Austhorpe Care Home Limited

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

Summary of findings

Overall summary

The inspection took place on 20 and 21 July 2016 and was unannounced.

Austhorpe House is in a rural location and consists of an old building on two floors and with a more modern and purpose built ground floor extension to one side. It provides nursing care for older people, some of whom may be receiving palliative care at the end of their lives. At the time of our inspection, there were 23 people using the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider's management structure made it difficult for the registered manager, as a nurse, to receive regular professional development and clinical supervision. The registered manager was struggling to proactively monitor and assess the quality and safety of the service. Their ability to do this in a structured and systematic way, rather than just on a day-to-day basis, was compromised by the need to cover nursing shifts regularly. Some of the concerns we identified had not been picked up and addressed by either monitoring systems within the home or the provider's oversight of the service.

Medicines were not always accurately recorded, accounted for and disposed of when they were no longer needed. This compromised the way the service could show they always administered medicines as the prescriber intended and minimised the risk of misuse or error. The registered manager had plans for addressing other potential risks to people's safety within the home.

Risks to people's health and welfare were assessed. The registered manager had plans to address potential risks within the environment and sought to address these with the providers. There was a lack of clear guidance within individual care plans about minimising risks for each person. However, the impact of this on people's safety and welfare was minimised because there was a consistent and stable staff team who understood how to support people safely and mitigate these risks.

Staff were aware of their obligations to report any concerns that people were at risk of harm and abuse. They were recruited in a way that contributed to protecting people from staff who were unsuitable to work in care services. Although some people were concerned they had occasionally to wait for support, they felt there were enough staff to support them safely. The registered manager was aware of the importance of keeping people's care needs and occupancy levels under review to ensure staffing levels continued to be safe.

People received a service that was effective. Staff received training and support to meet people's needs competently. The registered manager was arranging further training for staff to understand their legal

obligations towards those who could not give informed consent to their care. Staff understood the principle of seeking consent from people to deliver their care and in involving others who knew people well to help determine what was in people's best interests.

People had a choice of meals and enough to eat and drink to meet their needs. Where people needed assistance to eat and drink, staff supported them. As far as possible, people were supported in a way that made their mealtime experience pleasant and enjoyable. Staff ensured they monitored people's health and welfare and sought advice from other health professionals to promote people's wellbeing.

People experienced support from staff who had developed warm, compassionate and caring relationships with them. Staff treated people with respect for their privacy, dignity and independence. They considered people's individual preferences, needs and wishes so that they could deliver care focused on each person. People valued the support they had with hobbies, interests and social activities. This contributed to people's emotional wellbeing and helped to prevent them feeling isolated.

People, and their visitors, were confident that, if they had any concerns or complaints, these would be addressed. They felt that they were listened to and asked for their views about the quality of the service they received. Staff were also confident in expressing their views and making suggestions about the service. Staff morale was high and they demonstrated commitment to delivering good quality care.

You can see what action we told the provider to take at the back of the full version of the 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 always safe.

Systems for monitoring and managing medicines were not always robust.

Risks to people's safety were assessed and staff understood what they needed to do to minimise these. Some improvements were planned to reduce potential risks associated with the premises.

There were enough staff to support people safely at current occupancy levels.

Recruitment practices were robust and staff understood the importance of protecting people from the risk of abuse.

Is the service effective?

Good

The service was effective.

Staff were trained and supported to meet people's needs competently. They understood the importance of seeking people's consent to their care and treatment. Arrangements to promote their knowledge and awareness of people's rights in this area were being improved.

People received advice and support with their health and welfare if it was needed.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and cared about people's wellbeing and comfort.

Staff treated people in a way that respected their privacy and dignity and encouraged their independence.

Is the service responsive?

Good

The service was responsive.

Staff understood people's individual needs and preferences. They delivered care that was centred on these and which took into account people's individual hobbies and interests.

People were confident that their concerns and complaints would be listened to and addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Systems for proactively assessing, monitoring and improving the quality of the service were compromised by conflicting demands upon the registered manager.

People using the service, their visitors and staff, were supported and empowered to express their views about the quality of the service.

The approach of the registered manager contributed to developing a stable and consistent staff team, which was highly motivated to deliver good quality care.

Austhorpe 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and took place on 20 and 21 July 2016. It was completed by two 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.

