and said they were involved in decisions about their care.

Is the service responsive?

Requires improvement

The provider was not always responsive to people's care needs.

People's care plans did not always address identified risks and known conditions.

Summary of findings

The home's activities programme was supported by 23 volunteers, ensuring that people had access to social activities and were supported to maintain their interests.

Is the service well-led?

Requires improvement 

The home was not always well-led.

There was no registered manager in post at the time of the inspection, although there were transitional plans in place to relocate a manager from another home.

Quality assurance audits had started to take place in order for the provider to check and improve the service provided.

There was a positive and open culture within the home. Staff and people were happy and content.

Staff and people were involved in contributing to the future development of the service, such as decorating decisions.

A business improvement plan was in place. This meant that management knew how they planned to develop and improve the service for people and staff.

Brendoncare The Old Parsonage

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.

This inspection took place on 9 and 10 June and was unannounced. The inspection was carried out by an inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. A specialist advisor is someone who has clinical knowledge and experience of working with people who require nursing care and who may be 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 reviewed all the information we held about the home including the PIR, previous inspection reports and notifications received by the CQC. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

We spoke with 11 people using the service, one relative and three visiting friends. We also spoke with the acting manager, the area manager, the training co-ordinator, the chef, two nurses, four care workers and the activities co-ordinator. We reviewed records relating to five people's care and support such as their care plans, risk assessments and daily monitoring records. We reviewed medicine administration records (MARs) and looked at various records in relation to the running of the home such as staff rosters and training and recruitment records.

During our last inspection on 24 March 2015, we found no concerns.

Requires improvement

Is the service safe?

Our findings

Everyone we spoke with said they felt safe. One person said "I feel safe here; I had falls at home." Another person told us "They've kept me safe here all these years."

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage such as **Malnutrition Universal Screening Tool** (MUST) and Waterlow. The Waterlow tool assesses the risk of a person developing a pressure ulcer. We found that the provider did not always link risk assessments to care plans in order to address the identified risk. For example one person's Waterlow score meant they were at extremely high risk of developing skin damage, but there was no care plan in place to address the identified risk. Another person identified at high risk of developing pressure ulcers had had no care plan in place to address this risk. Records showed they had developed a pressure ulcer. A person with a swallowing difficulty had been assessed by a speech and language therapist (SALT). The SALT gave instruction that the person 'must sit up to eat.' We observed that this person was not sitting up whilst eating. Staff told us that the person did not like sitting up. This meant there was an increased risk of the person choking. There was no risk assessment around the person's decision to not sit up when eating, or any instructions about how to address the risk or what to do if the person choked.

The lack of appropriate risk assessments and risk management plans and in relation to pressure ulcer prevention and prevention of choking for some people meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment.

The area manager explained the dependency tool used to calculate staffing numbers to ensure they were appropriate to meet people's identified needs. Each person's dependency was individually assessed and rated low, medium ,high, very high or severe. Dependency was based on criteria such as mobility, continence, pain, speech and orientation and was reassessed weekly. This information was used to calculate the total number of staff hours required. Individual managers determined how the hours should be split between nurses and care workers. Nurses told us they were unhappy with the tool because it did not consistently calculate hours for the same care, such as prevention or treatment of a pressure ulcer.

We found care worker staffing levels were sufficient on the day of the inspection. We observed care workers and the hostess had time to chat socially with people as well as providing care and support. There were sufficient care workers to answer call bells promptly and support people to eat, if this was required. Some people mentioned that they occasionally had to wait up to 15 minutes for a call bell to be answered at peak times. We were not able to confirm this as it was not evident on the day and the call bell monitoring system was not working. However, staff told us occasionally they were unable to answer a call bell immediately if they were using the hoist to transfer a person as it would have been unsafe to leave them. Everyone said that staff came immediately if the emergency call bell was pressed. Care workers all told us there were enough staff to meet people's needs.

Nursing staff levels reduced from two in the morning to one in the afternoon. This made it difficult for the nurse on duty in the afternoon to complete all required tasks. For example GP notes from a visit on 8 June 2015 had not been written up until 10 June 2015, although a short note had been left in the communication book. This meant that nurses providing care for those people visited did not have an accurate record of what the GP had diagnosed and prescribed. The nurse told us she had not had time to complete the notes due to more urgent tasks. Nurses sometimes worked past their shift end to complete required actions. Long term sickness and a vacancy further impacted on nursing staff. This meant that agency nurses were used on a regular basis who were not always familiar with people's care and the running of the home. Nurses told us they felt stretched at times. They were not always able to complete people's records to the standard they would like because practical nursing was prioritised.

