Rushcliffe Care Limited

Partridge Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 5 May 2016 and was unannounced. Partridge Care Centre is a purpose built home set over three floors. It provides personal and nursing care for up to 117 older people, some of whom live with dementia. At the time of our inspection 65 people were using the service. Following our inspection of the service on 23 July 2015 we imposed a condition on the provider's registration to prevent them from admitting any further people to Partridge Care Centre because of the concerns that we found. This condition remains in place.

At the time of our inspection there was a manager who had been in post for nine weeks but they had not registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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. However, following our inspection we were informed that the manager had left the service.

When we last inspected the service on 14 and 15 January 2016 we found the provider was not meeting the required standards. We found breaches of the Regulations in relation to safe care and treatment, staffing, safeguarding people, consent, privacy and dignity, person-centred care, meeting nutritional and hydration needs, receiving and acting on complaints and good governance. At this inspection we found that some improvements had been made although systems to sustain improvements were still under development.

People told us they received care from staff which was safe and met their needs. The provider was using a high number of agency staff to cover for staff vacancies and planned and unforeseen absences. When we last inspected the service the high use of agency staff was poorly managed and put people at risk of harm due to the lack of information given to agency staff. We found that this had improved and agency staff working at the service were regular, pre-booked for a longer period of time to help ensure people had consistency in the care they received.

People were assisted by care staff who had been trained and had their competency assessed to help ensure the care provided to people was safe and met their needs. We found that staff followed recommendations from social and health care professionals involved in people`s care. However, we found that not all the nursing staff working at the service had the necessary skills and knowledge required to meet the needs of the people living at the home.

When we last inspected the service in January 2016 we found that people's freedom of movement had been restricted and restrained in ways that did not comply with nationally recognised good practice or the deprivation of liberty safeguards (DoLS). At this inspection we found that the manager has stopped these practices and where people required restrictions to their freedom, this had been done following the right processes.

Accidents and incidents were monitored and reported to the local safeguarding team and CQC where necessary and appropriate. We found that the internal systems to identify trends and patterns had improved and the manager and a consultant were working to develop the system further to ensure information and learning points were shared with staff to prevent accidents and incidents from reoccurring.

We found that both permanent and agency staff`s knowledge about safeguarding people from harm or any possible abuse had improved since the last inspection. Staff were able to tell us the process of reporting any concerns both internally and externally. Information about safeguarding and contact details for the manager and external safeguarding authorities were prominently displayed around the home.

Safe and effective recruitment practices were followed to check that staff were of good character, physically and mentally fit for the role and able to meet people's needs. However, there was still a high turnover of staff as the provider was not able to recruit and retain a permanent staff group.

We found that people had their medicines administered by nurses who were trained and had their competencies monitored by the manager. There were regular audits carried out in relation to medicines. However we found that records for administered medicines had not always been signed by the staff responsible. One person had missed two doses of their medicine, although this had been available staff had recorded that it was out of stock.

Records were reflective of people`s needs and were regularly reviewed by staff. We saw that improvements had been made to care records in relation to person centred information about people`s likes and dislikes. The manager, deputy manager and clinical lead had held meetings with relatives and people who used the service and involved them in reviewing their plan of care.

People had mixed views about the quality of the food provided. Although it was in sufficient quantities people told us that the choices and alternatives offered if they were not happy with the main meal on offer were not appropriate for main meal choices, like sausage rolls.

All the people we talked with and their relatives were highly complementary about the new manager. Everybody knew the manager by name although they had only been in the service since March 2016. People told us they had faith that anything they asked for or reported to them was taken seriously and resolved.

Staff told us they were well supported by the new manager and they appreciated how approachable and open they were. Staff told us the new manager had put systems in place to improve the service people received and that they were consistent in imposing high standards of care.

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 medicines were not always managed safely by staff.

Accidents and incidents were monitored, however information on trends and patterns and lessons learned were not always shared with staff.

Permanent and agency staff were able to describe how to recognise and report allegations of abuse.

There were a high number of agency staff used however staff were available in sufficient numbers to meet people`s needs safely.

Risks to people`s health and welfare were identified. Up to date plans were in place to mitigate the risks to help keep people safe.

Staff who worked at the service were employed following robust recruitment processes.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all the nursing staff had the right skills and knowledge to meet people`s needs.