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 the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or manager must tell us about by law. We sought feedback from three commissioners of services and the local authority quality assurance team.

During the inspection, we spoke with the registered manager, a nurse in charge, activities coordinator, cook and two members of the care team. We also spoke with seven people using the service and three visitors to the home. We reviewed records associated with the care of three people, medicines records for three people, and a sample of records associated with the quality and safety of the service. We checked recruitment records for one member of staff and training records for the staff team. We observed how people were being supported and how staff interacted with people and their relatives.

After our visit to the service, we asked the registered manager to arrange for us to see information about the syllabus for one piece of staff training. We received this promptly to aid with our inspection.

Requires Improvement

Is the service safe?

Our findings

Systems for managing and recording medicines needed improvement. Medicines records were not always accurate and complete. Checking processes did not identify potential errors promptly. This meant that the service could not be sure medicines were always accounted for and given as prescribed.

We noted that there were records of a medicine received into the home on 22 June and 5 July 2016 for one person. We checked what records showed was received and given and found a surplus of ten tablets that were unaccounted for. It was not possible to determine whether the person had taken their medicine as prescribed or whether their records were inaccurate. The registered manager and a nurse checked our findings after the first day of the inspection. They concurred that there was a surplus and concluded this was most likely to have been an error in counting the medicines when they were received.

One person was prescribed a medicine to be given twice daily. We checked records of those given in the morning and the corresponding blister pack. Nursing staff had signed the medicine administration record (MAR) chart four times to show this medicine was given on four successive mornings. However, five tablets were missing from their blister pack without explanation of what had happened to the additional tablet.

We also found that one medicine remained in the home for someone who had left in January 2016. It had not been disposed of promptly when it was no longer required. We also found 13 tablets of an anti-coagulant medicine, supplied in October 2015 and not currently in use. The registered manager explained that the person's dosage fluctuated, which is usual for this medicine. They told us that they kept the tablets in case they were needed. However, we found that they had not used that strength of tablet for some time and the medicine was unaccounted for in records. This presented a potential risk of error, misuse or misappropriation.

We checked a sample of completed MAR charts in use from mid-May. We found that there were some minor omissions of signatures or codes. For example, one person's chart had three omissions of signatures or coding for the same medicine, due for administration at night. There was no indication that staff on the next shift followed this up promptly to check what had happened. This meant the service could not show whether the person had received their medicine or not.

The audit checklist for medicines management was not sufficiently robust. Staff ticked the audits to show that they had completed random stock checks. The registered manager informed us that staff responsible checked medicines at the end of the monthly cycle to make sure they did not over order. We discussed with the registered manager that this did not represent a random stock check or audit and did not identify concerns or anomalies promptly, such as those we found.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us, "I get my medication on time." We observed that staff made sure they administered

insulin promptly at the times it was required. They gave medicines for Parkinson's disease regularly as prescribed and outside the confines of the routine medication rounds if this was necessary. Where people needed regular blood tests to assist with managing anti-coagulant medicines, these took place promptly. Where doses changed after blood tests, staff amended MAR charts promptly to ensure there was guidance about the correct doses of medicine.

We checked a sample of people's medicines that required additional precautions in their management. We found these were all appropriately recorded and accounted for. Nursing staff retained medicines keys safely to ensure that unauthorised staff could not access them.

Risks associated with the operation of the home were assessed. Equipment in use was tested and serviced regularly to make sure it remained safe to use. This included equipment for detecting and extinguishing fires and for assisting people with their mobility.

We noted that test reports for the water system identified one species of bacteria as present, but stated this was not associated with significant harm to health. The registered manager told us investigations were underway to identify the source of potential problems. We have referred our findings to the relevant regulatory body.

There was an assessment for the risk of fire in place indicating some remedial work was needed. This was not all complete. However, the fire brigade inspected the service in April 2016. Although they made recommendations, they did not identify urgent concerns. The registered manager was able to show that she had obtained quotes for the work and updates needed and was awaiting the provider's response and approval.

The completed provider information return (PIR), told us that the registered manager had obtained quotes to update the call bell system to a 'wireless' system. The PIR indicated there were plans to update this during the next 12 months. The registered manager recognised some concerns for the coverage and adaptability of the current system. They were awaiting the provider's response to quotes.

