Complete Care Homes Limited

Rambla 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 5 April 2017 and was unannounced. We carried out the last inspection in October 2016, where we found the registered provider was not meeting all the regulations we inspected. We found at that inspection the provider had failed to provide safe care and treatment, person centred care and the overall governance of the service was not effective in identifying issues that needed to be addressed. There was also a lack of understanding by staff around the safeguarding of people from abuse and improper treatment, adequate training and recruitment processes. We told the provider they needed to take action and we used our regulatory powers to address the shortfalls. We also asked for and received an action plan telling us what they were going to do to ensure they were meeting the regulations.

At this inspection we found efforts had been taken to address the shortfalls identified at the October 2016 inspection. We saw what improvements had been made and that a structured plan was in place to move the service forward.

Rambla Nursing Home provides personal care for up to 30 older people who may have nursing needs. The service is also registered to care for younger adults, people who are living with dementia and people whose needs are predominantly associated with physical disability. On the day of the inspection there were 25 people living in the home, 23 of whom required nursing care.

Since the last inspection the registered manager had left the service. The registered provider had recruited a new manager who told us they were intending to apply to be registered with the Care Quality Commission. The service has to have a manager 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.

Overall people told us they felt safe. Staff understand how to safeguard people from abuse. People and staff we spoke with expressed mixed views regarding staffing levels. We saw from the rotas staffing levels were based on the provider's assessment of people's needs and occupancy levels. The recruitment process was robust and staff completed an induction when they started work.

We found the amount of information in care plans had improved and contained more relevant information and noted that further staff training was in progress. This meant people were protected against the risks of receiving care that was inappropriate or unsafe. Care staff had access to people's care plans. On the whole individual risks were updated regularly and contained sufficient information. However, some further work was needed in some cases to make sure staff fully understood the actions they should be taking to minimise any potential risks identified. It was clear, however, that staff were receiving additional supervision to allow them to understand the importance of accurate record keeping. This stance had been adopted so that staff knew the principles of record keeping rather than a senior member of staff rewriting all the care records. We have made a recommendation regarding the completion of risk assessments.

We found people had access to healthcare services to make sure their health care needs were met. People lived in a clean, comfortable and well maintained environment. People were mostly protected against the risks associated with the administration, use and management of medicines. We have made a recommendation regarding the use of 'as required' medication and the completion of records relating to prescribed topical creams.

Staff had completed a range of training and additional training had been planned for the remainder of the year. We saw from the 2017 supervision schedule that staff had received supervision and a programme of regular updates was in place.

The care plans we looked at contained a range of mental capacity assessments, but the amount of detail was inconsistent. Staff told us they knew and understood what 'Deprivation of Liberty Safeguards' (DoLS) meant and comprehended the implications of having a DoLS in place.

We observed the lunch time meal in the main dining room. Most people on the day of our visit were served their meal in their bedroom using a 'tray service.' The food looked and smelled appetising. We saw a systematic approach to the monitoring of people identified as being at risk of poor nutrition or hydration and weight monitoring records were completed as required.

Throughout our visit, people were treated with kindness and compassion. Staff had a good rapport with people, whilst treating them with dignity and respect. There was opportunity for people to be involved in a range of activities within the home or the local community where possible.

Staff provided positive feedback about the manager and the support being given by the general manager for the organisation. They told us improvements had been made to the service. People who used the service, relatives and staff members were asked to comment on the quality of care and although surveys and meetings had not yet been set up as planned, there was a visible presence in the home of senior staff. Complaints were investigated and responded to appropriately.

We found some of the quality assurance systems were working well, but others needed to be improved to ensure people received a consistent quality service. Notifications had been sent to the CQC by the service as required by legislation.

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 safe.

People and staff we spoke with expressed mixed views regarding staffing levels. We saw from the rotas staffing levels were based on the provider's assessment of people's needs and staffing levels were adequate. The recruitment process was robust.

On the whole individual risks were updated regularly and contained sufficient information. However, further work was needed to make sure all information was recorded. Medicines were mostly safely managed.