There were not enough nurses on duty at all times to meet everyone's needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to staffing.

Medicines were not always stored safely. Medicines were usually stored in locked cabinets in people's rooms. However, some medicines were stored in an unlocked cupboard in the clinical room. We found the door to the clinical room was not always locked. There was a risk that these medicines could be inappropriately accessed by

people, staff and visitors to the home. We carried out a full check of controlled drugs and found there were no discrepancies. Controlled drugs are medicines which require a higher level of security.

Medicines prescribed on a regular basis were administered safely and accurately. Medicines were dispensed appropriately by the nurse on duty and administered according to GP prescription. Medication administration records (MAR) were kept for each person. We found these to be an accurate record of medicines administered. Some people needed PRN medicine. PRN medicine is given when required. The provider did not have a PRN protocol for each person for each PRN medicine prescribed. This should have described the circumstances in which the medicine would be administered. There were records which showed that some people were in pain. Pain assessments were not completed in response, which would have indicated whether PRN medicine was required. This meant that we could not be assured that PRN medicines were safely administered when needed.

Some people preferred to manage their medicines themselves. There were risk assessments in place for this and individual lockable cupboards in people's rooms to store them safely.

All staff had received training in medicines administration and had had their competency checked. This included care workers who were not primarily responsible for administering medicines. This meant that care workers could administer medicines in an emergency and also witness the administration of controlled drugs.

The medicines policy was out of date in that it referred to an organisation which was replaced ten years ago. Guidelines in relation to medicines management, which were displayed in the treatment room, were dated 2011. These were superseded by National Institute for Health and Care Excellence (NICE) guidelines for the management of medicines in care homes, 2014. The provider could not be assured that up to date policies and procedures in relation to the management of medicines were being followed.

The unsafe storage of medicines in the treatment room, lack of PRN protocols and out of date guidance meant there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment.

There was a lack of storage space within the home for equipment such as walking frames, commodes, wheelchairs and hoists. One bathroom was used to store walking frames and wheelchairs. In order to use the bathroom staff had to remove all the equipment. Equipment was stored in corridors, halls and stair wells. This presented a potential trip hazard. The storage of equipment was not safe for people with limited mobility or eyesight or those people at risk of falls. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to safe care and treatment.

Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "You can tell if residents are happy. If I had a concern I would record them and discuss with my line manager. You can report outside the home as necessary." Staff told us they would report concerns to a senior nurse, safeguarding or the CQC. The safeguarding policy was available for staff to review.

Staff were supported to 'whistle blow' if necessary. Staff were aware of the provider's 'whistleblowing' policy. The provider used an independent external company to give staff a confidential route to report concerns. The details were displayed on a noticeboard within the home. Staff were able to report concerns such as theft, safeguarding or fraud.

Recruitment and induction practices for staff were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. The acting manager told us that one of the references had to be from the person's last employer and that nursing and vocational qualifications were checked. Records we reviewed showed that a full employment history had been obtained. The provider ensured that potential employees had no unexplained gaps in their employment history which might make them an unsuitable candidate.

The home had a 'Safety Matters' noticeboard where information in relation to fire procedures and health and safety were displayed for staff and people to read. The provider had an evacuation plan for the home and specialist equipment to enable people with limited

Requires improvement

Is the service safe?

mobility to evacuate quickly from upstairs rooms in the event of an emergency, such as a fire. Care plans included individual personal evacuation plans for people, ensuring that each person would be able to leave the building safely if necessary.

Requires improvement

Is the service effective?

Our findings

A small number of people were identified as being nutritionally at risk. They required food and fluid monitoring charts. Fluids were recorded, but no daily intake target was set and amounts consumed were not totalled. Food was not recorded with sufficient detail to allow clear monitoring. Where people had been offered food but refused, this was not recorded. Some people had a low fluid intake but it was not clear that monitoring was taking place and additional food and fluid offered where necessary. Snacks and drinks were available in the home all the time and regular drinks rounds were undertaken such as morning coffee, afternoon tea and bedtime. The concern was around a few people who refused to eat and drink or chose to eat and drink very little. One person had been prescribed fortisip by their GP. Fortisip is a nutritionally complete, high protein supplement for the management of malnutrition. Records showed that the person had not had any fortisips although staff told us the person repeatedly refused them. This meant that the records were not clear in relation to this person's food and fluid intake, and so could not be used to monitor and manage their risk of malnutrition. There was no evidence that food and fluid chart monitoring was taking place and this meant that people were at risk of malnutrition and dehydration.