We confirmed concerns for the coverage of the current system. People were not always able to call for assistance from staff, depending on where they were spending their time. There were no 'pendant' type alarms for people to call for help if they were away from a call point, for example using the garden. Staff had provided people in the garden with a small china bell to call for help if they needed it. However, the bell was inaudible if staff were not very close by. We used the call point in the conservatory when one of the six people in the garden called for help and staff were not close by.

There was only one call point in the large conservatory. Only someone who was able to reach the call point on the wall would be able to request help, as there was no call bell cord fitted. This area was not in use during the inspection, due to the heat, so no one was affected at the time. However, one person using the service told us this had presented problems. They explained that they had not been able to use the bell to call for help. They said they needed to alert staff on behalf of another person, who had slid from their chair. They explained that they could not use the bell because it was not within reach. The proposed replacement system would help address these concerns.

Nursing staff assessed risks to people's safety, for example from poor nutrition, pressure ulcers and when staff assisted people with their mobility. There was not always clear guidance for staff about how to minimise risks, particularly to people's skin integrity. However, staff were able to tell us who was at risk, what checks they made and how they promoted people's safety. We noted that people had pressure-relieving

equipment in place.

People told us that they felt safe in the service and had no concerns about the way that staff treated them. For example, one person told us, "I am very safe and comfortable here." Relatives were also confident about the welfare of their family members. One visitor told us, "It is a relief to me that [person] is here. I can leave safe in the knowledge that [person] is being cared for so well." Another commented, "My [relative] is 100% safe here – very much so."

Staff spoken with confirmed that they had training to recognise and respond to concerns someone may be at risk of harm or abuse. They told us about the kinds of things that would lead them to be concerned. They were aware of their obligations to report suspicions or poor practice from colleagues, and were confident that the manager would deal with issues they raised. The registered manager was aware of their obligations to pass suspicions about people's welfare to the local authority's safeguarding team.

We received some conflicting views from people using the service, about whether staffing levels were always sufficient to respond to their needs promptly. Three people identified the period after lunch as being when they had to wait longest for assistance. They attributed this to the time that staff were having their breaks. However, on further discussion, people did not feel that they were unsafe because of this.

One person told us, "The worst bit for me is the wait after I ring my buzzer. The afternoon is when it is worst - probably when the staff change over. If I want to go to the toilet, I need to go. The person opposite wanted to go the other day and had a long wait." However, people also confirmed that they always received support from two staff when they needed it, for example to move or transfer safely. One person told us, "The most difficult period is when the staff change over in the afternoon." They went on to say, "There's always two staff to transfer me to my wheelchair. I'm very comfortable here and have nothing to worry about." Another person said, "There are enough staff around. I might have to wait five minutes for the buzzer to be answered but in a busy place that is acceptable from time to time."

Three visitors to the home confirmed that they felt there were enough staff available to support people. One of them told us, "I looked at loads of other homes before deciding on this one. In others, I heard buzzer alarms going off all the time, without being answered in good time. It's not like that here." Staff told us about how they prioritised their work at busy times of day, for example in the morning, so people could get up close to their preferred times. Staff said that, although they were busy, staffing levels were not unsafe. They felt that the team worked well together to ensure they met people's needs.

Nursing staff levels were maintained because the registered manager worked regular shifts to provide nursing cover. They were on shift on both days of this inspection and rostered for three shifts during the following week. The registered manager confirmed that they were trying to recruit to nursing posts but without success. The registered manager completed assessments of people's dependency. These showed that the dependency levels of people currently using the service were increasing. The registered manager recognised that staffing levels needed further consideration and discussion with the providers if they filled rooms and depending on people's needs. They had identified that an additional care staff member on each floor would be beneficial.

Recruitment practices contributed to promoting people's safety. They showed that the registered manager completed the checks required before staff were appointed. This included taking up references and completing enhanced background checks to ensure prospective staff members were suitable to work in care. The registered manager also showed us confirmation from the agency they used, that appropriate checks on staff supplied were complete. There was evidence that agency nurses had current registration

with the Nursing and Midwifery Council to entitle them to practice.

Good

Is the service effective?

Our findings

People told us that they felt staff were competent to meet their needs. This included relief staff. For example, one person commented, "We get some from an employment agency and they fit in well and know what they are doing." Another person told us, "The carers know what they are doing so I expect that means they are trained properly."