People told us they felt safe. Staff understood how to safeguard people from abuse. We saw overall, the home was clean and hygienic.

Is the service effective?

Good

The service was effective in meeting people's needs.

Staff received supervision and a schedule was in place for the coming year. A staff training programme was planned.

The care plans we looked at contained a range of capacity assessments. Staff told us they knew what 'Deprivation of Liberty Safeguards' (DoLS) meant and the implications of having a DoLS in place.

We saw the food served looked hot and appetising. People identified at being at risk of poor nutrition or hydration were monitored appropriately. People attended regular healthcare appointments.

Is the service caring?

Good

The service was caring.

We saw caring interactions when staff provided support and assistance and people looked well cared for.

Staff respected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was responsive to people's needs.

We found the amount of information in care plans had improved and noted that further staff training was in progress to make sure that all staff had a through understanding of the processes and the importance of accurate recording.

There was opportunity for people to be involved in a range of activities within the home and the local community.

Complaints were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was well-led. However, due to there being no registered manager in place the rating for this domain cannot be higher than requires improvement.

The provider demonstrated they had made adequate improvements following breaches identified at our previous inspections.

Some of the quality assurance systems were working well, but others needed to be fully embedded to ensure people received a consistent quality service

We received positive feedback about the manager. People who used the service, relatives and staff members were asked to comment on the quality of care.

Rambla Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered 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 5 April 2017 and was unannounced. The inspection team consisted of two adult social care 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.

At the time of this inspection there were 25 people living at the service. During the visit we spoke with 13 people who used the service, one relative, two visitors, 10 staff, the manager, the deputy manager and the general manager. We spent some time looking at documents and records that related to people's care and support and the management of the service. We looked at 4 people's care plans. We also looked around the premises. We sometimes use the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. However, there were only a small number of people using communal areas at any one time and the use of SOFI was not appropriate. We made general observations throughout the visit of staff interactions.

Before the inspection, the provider had 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 also reviewed all the information we held about the service, including that from the local authority and the safeguarding team.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we rated this key question as inadequate. At this inspection we noted improvements had been made and further improvements were planned. We have made one recommendation about the management of medicines and one about the work to be continued with risk assessments.

We received mixed views from people who used the service about the levels of staffing in the home. Comments from people included, "Yes we are all friends and you get to know them [the staff]." Another person told us, "Yes there is enough staff." And, "Staff do chat to you." One person particularly enjoyed hearing from the staff about their families and life outside of the service. They told us they had been "entrusted into their families" and felt very much a part of it. This they said gave them a positive relationship with the staff and that they felt included. In contrast people also told us, "Staff are not here long enough to chat to you" and "We could do with more night staff." One person also commented, "There are not enough staff when toileting." However, we were unable to gain examples of this or how this had impacted on the person.

Staff told us they thought the staffing levels were suitable for the number of people living at the service and that although they were kept busy, they did not feel they could not provide appropriate care in a timely way. One visitor reported staffing levels had improved over the last few months and that they had always managed to find a member of staff when they needed to. The person they were visiting had not raised any problems regarding staff attention. Throughout our visit the call bells could be heard and these were responded to promptly. The manager told us that when staff were absent from work, at short notice, they sometimes struggled to get cover for the missing person. They did not use agency staff and relied on existing staff to pick up extra hours. However, she told us this was rare and that when possible existing staff would stay late or come on shift early to make sure the home was fully staffed. At the time of our visit the home was actively recruiting and new members of staff had been employed.

We made observations relating to staffing numbers. We saw the medicines round was carried out without delay and that there were sufficient staff in communal areas and available to provide personal care and support throughout the day.

The general manager showed us the dependency tool they had introduced to help them make sure there were sufficient staff on duty. This was a relatively new tool so there was also a reliance on the manager reviewing staffing levels according to care need, layout of the building and the skills mix of staff on each shift. The manager told us the normal staffing levels were two staff during the night plus a nurse, six staff plus a nurse during the day, reducing to four staff plus a nurse from 2pm until 9pm. We looked at the rotas for 20 February 2017 to 9 April 2017, which showed the staffing numbers were routinely maintained as described, with additional staff on some shifts, particularly on a morning. We did not find any evidence that the staffing levels were unsafe or that there were not enough staff to meet the current dependency levels of people who used the service.