People`s day to day needs were met effectively, however people reported a difference between the quality of the care provided by permanent staff and agency staff.

Mental capacity assessments and best interest processes were followed and staff asked people for their consent before they delivered care.

Deprivation of Liberty Safeguards applications were submitted to the relevant authorities detailing the restrictions in place if people were deprived from their liberty.

Permanent and agency staff were supported and had received

training to develop their skills to meet people's needs effectively.

Is the service caring?

Good

The service was caring.

Staff showed respect to people, they were kind and caring in their approach.

People and their rightful representative were involved in planning and reviewing their care.

Staff showed empathy, patience and a calm approach when caring for people who lived with dementia.

People`s dignity and privacy was respected and promoted by staff in most circumstances.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had comprehensive care plans to detail their physical and health needs. Staff were working to update care records with details about people`s life history, preferences, likes and dislikes.

Activities provided were varied, however people who were in their bedrooms all the time had little opportunities for individual activities.

People, staff and relatives told us their voices had been listened to by the new manager which had given them confidence in the service.

Complaints were appropriately logged, however there were not always appropriately investigated and responded to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Daily observation charts were not always completed by staff.

The service was not always well led.

At the time of our inspection there was a newly appointed manager in post who had worked in the service for nine weeks. The manager had not registered with the CQC. The manager left

the service shortly after our inspection visit.

The manager had started to develop systems to monitor and improve the quality and safety of the service provided but these were not yet effective in sustaining improvement.

Staff deployment had improved across the service and staff told us that the manager had ensured they had appropriate support by working alongside them and giving direct guidance.

Staff were complimentary about the leadership skills of the manager who they told us promoted an open culture and high standards of care.

Care records, risk assessments better reflected people's needs and work was being done to personalise the care records with people`s likes and dislikes.

People and relatives knew the manager by name just after a few weeks of them managing the service. They told us they had trust and confidence in their ability to improve the quality of the care provided.

Partridge Care Centre

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 made the necessary improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012.

The inspection was carried out on the 5 May 2016 and was unannounced. The inspection team consisted of three inspectors, a nurse specialist advisor and an expert by experience. The specialist advisor had the experience in nursing and healthcare, elderly care and within the field of palliative care. The expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with eight people who lived at the home, eight relatives, nine care staff some of whom were agency staff, four nurses, one team leader, the manager and a newly employed quality assurance consultant. We looked at care records relating to 10 people and other records relating to the management of the home. We reviewed information we received from the provider following the inspection visit.

We also received feedback from the local authority and commissioners prior the inspection.

Requires Improvement

Is the service safe?

Our findings

People had not always received their medicines safely. We found that for one person staff had recorded on the medicine administration record (MAR) that a medicine prescribed to be taken twice a day was not available. We asked the nurse in charge about this and they told us they had found the medicines the following morning and they did not know why the previous nurse had recorded `out of stock`. The person had missed two doses of their medicine. We asked the manager if they knew about this incident and they told us this was not reported to them. They told us they were going to investigate and increase their medicine audits and observe staff competencies.

We found that on two occasions staff responsible for administering medicines to people had omitted to sign the MAR to indicate they had administered the medicines. The agency nurse told us they would report any missing signatures to the management for them to follow up this with the staff member who had omitted to sign. We had not found any evidence that this was reported. We were able to establish that people had been given their medicines and nobody was harmed, however this was an area in need of improvement.

People and their relatives told us the service was safe and improvements had been made to the quality of the care provided. One person told us, "I am very safe here." One relative told us, "I can leave here after a visit with a clear conscience knowing [person] will be safe and well cared for." Another relative said, "Much improved. Residents are definitely safe."

At our last inspection we found that the service was not safe, the provider had failed to ensure there were sufficient numbers of staff to meet people`s needs safely at all times. At this inspection we found that improvements had been made in how staff were deployed. The manager had implemented a system to give staff clear lines of responsibilities and had ensured staff understood their responsibilities towards people and tasks. For example we observed the morning handover where staff were told the people they were responsible for, who they were working with and if they had to complete any other tasks after they had ensured that people`s needs had been met. Staff told us that the manager regularly attended staff handovers.