All of the staff we spoke with told us that they had good access to training. They confirmed that they had updates to training which needed renewing regularly, such as in first aid and moving and handling. The registered manager showed us how they obtained information from agencies about the training staff had completed if they needed to use agency staff. They also showed us how they had improved the way that they monitored training so they could arrange updates in a timely way.

Some staff had also achieved qualifications in care and a staff member we spoke with confirmed that they had done so. One staff member told us how they supported new care staff during their induction. They explained how staff shadowed experienced colleagues, to learn what was expected. They explained how they advised care staff about the best ways of supporting people with their personal care. They felt that there was a low turnover of staff so standards and consistency could be maintained. This confirmed what the registered manager told us in their provider information return (PIR).

The registered manager told us in the PIR, that staff received yearly appraisal and supervision to evaluate their practice. We saw that they had a schedule for delivering these and for monitoring and improving the regularity of staff supervision. Staff told us that they felt well supported by their colleagues and by senior staff. For example, one staff member told us they had received a couple of supervisions and felt they could always go to senior staff or the manager for advice and support.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether there were any concerns that people may be being deprived of their liberty.

A person using the service said, "They [staff] are polite and always ask permission before doing anything for me." Staff were able to tell us how they would explain to people what they needed to do when they were delivering care. They recognised that they should ask people for consent to deliver care and told us how they would try to persuade people what needed to happen to ensure their welfare. Staff also understood

that sometimes people's health would affect the way they were able to understand information. They told us that they could not coerce people into accepting care.

Staff were not entirely confident in their roles if people were not able to give informed consent. We spoke with the registered manager about this who explained they had changed training providers. They arranged for their new training provider to send us information after our inspection visit. The trainer confirmed with us that the MCA and DoLS were included in the syllabus for safeguarding training to ensure staff understood how to protect people's rights. We were aware that this training was updated and renewed regularly so staff awareness of these areas would be improved.

The registered manager and a nurse recognised the importance of ensuring others who knew people well, were involved in discussions if people found it difficult to understand what was happening. They were able to give us examples of how they had discussed the background and previous views of one person with their family. As the person's health deteriorated, they recognised the need to discuss with close family members what was in the person's best interests.

The registered manager explained that their assessment process took into account whether people were living with dementia and how this affected them. They were aware when they should consider making an application to deprive someone of their liberty. They were awaiting the outcome of one of these to ensure the person's rights were protected. In the interim, they were trying to ensure that they considered the least restrictive options to ensure the person's welfare.

People were supported to eat and drink enough to meet their needs. Where monitoring charts were in use, these did not always show the amounts of food and drink people had accepted. However, a member of the nursing team described care staff as being very skilled at encouraging people to take food and drink. They said this included those who were nearing the end of their lives. They explained that they knew staff did assist from records of personal care and attention to people's continence needs. The majority of people had their weight checked regularly if there were concerns about their nutrition. Staff explained that some people were not weighed regularly as this would have been distressing, difficult or painful because they were receiving palliative care.

People spoke well of the meals they were offered and looked forward to mealtimes. They told us they had a choice of meals. For example, one person said, "The food is very nice and I look forward to the meals- a highlight of the day. There's always a drink next to me." Another person commented, "If I don't like the choice on offer, they'll make me something else. There's always a drink by my side if I want one." A third person told us, "The food is nothing short of excellent!"

We noted that one person did not eat much of their lunch and received only occasional reminders or prompts from staff. However, staff told us that this was usual, would vary, and if they did not eat lunch would very often eat a larger tea. They explained why they did not offer practical assistance. They knew that if staff or relatives were present while the person was eating the person would push it away. We reviewed the person's care records and found that their weight was stable.

We observed that people received assistance to eat and drink if this was necessary. We saw that staff assisted two people to eat their lunch. Both were in an upright position to aid with digestion and minimise choking risk. The staff supporting people chatted with them during their meal, helping to make this a more pleasant experience. For people who were assisted in their rooms, staff made sure they were in a sitting position so that they eat and drink properly and comfortably.

The cook told us that they made all meals from scratch without recourse to pre-prepared food. They confirmed who needed their meals fortified to increase their calorie intake due to their risk of weight loss. They also knew who needed their food to be prepared in a way that minimised choking risk. The information they gave us was consistent with what staff said and care records contained. A visitor to the home confirmed that their relative's meals were, "…made to a consistency that suits."