We reviewed the recruitment process to ensure appropriate checks had been made to establish the

suitability of each candidate. We found recruitment practices were safe and the service had clear policies and procedures to follow. We saw relevant checks had been completed, which included a disclosure and barring service check (DBS). The DBS is a national agency that holds information about criminal records. This helped to ensure people who lived at the home were protected from individuals who had been identified as unsuitable to work with vulnerable people.

We saw each person had a personal emergency evacuation plan (PEEP) so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. We saw the home's fire risk assessment and records, which showed fire safety equipment was tested and fire evacuation procedures were practiced. Fire-fighting equipment was available, emergency lighting was in place and regularly tested. We found all fire escapes were kept clear of obstructions. There were clear directions to fire exits. Staff training records showed most staff had received fire safety training and further fire safety training had been booked for May 2017.

Staff we spoke with said their training included fire evacuation drills, and said they felt confident they could respond to a fire alarm appropriately and knew how to keep people safe. One staff member told us, "We have a fire drill and we know to congregate at the nurse's station. The fire alarms are tested every Monday. I am confident I would know what to do. I have done my fire training too." One person who used the service told us about the fire alarms going off, "The doors close, bells ring and staff are soon back to open the doors."

We saw equipment had been regularly tested, which included the call bell system and passenger lift. All maintenance certificates we saw were in date.

On the whole individual risk assessments were updated regularly and contained sufficient information. However, some further work was needed in some cases to make sure staff fully understood the actions they should be taking to minimise any potential risks identified. For example, when using a lap belt in a wheelchair or when bed safety rails were in use. It was clear, however, that staff were receiving additional supervision to allow them to understand the importance of accurate record keeping. This approach had been adopted so that staff knew the principles of record keeping rather than a senior member of staff rewriting all the care records and staff not being involved. We recommend the provider continues to train and provide supervision to staff to make sure they understand and maintain accurate records.

We spoke with staff about their understanding of specific risks relating to one person. They were able to discuss these and were aware of the need to regularly record observations relating to where the person was and what they were doing. This included nonverbal prompts as well as physical signs of well-being.

We asked people who used the service if they got their medication on time. No-one reported any concerns. One person told us, "They never forget you." And another person said, "You know when they are going to arrive."

Medicines were stored securely and safely in a well-ordered room. The temperatures were checked daily and staff told us they would report any problems with temperatures to the maintenance person. Records were kept for the fridge temperatures, and we saw only medicines which required refrigerated storage were kept in this manner.

We observed medicines rounds and saw some staff practice was good. They knew the person's needs, for example, when a medicine needed to be given and how the person preferred to take their medicines.

We saw medication administration records (MAR)'s contained a picture for identification purposes and information about each person, including any known allergies and any conditions such as those which made swallowing a risk. We saw that staff were patient and did not rush people and also observed staff offered an explanation and asked for the person's consent before administering medicines and observed the person taking them before signing the MAR.

We saw MAR's were completed correctly overall but some gaps were noted. This was raised with the manager who agreed to address this. Most medicines were delivered in 'dosette' boxes, and we saw these contained the correct amounts of medicines, meaning these had been administered as required. Some people had medicines to be taken 'as and when required ', also known as PRN medicines. We did not see any written guidance to help staff understand the dosage and how a person communicated that they may need the medicine, including non-verbal indicators such as changes in body language or position. We saw records of medication management were completed but this was not a full audit and it was a check of balances in stock. We discussed with the general manager about how this could be developed to help staff identify any problems with medicines management and the benefits of auditing. Staff who administered medication received appropriate training.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw controlled drug records were accurately maintained. The administering of these medicines and the balance remaining was checked by two appropriately trained staff.