These concerns about food and fluid recording and monitoring for those at risk were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to meeting nutritional and hydration needs.

Most people were supported to have sufficient to eat and maintain a balanced diet. People told us they were happy with the food. One person said "The food is fine – I've no complaints." Another person told us "I like plain, dry food; I don't like cream or custard or any milky stuff, and they know that, so I always get what I like." People's dietary needs including their intolerances, allergies, likes, dislikes and individual requirements were recorded on admission. The chef was knowledgeable about people's dietary requirements and preferences. Each day a main choice, a vegetarian choice and a salad was on offer for people to choose from. The chef told us he was happy to cook alternatives such as jacket potatoes, omelettes or sausages. One person was allergic to strawberries and the chef said he made an alternative pudding on the days that strawberries were included in the main dish. A hot supper was available and two choices of homemade soup. During lunch, the food was hot and plentiful and there was not much waste. We saw the food was attractively arranged on the plate, and food was dished up according to people's preferences of how much food they liked and what they liked to eat. Eating aids were in use such as plate guards.

Tables were nicely laid with fabric cloths and napkins and people were supported to tuck a napkin in, if needed. The lunch experience for people was leisurely, chatty and friendly. Care workers supported people to eat discreetly where needed and there was sporadic chatter and encouragement overheard. Staff asked people if they had enjoyed their meal and whether they would like another helping. For example one care worker was overheard saying "Can I help you with that, or are you OK?" The care worker cut through a pie crust and then the person carried on eating with no further help.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and health and safety. The training co-ordinator was a trainer for moving and handling and assessed all staff annually. Staff told us they had received the right amount of training to meet people's needs. One member of staff said "They are really hot on training here; I am up to date with my training." Training for key areas such as first aid, medication and moving and handling was updated regularly on a rolling program. One off extra training had been provided for staff in relation to dementia and tissue viability. Each member of staff had an individual learning record where all their training was recorded and monitored. A training programme was also available for the large team of volunteers who helped in the home and on outings.

Staff said they felt supported by management. They received regular supervision meetings and annual appraisals.

Nurses had completed clinical training in specific areas such as venepuncture (the process of obtaining intravenous access). Some care staff had been supported to obtain health and social care qualifications and said that this was encouraged.

Requires improvement

Is the service effective?

We observed that the staff practised person centred care. Person centred care involves putting people and their families at the heart of all decisions about their care. Staff showed they knew people well and interacted with them in a calm and affectionate way. One person said "The staff are lovely, can't do enough for you. You get all the help you need." Another person told us "They're pretty good. I get my tablets on time."

1. We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA protects and supports people who do not have the ability to make decisions for themselves. We found that care staff and nurses had received training in respect of the principles of the MCA. Staff understood the key principles of the MCA but were not always clear about how mental capacity should be assessed.

Most people had capacity to make decisions about their care and so there were few mental capacity assessments in place. One person, who was known to have fluctuating capacity and a tendency to refuse medication, had a mental capacity assessment in place. Although the capacity assessment had not been fully completed, the provider had taken action by requesting a further visit from a specialist psychiatrist. The person had agreed to follow the medication treatment plan prescribed by the psychiatrist and also work was being undertaken to find a more suitable placement. Although assessment paperwork was incomplete, there was no impact for the person as appropriate action had been taken. The provider was following the principles of the act.

We recommend that mental capacity assessments are fully completed and accurate and relate to a specific question about the person's care, as stated in the Mental Capacity Act 2005.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the acting manager understood when an application should be made. No applications had needed to be made for anyone living in the home at the time of the inspection.

People were supported to maintain good health through access to on-going health support. A GP surgery was held in the home once a week and access to other health professionals was evident from records, such as a speech and language therapist (SALT) and a psychiatrist.

Good

Is the service caring?

Our findings

There was a family atmosphere amongst people living in the home which was encouraged by staff. People told us they had made friends and 'looked out' for each other. One person said "She and I get on really well – I look out for her." Another person told us "I've only been here 2-3 weeks, but it's lovely. I hadn't thought about coming to live in a home, but now I'm absolutely happy to be here."

The home had a pleasant atmosphere and people received care from staff, delivered in a kind and compassionate manner. Staff responded promptly to people requesting assistance and they did so in a patient and attentive way.