Staff supported people with their health and to access health professionals when they needed to. At hand-over a member of the nursing team explained their concerns about a person's swallowing. They were arranging to contact the GP to ensure the person was referred for specialist speech and language therapy advice about this.

We could see from records that people received visits from their GP, optician, dentist and podiatrist as necessary. Nursing staff told us that they sought advice on the telephone from the tissue viability nurse when this was required. They had done so because of difficulties healing a pressure ulcer that one person had when they were admitted. The registered manager confirmed that they were able to access advice about people's care needs at the end of their lives from the hospital's palliative care team as well as a hospice team.

Good

Is the service caring?

Our findings

Staff had developed compassionate and caring relationships with people using the service. This included staff not directly engaged in delivering care, such as the maintenance staff. People and their visitors spoke very positively about the approach of staff and the way they supported people. They valued the homely atmosphere within the service.

One person told us, "I use a wheelchair. Whenever I get assistance in or out, it is done in a gentle, unrushed way." Another person commented, "The staff here are lovely. The quality seems to get better over time... They not only do a good job looking after us but they have got a great sense of humour." A third person said that staff, "…treat me like family. The carers are very gentle with the residents- I expect they hardly know they're being supported or moved."

Visitors told us how welcoming and kind staff were. For example, one commented, "It's very reassuring to see how kind everyone is. It means when I leave I can feel everything is going to be fine. My relative is a real person with feelings and emotions to staff." Another said their relative, "… thinks the world of the staff. Everyone in the home - staff and residents - are happy and that's what makes it a special place for them and us." A third visitor told us, "The staff are lovely to [person]. They are not at all condescending. They make sure there is banter going on between them. They are lovely to me too."

One relative commented in the home's record of compliments in mid-June 2016 expressing their views. They wrote, "Your staff were exceptionally helpful in getting [person] ready. Their pride in their work was most evident."

We observed that one person became confused and distressed. A staff member held the person's hand and offered reassurance until the person became calm and settled. We also heard a member of the maintenance team engaging someone in conversation and talking about some new photographs of their family.

Some people were not clear what was in their care plan and their participation at review was not always shown within their records. However, they did acknowledge that staff supported them to express their views and be involved in making decisions about their care as far as possible and treated them as individuals. One said, "I am definitely a person to them with feelings." Another told us, "We have fun here. The carers are lovely. They definitely see me as a person with feelings and opinions."

Staff spoken with were respectful of people's individual needs and preferences. For example, one told us, "This home treats people as family. It all depends on the individual." They went on to explain how family members assisted them with information about a person's likes and dislikes. All of the staff spoken with said they would be happy for a relative of theirs to be cared for at Austhorpe House because of the approach of the staff team.

Staff supported people in a way that respected their privacy, dignity and independence. For example, one person told us, "They [staff] never talk about any other residents in front of me." We observed that staff

knocked on people's doors before they entered their rooms. Staff spoke to people in a respectful manner. Staff were also able to give us an example of how one person's health had led to them feeling self-conscious. They respected the person's wish for privacy and time in their room.

The hand over between staff shifts took place in private so that others would not overhear information. We also noted that staff ensured records associated with people's care needs, assessments and health, were not accessible to others. This contributed to promoting people's privacy and confidentiality.

People told us how their independence was encouraged. For example, one person said, "They [staff] encourage me to do things for myself but step in if they see I can't do something." The staff we spoke with recognised the importance of encouraging people and not taking away their independence. One staff member described how they supported people with their personal care. They said, "It takes as long as it takes. We don't take any independence away."

Good

Is the service responsive?

Our findings

Staff supported people in a way that focused on their individual needs. People made positive comments about how well staff understood the support they required. For example, one person told us, "The carers know exactly what my needs are. Every one of us needs something different and they certainly recognise that." Another person said, "The staff know me well and know exactly what I need as an individual." A visitor confirmed that they felt staff understood the needs of individuals. They told us, "The staff really understand my relative's needs and try to meet whatever it is [relative] wants."

We observed hand over between nursing staff and an incoming member of care staff. We noted that the information shared was primarily about people's health needs but there was also discussion about people's backgrounds and preferences. The information focused on how individuals had been during preceding shifts. The nurse handing over made incoming staff aware of changes in people's wellbeing or health so they could monitor people's welfare.