Staff applied cream and lotions to people when this was required. These are known as 'topical medicines'. Records to show where on the body this should be applied and how often were being introduced. However, we found gaps in the recording. Some people's records stated cream should be applied regularly and one person needed cream applying after continence care. Records looked at did not show this to be the case. We spoke with manager about this during the inspection. The manager told us they were in the process of introducing a new recording tool and that this would be addressed. The manager asked staff on duty if creams had been used as prescribed and reported to us that this had been done. The records did not reflect this.

Unused medicines were returned to the pharmacy. This medication was recorded in a specific book for this purpose.

We completed a tour of the premises as part of our inspection. We looked at a number of people's bedrooms (with their permission), bathrooms, toilets and various communal living spaces and saw the home was clean and hygienic. We saw personal protective equipment, alcohol hand rub and liquid soap was available. We were told by the housekeeping staff that a deep clean of each person's room was carried out on a rotational basis and that they had managed to keep on top of the cleaning now they had recruited more staff. We saw from the training records most staff had completed infection control training and further training was scheduled to take place.

People, relatives and visitors we spoke with told us they thought the home and care provided was safe. Comments included, "I feel safe upstairs" and "I feel safe and staff are very good." Staff told us, "We make sure we offer reassurance if people are fearful or showing signs of worry. We know when people are feeling vulnerable and we know how to make them feel safe."

Staff we spoke with had received training in safeguarding and understood what they should be vigilant for in a care home setting, and knew how and when to report any concerns. One staff member said, "People who

are ill or have dementia are especially vulnerable." Staff told us managers would act appropriately on any reports made, and staff were aware they could contact other agencies such as the Care Quality Commission (CQC) if they felt their concerns were not acted on. Staff training records we saw showed most staff had completed safeguarding training and further safeguarding training was planned.

The service had policies and procedures for safeguarding vulnerable adults and we saw the safeguarding policies were available and accessible to members of staff. We saw the whistleblowing procedures were displayed in the office and available to staff if needed. This helped ensure staff had the necessary knowledge and information to help them make sure people were protected from abuse.

Good

Is the service effective?

Our findings

At the last inspection we rated this key question as requires improvement. At this inspection we found the provider had taken the required action.

During this inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We looked at the supervision schedule for 2016 and 2017. We saw that staff were seen on a regular basis during their working shift and where necessary additional supervision had been carried out if there were particular issues around practice or senior staff needed to communicate changes to policy or procedures. The general manager had introduced 'recovery' supervision. This involved working closely with new staff and supporting the new manager in her role. This, staff told us, worked well and they were finding a benefit from this approach. A new training manager had been recruited since the last inspection and there was an expectation that their role would include the scheduling of supervisions, staff development, appraisals and training in the service. The general manager said they had also introduced a system for monitoring training and what training had been completed and what still needed to be completed by members of staff.

We looked at staff training records which showed staff had completed a range of training sessions in 2017. These included topics the provider thought were compulsory for example, moving and handling, safeguarding, falls awareness, nutrition, hydration and assistance with eating meals. We saw further training had been booked in coming months and a nurse's forum had started.

We were told by the manager that new staff now completed an induction programme. From the records we looked at we were able to see information relating to the completion of induction. Staff said they had received an effective induction including training and time shadowing more experienced staff. They told us they were asked if they felt confident before being asked to work as a full member of staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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).

Care plans we looked at contained a range of capacity assessments, for example, in relation to decisions about remaining at the service and consent about receiving personal care. However, not everyone who used a lap belt whilst in a wheelchair had a record of a best interest meeting having taken place. This was discussed with the manager during the inspection and action was taken to organise this. Where people lacked capacity there was guidance about who would support them in making that decision. Where people lacked capacity to make a decision about where they lived, we saw DoLS were applied for appropriately.

Staff we spoke with told us they had received training in the MCA and understood what the main principles were and how this might impact upon people using the service.