Staff showed they had good relationships with people, speaking about them warmly indicating they held them in high regard. Staff had a good knowledge of people as individuals and knew what their likes and dislikes were. They showed respect for people by addressing them using their chosen name, maintaining eye-contact with people and ensuring they spoke to them at their level, seated and not rushed. One person said "The girls are so welcoming, always smiling; they know our names." We noticed staff showing an instinctive ability to empathise with people and involve them in conversation calmly and cheerfully. Everyone told us that staff were caring and kind. One person said "It's a lovely home; lovely staff – caring, well-trained and long-standing."

Kindness and understanding was demonstrated across all staff groups. The hostess serving drinks and taking lunch orders spent time chatting to people as she did her rounds. We overheard care staff offering support to people in their rooms and telling them to ring the buzzer if they needed anything. Nursing staff were outstanding in their care and understanding of people's needs. They were confident and caring with a calming influence on those around them. One nurse was overheard asking a care worker to keep an eye on a particular person "Will you keep an eye on (the person) – she's very tired and wants to go to bed soon after lunch – do you see the way she is leaning to one side? It shows you how weary she is. She didn't sleep too well last night." During the afternoon one person experienced a psychotic episode. This was a difficult time for the person but the nurse took much care and time using breathing exercises to calm the person down and then sat with them in a darkened room until they were settled.

Staff understood the meaning of person centred care and were observed to be provide this. Staff talked about a strong ethos that sought to respect independence, privacy and dignity for each person. They put the comfort and needs of people first and were quietly professional.

People's dignity was respected. Doors were closed when personal care was given. Staff asked people about their choices, showing that care was individualised to the person and making them feel important and cared about. People were dressed in a dignified way in their own clothes with sensible and safe footwear. People's hair and nails were clean and neat and the hairdresser visited weekly so people could look their best.

People were involved in decisions about their care where they wanted to be, and families were involved if the person wanted this. It was not always clear in care plans that the plan had been reviewed with the person, however people said they had been consulted and were able to make choices about their care.

Requires improvement

Is the service responsive?

Our findings

Staff responded appropriately to people's physical needs by answering call bells and delivering personal care. However care planning in response to people's needs required improvement.

Care plans did not provide staff with guidance to manage Parkinson's disease or associated sypmtoms, although this was a condition affecting people living in the home. Parkinson's is a fluctuating but deteriorating neurodegenerative condition. The GP had recently visited someone with a chest infection, but this was not referenced in the person's care plan, and there was no short term care plan in relation to this. This meant that staff may not be aware of the chest infection or the additional care required, such as encouraging extra fluids. There was a risk that people would not receive appropriate care in relation to Parkinson's disease or other health conditions.

A person had been recently admitted to the home for end of life care. Records showed they had known health conditions. Their care plan did not address their health conditions, and there was no end of life care plan in place. The home had a gold standard accreditation in end of life care. The National Gold Standards Framework (GSF) Centre sets out training programmes which enable frontline staff to provide a gold standard of care for people nearing the end of their life. As there was no end of life care plan in place it was not possible to determine whether the person was receiving a gold standard of care as prescribed within the framework. There was a risk the person may not have received appropriate end of life care.

A number of records showed that Waterlow assessments had been carried out to determine whether the person was at risk of developing pressure ulcers. Some people were scored highly (indicating they were at high risk of developing pressure ulcers) but this was not linked to a pressure ulcer prevention care plan. For example, one person had a Waterlow score which indicated they were at significant risk of developing skin damage. On the 15 May 2015 records showed a dressing had been applied to the person's hip because it was red. There were no further entries relating to this. Another person who was admitted on 3 June 2015 had a preadmission form which stated the person had 'red heels' but there was no care plan in place to address this.

The lack of care plans to address individual needs and preferences for some people meant there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to meeting person-centred care.

The service was responsive to concerns and complaints from people and staff. One person said "Whenever I have given information or maybe made a request, it is always noted or acted upon." People and staff were encouraged to provide feedback through regular meetings and annual surveys. At the last residents and relatives meeting on 6 March 2015, people were asked if they wanted their rooms repainting and new furnishings and refurbishment were discussed. We saw that new furniture had been delivered which indicated that the provider had responded to feedback. Actions were also recorded following the annual survey which included asking relatives how they would like to receive the newsletter and requesting the chef to attend residents meetings. On the day of the inspection one person raised a concern about the type of milk available in the home, as they said they would prefer a different type. The chef immediately responded to this ensuring that the person's preference was met.