People told us how staff tried to meet their individual preferences. For example, one person said, "I have a back problem and when it really hurts I like to get to bed by 8pm. There are times when they can't help at that time but it's not usually a problem." Another commented, "I mostly get to bed when the time suits me." A third person said that staff were normally able to help them get to bed when they wanted to.

Interviews with individual staff members showed that they understood the support people needed and tried to meet people's preferences. For example, one staff member told us how some people liked to get up early where others preferred to stay in bed longer. They described how they considered this when prioritising personal care for people. We found that nursing staff reviewed people's assessments and care records regularly to ensure these were up to date and reflected current needs.

People's care plans did not always record that they were involved when their care was reviewed. However, people felt that their needs were taken into account. One person confirmed that their relative had been involved with staff in developing their care plan and decisions about this. A family member for another person also told us that they had been involved in supporting the person to decide on the care and support the person needed. They told us, "The staff ask me regularly if everything is all right with my relative's care."

People had access to recreational and social events, which considered their interests. People spoke highly of the way that the service took into account their hobbies, interests and social needs. They recognised the work the activities coordinator put into this and valued that staff member's role. People valued the opportunities they had to engage in social activities and saw this as a major contribution to the quality of their lives. For example, one person told us, "What is really nice is that the activities' co-ordinator comes round and chats to us. That is appreciated very much. She also talks about what is going on and what we can take part in." People and their relatives described how they were encouraged to join in with events if they chose to do so.

Members of the wider staff team also supported people with the larger group activities outside the home

such as a recent outing the activities coordinator organised for ten people. One person told us, "We had a fabulous day out in Lowestoft. It was great fun and something that lives in my memory." Another said, "I absolutely loved the trip out to Lowestoft. We had a great day out. On the last Thursday of the month, a group of us goes to the pub next door for a meal and some other activities. Things like this make life enjoyable. I like the quizzes and the bingo." One person's relative also commented about this outing in the home's record of compliments. They wrote, "[Person] so enjoyed the outing to Lowestoft. I've never seen [person] so happy."

During our inspection, we observed that a group of residents played dominoes enthusiastically. In the afternoon five people joined in a quiz and we observed they were actively engaged in the process, not only answering questions but in discussion about the answers.

The activities coordinator was able to tell us clearly about their role and responsibilities. They explained how they encouraged people to join in activities unless they did not want to be. They also made considerable efforts to support people who were unwell and spent most of their time in bed. They explained how they would try to find some activity they could do together, such as reading a book, poem, listening to music or looking at photographs.

People and their visitors expressed confidence that the manager or staff would listen to any concerns or complaints they had and address them. There was a folder prominently displayed in the reception hall of the home, for visitors to the home to register complaints or comments if they wanted to. However, people felt that staff addressed any concerns at an early stage and no one had needed to raise a formal complaint. The provider last needed to investigate a formal complaint more than seven months before this inspection and took action to address it.

One person told us, "They are very good at informally checking that everything is OK generally. They are attentive and aware that things might not always be as we want. If I'm not very happy about something, they try to put things right." Another person said, "The senior carer is the one I look to for support, or the person I would go to. Even the domestic staff will deal with a problem." A visitor told us, "I can talk to staff if something isn't quite right and it will be sorted."

Staff told us that, if people raised a concern, they would try to act straight away to put it right. They told us that, if this were not possible, they would report it to a more senior staff member or the manager so that they could take action to address the problem.

Requires Improvement

Is the service well-led?

Our findings

The home had a long-standing registered manager in post. They had fostered a homely and family atmosphere which people using the service, their relatives and staff told us they valued. Staff commitment to, and concern for, people's welfare was high as was morale. This contributed to low staff turnover with staff telling us how much they enjoyed their work. However, the registered manager's abilities to monitor the quality of the service proactively were compromised by conflicting demands upon their time.

The registered manager explained that the provider's regional management team had changed in March 2016 and that there was a new team in post completing checks and reporting to the provider. These had not identified or followed up some of the issues presenting potential risks to the quality of the service.