Staff we spoke with had good knowledge around when they should support people with decision making and when people had the right to make decisions even though these might be unwise. One staff member said, "We assume the person has the capacity to be able to make their own decisions if they wish." We saw examples of staff giving people choice about their daily lives. One example was when someone wanted to go outside and they were supported to do this without question. However, it was cold so the member of staff explained, "I will get you a little jacket, it's a bit chilly when the sun moves behind the clouds."

Staff told us they knew what 'DoLS' meant and the implications on a person of having a DoLS in place. There were clear records about who had a DoLS in place and staff were able to tell us who this referred to and why. We could see that least restrictive practice was being followed.

People told us they got a choice at breakfast time and teatime. They also told us the main meal at lunchtime was a set menu but that alternatives were available too. We noted there were cold drinks and snacks available in the communal areas throughout the day and hot drinks were served from the trolley. We received mixed views about the food provided. Some people told us they were given plenty to eat and drink and that the food was good. Comments included, "Food is very good. You get what you want and I have my own bag of snacks" and "Food is excellent." One visitor told us how the staff had made extra provision to make sure one person received specific food they particularly enjoyed at no extra cost. They also told us staff made sure they had enough in stock so that the person could exercise a choice on a daily basis. In contrast, one person told us, "Not again is a term I constantly use, stew again, fed up of cake and custard for pudding. Food repeated over and over again." We looked at the menu planning and noted a variety of dishes were served over a four week cycle. The manager told us that staff were careful to make sure people had a choice at meal times and the importance of making sure people were receiving sufficient nourishment and fluids. Staff confirmed this to us too.

On the day of our visit, three people ate their lunch in the communal dining room. Everyone else had either opted for a tray service or received their meals in their room due to their specific care needs. During the dining room experience people were assisted appropriately and given time to eat their meal with staff in attendance. One person was encouraged to eat independently and staff knew when to offer support when the person tired. Another person was seen to shout a repeated word and staff instantly understood what the person wanted. They assisted the person away from the table and offered to take them to their room. We saw the atmosphere in the dining room was relaxed and staff were attentive, kind and gentle and ensured everyone was able to enjoy their meal. We did not carry out observations of people being supported to eat in their individual rooms, as this can be intrusive. However, staff reported to us that each person was given ample time to enjoy their meals and any delays were kept to a minimum as staff know who can eat independently and who needs full assistance. We asked about the order of service and how staff knew what people preferred. Particularly those people who were living with dementia or were unable to communicate their preferences. Staff were able to tell us how this was managed, including the involvement of relatives and making sure they communicated at each handover who had eaten well or not and completion of monitoring sheets.

We looked at the records for managing special dietary requirements, likes, dislikes and allergies. Staff served milkshakes and smoothies and enriched meals by adding cream in pasta dishes, mashed potato and porridge for people who needed high calorific foods.

We saw care plans contained a tool, which was used to identify people at risk of malnutrition. The tool

contained guidelines which could be used to write a relevant care plan. We saw the tool was being used to record people's weights on a monthly and/or weekly basis and any risk identified was addressed.

Visits by health and social care professionals were recorded in people's care plans, together with notes relating to advice or instructions given. We saw people had access to a range of visiting professionals including doctors, opticians, chiropodist, dieticians and physio therapists. People told us they could see a healthcare professional when they needed to and this was organised for them. We also noted that relationships had been built with a local hospice and that a clinical lead from that service regularly visited to offer guidance and support to staff when they were providing end of life care.

A rolling programme of redecoration and refurbishment was in place, including floor coverings and facilities. The majority of people spent time in their bedrooms, however, the registered provider was looking at enhancing the environment to include more signage to support those living with dementia.

Good

Is the service caring?

Our findings

At the last inspection we rated this key question as requires improvement. At this inspection we found the provider had taken the required action.

At this inspection, people who used the service and their relatives told us they were generally happy with the care and support provided. They said staff were kind, compassionate and caring. Comments included, "Yes, staff are very helpful" and "I started with the walking frame and I've come on well." A relative told us, "The staff are caring, and welcoming and always have a pleasant word with me." A visitor told us about transferring a person from another service, where they had been unhappy, "Staff here are prepared to go further than required. The care is between eight and nine out of ten."