People were supported to take part in social activities. There was an activities co-ordinator on shift on the day of our inspection. A trip to Furzey gardens, including a picnic lunch had been arranged. Several people went out in the home's mini bus and all said they had enjoyed the trip very much. Activities were displayed on a noticeboard in the main lounge area and were available for people Monday to Friday. Craft activities and quizzes were available and we noticed a large jigsaw puzzle was underway on a separate table. Staff told us there was always a puzzle 'on the go' and a number of people really enjoyed this activity. In addition outside entertainers visited the home and animal and bird visits were booked.

.A total of 23 local volunteers supported the home helping out in areas such as escorts on trips, chatting to people, gardening and advising on growing flowers or vegetables. This meant there were additional activity opportunities available for people in excess of those displayed on the board, such as one to one shopping trips, gardening sessions, painting sessions and reading.

Requires improvement

Is the service well-led?

Our findings

The provider did not have a clear system of monitoring and demonstrating improvements to the quality of service, through quality audits. However this had been recognised and there were plans in place to instigate regular quality monitoring audits of different parts of the service. There had been a delay in instigating this due to changes of management. A recent catering audit had taken place, however, and the chef had taken appropriate actions as a result. Provider visits to the service were carried out monthly although a full audit was not carried out on each visit. The last visit had found that improvements needed to be made however an action plan had not yet been drawn up due to the recent changes in management. The provider was already addressing improvements which were required in this area in order to assure themselves of the quality of the service provided.

There was a positive and open culture within the home. Staff said they felt able to raise concerns and there was good morale. For example, one member of staff said "I love working here." The registered manager had recently left the home and the provider was in the process of recruiting a manager from another of their care homes. During the transitional period the manager concerned was working two days a week in the home but at the time of the inspection was not yet familiar with the service. Staff had been supported during this time by the area manager and they told us that morale had not been affected by the recent changes.

Staff told us they thought that there was honesty and transparency at all management levels, although it was felt that the previous manager had not been visible 'on the floor' enough. This was supported by feedback from people through the annual survey where only 14% of people said they regularly saw the registered manager. One person when asked about the registered manager said "I don't know who this is." The new manager was not yet working in the home in a full time capacity and had only very recently been recruited, therefore there was no feedback from people. He had not yet registered as the manager for the Old Parsonage and therefore the home did not have a registered manager in post at the time of the inspection.

The provider and previous registered manager had shown openness and honesty, submitting relevant notifications to the CQC. The provider had developed a staff, residents and relatives feedback survey centred around the five questions which CQC ask when they inspect. This meant they had feedback in relation to each domain and were able to develop action plans accordingly.

Staff told us they understood their role and responsibilities. The provider had a statement of purpose for the home. A statement of purpose is a statement about the provider's core purpose and focus. Staff told us they understood their role in relation to the statement of purpose They said they had had training in order to ensure their role was effectively delivered within the home, and they had all been given a job description when they were recruited. The staff survey showed that 100% of staff said they understood their role within the team.

Staff were involved in contributing to the future of the home. One member of staff told us they had attended a staff forum where plans for the future of the home had been discussed and they had been given an opportunity to 'have their say.' As part of the staff survey staff had been asked if they felt they were able to contribute to improving services in the home. 82% of staff responded positively. Management listened to people using the service. An annual survey was carried and an action plan had been developed responding to people's comments.

There was a clear vision for the future of the service. The provider had developed a business plan for 2015-16. Targets in relation to service quality, environment, supporting staff and finance had been set and detailed action plans were in place to demonstrate how the targets would be met. For example in relation to improving service quality there was an action plan to look at an activities programme for the weekend and to consider more musical events. There were also plans to undertake a recruitment process in order to reduce the use of agency staff and promote a greater continuity of care.

Policies and management arrangements meant there was a clear structure for the efficient running of the home. There were policies in place which included privacy and dignity, nutrition, complaints, use of bedrails, mental capacity and DoLS.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not carry out an assessment of the service users preferences and needs for care and design a plan of care ensuring those needs are met. Regulation 9 (1) (a)(b)(c) (3) (a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not assess the risks to the health and safety of the service user of receiving care or treatment and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2)(a) (b) (g)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **The nutritional and hydration needs of some service users were not met. Regulation 14 (1) (b) (4) (a) (b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced staff were not deployed in order to meet requirements. Regulation 18 (1)**