The registered manager explained how this team no longer included staff with a clinical background. When asked, the registered manager was not able to produce any recent records of their own formal supervision with any of the provider's representatives, to show this took place regularly. There was a lack of professional and clinical supervision for the registered manager and discussion about their performance, support and development needs. The registered manager told us how this had presented difficulties with revalidation with the Nursing and Midwifery Council, to ensure they remained able to practice.

The registered manager acknowledged that it was difficult to monitor the quality and safety of the service as robustly as they wanted to. Duty rosters confirmed that the registered manager worked regular shifts. They explained that they needed to work two shifts a week regularly and this sometimes made it difficult for them to fulfil their managerial role. We found from the duty roster that the manager was down for three shifts out of her five working days, during the week after our inspection.

Of the ten nursing staff providing regular cover (including the manager), half were identified on the roster as relief staff and not permanent. The registered manager explained that they felt there was little alternative but to provide the additional nursing cover herself. This enabled the manager to monitor some aspects of care delivery and keep up to date with people's needs but compromised their day-to-day management tasks. There was no deputy in post to assist with this. Both inspectors were concerned that the registered manager was under considerable stress and that the current situation was not sustainable in the long term.

Our discussions with people, their relatives and the staff team, led us to conclude that there were shortfalls in record keeping rather than the care people received. The records themselves were not properly checked to see where improvements could be made.

Although people's needs were reviewed regularly, there was a lack of detail in care plans to show the specific actions staff needed to take to meet individual needs. For example, two people, at very high risk of pressure ulcers had no guidance about how often staff should assist them to reposition to reduce the risk. Records of the care that staff gave lacked clarity with regard to the position they had assisted people to adopt to relieve their pressure areas.

Record keeping practices and medicines were not audited robustly and so had not identified the concerns we found, including in medication records. The potential adverse impact of this and risk to people's welfare was mitigated because of the stability of the staff team. They had developed a good understanding of people's needs and worked well as a team. However, there would be a risk and a challenge to the service if staff turnover increased for any reason.

We noted that the provider had submitted two applications to the Care Quality Commission to vary the registration conditions of the service, reducing the numbers of people they wanted to accommodate. They made these applications during 2015 but they were rejected because they were incomplete or inaccurate. They had not taken further action to ensure they submitted correct and complete information. This meant that the registration conditions applied to the service were inconsistent with the provider's intentions and statement of purpose.

The registered manager reviewed accidents and incidents within the service to see if there were any developing patterns or risks, which they needed to address. They had also improved the way that training was monitored. We noted that the registered manager and administrator had given considerable thought to the evidence they had within the home which would demonstrate how they met expected standards. They produced a folder for staff to assist if the manager was absent at inspection, directing them where to find sources of information to help show how the service was working.

People were empowered to express their views about the service they were receiving. We found that there was a recent survey of people using the service and their family members, to assess how caring they felt the service to be. Those we reviewed expressed high levels of satisfaction with the service people received and the approach of staff. People's family members and other visitors to the service also had the opportunity to express their views in record books available in the reception area. The registered manager and administrator explained how the programme of surveys would take into account the five key questions we ask about services so they could evaluate performance.

Staff told us they were asked for their views. One staff member explained to us that they could complete surveys anonymously if they wanted to, but that staff usually raised any issues straight away. They said they also had opportunities to express their views at staff meetings. We found that these took place with variable frequency, but that staff felt that the manager was approachable if they needed to talk about anything.

Our discussions with staff working in different capacities led us to conclude that morale throughout the service was high. They described the staff team as working well together, regardless of their job role and the capacity in which they were working. One staff member said, "I love it here. Everyone is so supportive and the manager is wonderful – she encourages me in what I do." Another staff member explained that they had worked in care elsewhere but did not feel the care or atmosphere was anything like as good as they found at Austhorpe House. The staff team consistently commented on the homely, family atmosphere. They told us they loved their work.

People using the service were not always clear who the manager of the home was. However, on further exploration they recognised that the registered manager also took on a nursing role. People and visitors saw them more in that capacity. They were confident about the way the service was running. For example, one person commented, "I don't really know who is in charge. Everything runs well." Another said, "I'm not sure who runs the place. We speak to the lady in the office and she answers most queries. I can't fault the place." A third person told us, "This is definitely the best place for me. Find me a better home and I'd be surprised."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always consistently managed in a way that robustly contributed to promoting people's safety. Regulation 12(1), (2)(g)