Throughout our visit staff were attentive to people they were caring for and demonstrated they knew people very well, including people's relatives and visitors. Staff knew people by name, and some of the conversations indicated they had also looked into what they liked, and what their life history had been. People were comfortable around staff.

We noticed when one or two people were distressed or uncomfortable, staff responded in a kind and calm way. We also saw a staff member walking along a corridor with one person linking their arm and they were walking at a slow pace actively engaging with the person. We noted staff coming in and out of peoples bedrooms throughout our visit. Some people had their bedroom doors open and staff were careful to make sure these were closed if the person was receiving personal care. Staff acknowledged people as they walked past open doors and always responded if someone shouted them back.

The premises allowed people to spend time on their own if they wished. We saw people spending time in their bedrooms and in the smaller seating areas. People looked well cared for. They were tidy and clean in their appearance which was achieved through good standards of care. People being supported in their beds looked comfortable, had suitable clothing and had their hair groomed.

We observed some good practice from staff during the inspection. We saw staff knock on doors and ask people before providing any interventions such as personal care. We saw staff offered reassurance and reorientation when people were confused or distressed, and encouragement where people were attempting to do things for themselves.

Staff we spoke with were able to tell us how they maintained people's privacy and dignity, and supported them to remain as independent as possible. One staff member said, "I make sure the curtains and doors are closed before doing anything. I keep the person as covered as possible." Another member of staff said, "We encourage people to keep their independence going for as long as we can. If I'm helping someone to have a bath I'll let them wash themselves as much as they can." People told us they were treated with respect and their privacy and dignity was taken care of.

Relatives we spoke with told us they were made to feel welcome and told us they found staff patient and

kind. One relative said, "We can visit at any time."

The manager told us people's equality, diversity and human rights were respected. They told us staff had received training and any written information could be produced in large print if needed. Records were kept securely and were only accessible to appropriate staff members.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated this key question as requires improvement. At this inspection we found the provider still had work to do but that improvements had been made overall.

We saw care plans contained pre-admission assessments that were used to determine whether the person's care and support needs could be met before they moved to the service.

We found the amount of information in care plans had improved and contained more relevant detailed information. However, some care plans were more person centred than others. For example, details such as, "I like to have showers and I can wash my own hair. My shampoo is kept in my bedroom" and "I like my food hot and only small portions. I enjoy a cup of tea with ½ sugar and a little milk. I should be given a silver pot of extra hot water on my tray, so I can make another cup if I wish." In contrast other care plans needed more detail for staff to follow, for example, "Unable to use the bath or shower. Bed bath to be given." More details were needed to guide staff about how this was to be done. Despite this additional detail it was clear when speaking to staff they knew the people they were looking after very well and how to provide appropriate care to them. We also noted that further staff training was in progress. This meant people were protected against the risks of receiving care that was inappropriate or unsafe. Care staff had access to people's care plans and fully understood their needs.

Any changes in people's needs were documented in their reviews and this triggered an update to their care plan. This meant staff had access to the most up to date guidance relating to the person's care and support needs, risks associated with those needs and the methods by which risks would be minimised.

There were inconsistences around people's involvement in care plans. There were some absent signatures to confirm people had agreed with the content of their care plans, and some care plans lacked personalised information for staff to refer to in order to build caring relationships with people. For example, details of a person's childhood and career, names of important family members and friends, and cherished memories from their lives to date. All care plans contained dietary preference sheets, which is part of the admission process. The information is also kept in the kitchen and updated as people's dietary needs change.

People we spoke with told us they were satisfied the care provided reflected their needs and staff were vigilant and responsive if they spotted anything of concern. Staff told us they knew the care plan content but that they got to know people through the conversations they had and by seeing them regularly. We discussed this with the manager and general manager as records needed to be clearer and if important information was not being captured in the records then this could create an over-reliance on informal information sharing between staff.

We saw some care plans contained a full audit and review and that these were being done as part of the improvement strategy for the service. Actions were identified including updating information about people's conditions, risks associated with these and guidance for care. The information included who was

responsible for completing the improvements and by when. One care plan review had been acted upon and the information had been completed in the timescale set.

We saw people living at the home were offered a range of social activities and a programme of activities was on display in the foyer. We saw activities included games such as dominoes, painting, crafts, flower arranging and chair exercises. There were also planned trips out and entertainment provided by an external artist.

The home employed an activity co-ordinator and a volunteer came into the service to support activities. Everyone had a plan around their activities, which included information about interests and their level of activity. We also saw that time was allocated on a one to one basis for people who could not join in group activities and spent their time being cared for whilst in bed.

On the day of our inspection we saw people enjoying the garden area and one person was looking through some photographs with staff, the staff member was identifying relatives of the person in the pictures. People told us they joined in with activities if they wanted to but some people preferred to have one to one time without joining the groups. One person told us, "They send a list round but I don't join in now, I read my paper." Another person told us, "We do quizzes and they come to your room." One person told us they enjoyed the library books which were in large print.

We looked at the complaints records and saw there was a clear procedure for staff to follow should a concern be raised. We saw the complaints procedure was in the 'welcome to care' folder located in each bedroom and displayed in the entrance. We saw complaints were fully investigated and resolved where possible to the satisfaction of the complainant. This showed people's concerns were listened to, taken seriously and responded to promptly. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. People and relatives told us, they had no complaints and could talk to staff at any time.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we rated this key question as requires improvement. At this inspection we found there were areas of improvement but that the service was generally well-led overall. Due to there being no registered manager in place the rating for this domain cannot be higher than requires improvement. The previous registered manager no longer worked at the service and a new manager had been appointed who intended to submit an application to become registered with CQC.

Notifications had been sent to the CQC by the service as required by legislation. We saw a monthly programme of checks was in place, which included medication, falls, care plans, safeguarding and tissue viability. However, the quality monitoring and audit system was not fully effective as there were gaps particularly in relation to medication and other documentation. For example, the medication check needed expanding to include other areas in addition to stock checking for example. We could see that systems were being implemented and introduced to make the quality assurance and governance procedures more robust. We saw the management team carried out daily walk rounds of the home and that the general manager was at the service on a frequent basis offering support to the new manager. These daily checks included staffing levels, areas of the home and fire exits.

Accidents and incidents were not routinely analysed. It was not clear what action was taken, if any, following an accident to enable lessons to be learnt or steps to prevent reoccurrence's.

Staff we spoke with said communication and support within the home was good and that staff morale had improved with the visual changes being introduced including the support of the general manager. Staff said the manager maintained a visible presence and often spent time with them and people who used the service. One staff member said, "[Name of manager] is out and about all the time and wants to know what is happening in and around the home." Staff told us they enjoyed their role and felt well supported now. One staff member said, "I feel we are listened to." Other comments from staff included; "The seniors are on the ball. We are pulling together and things are getting easier."

Staff meetings were to be scheduled once the training manager was in post. The general manager told us they met with staff on each shift at the current time and had done so in the last three months to make sure staff were kept abreast of changes and what was expected of them. She told us the involvement with staff had been intensive and structured during a time of significant change. Staff told us, "It has been unsettling with all the changes, but they were changes that were needed and everyone realises that now. Things are going quite well at the moment." One member of staff said, "The manager is approachable and gets things done. I have no problem going to them if I have a concern or want to discuss anything."

People and relatives we spoke with said staff were open and friendly and the management team, were visible and around the home. Comments included, "[Name of manager] is very nice. I think they are open and honest and I trust them absolutely."

Relatives told us they had attended a meeting a few months previously where they discussed the changes to

the service and the absence of the manager. They told us the meeting was helpful. Asked if they had regular meetings, they told us they had not had another meeting but this did not mean they could not raise issues with the management team or speak to a member of staff about their relative. They told us the lack of meetings was not a problem to them.

The general manager and activity co-ordinator were actively forging relationships with the local community to help with involvement. Local amenities were used by the home and people who used the service.