At the previous inspection we found that the quality and safety of the care people received was inconsistent. Permanently employed staff had a good understanding of people`s needs, however when agency staff were used to cover for staff shortages people were at risk of harm, because of the lack of information they were given about people`s needs. At this inspection we found improvements had been made to the way agency staff members were deployed and managed. For example the manger ensured they selected a number of agency staff and booked them for a longer period of time to work on the same units within the service. This helped agency staff to get to know people and their needs and they could offer the same level of care to people as permanent staff.

Risks associated with people`s daily living were recognised and risk assessments were in place with clear instructions and guidance for staff how to mitigate these risks. For example we saw a person had a `Hot drinks` risk assessment. This detailed the person being at risk of scalding if they were given very hot drinks.

Staff were instructed to offer support and monitor the person whilst having a hot drink. We saw staff sitting with the person and they ensured the cup was not too hot to touch before they gave the drink to the person. This showed the staff were knowledgeable about risks to people`s well-being and how to manage these to help keep people safe.

People told us there were still differences between permanent and agency staff, however they were happy with staffing levels and the overall improvements in the standard of care they received. One person told us, "Staff is nice, agency staff is nice too. The only problem is that they are not as confident in what they have to do for me and I have to constantly instruct them." One relative told us, "The atmosphere is excellent it is enough staff but I wish for more permanent staff rather than agency. Permanent staff is more knowledgeable and dedicated."

Permanent staff told us that staffing numbers had improved and been maintained. They told us they worked mostly with regular agency staff and just on occasions they had a new agency staff coming. One staff member told us, "We have some very good agency staff who are very regular. Rarely we have a new one [agency staff] coming and if we [staff] observe they lack knowledge we will work with them together to ensure they learn." This demonstrated that permanent and agency staff worked as a team and permanent staff helped ensure that people received safe care at all times.

Staff told us the manager was very visible on the units, constantly guiding them and assessing the staffing levels. They told us on occasion they were re-deployed to a different part of the home if it was a need for it to help. They said, "Staffing is very strongly monitored by the manager. If it is a need to go and help on another unit they will ask us to go and help. This is very good because people don't have to wait a long time for anything." One agency staff told us, "I didn't work here for a few months and recently I returned. I can really see the change in better. Staffing is very good comparing with the number of people." This meant that there was enough staff effectively deployed around the service to meet people`s needs at all times.

At our last inspection we found that staff did not always follow safe procedures and practices when supporting people to move around. At this inspection we observed staff practices had improved. Staff were knowledgeable about what mobility aids people used and they followed recommendations from health care professionals. We saw a white board in each nurses office where staff had access which listed people`s name, room number, their GP contact details, and symbols corresponding to the equipment they needed. The board also gave information which only staff could understand if people had a Do Not Attempt Cardio Respiratory Resuscitation (DNACPR) decision in place. This was a very good system the manager had introduced for agency staff as well as permanent staff to have at a glance the most important information about people.

At the last inspection we had found that permanent staff were knowledgeable about how to safeguard people from abuse and avoidable harm. However agency staff members had not been able to tell us signs and symptoms of abuse or the procedure to follow in reporting concerns. At this inspection we found that this improved significantly. The manager had requested and checked agency staff member's profiles and training logs and provided training for them if they felt they lack knowledge. All the staff we talked with knew the signs and indicators that could suggest abuse and how to raise any concerns. One staff member told us, "I know about whistle blowing, I would report concerns to a nurse or the manager, I also know to go to the local authority and CQC." Another staff member said, "I use observation, see if the person is comfortable and talk to them. If I have any suspicion or concern I report it to the manager."

The manager held all the information regarding on-going or past safeguarding concerns. They told us they were reading through the information to get familiar with past and present concerns. We saw details of

investigations carried out by the provider and recommendations from the internal investigation and any local authority investigation. There were no records to demonstrate where recommendations had been acted on or learning shared with staff. The Quality Assurance Manager told us they were looking into this as part of their remit. Discussions we held with the manager showed that they were aware of the issues that had been identified through safeguarding investigations. For example, the need for additional pressure care training and skill mix of nursing staff.

Information about safeguarding procedures and contact details from relevant safeguarding authorities were visibly displayed around the home. There were notices with the manager`s phone number and a message for staff, people and visitors to contact them with any concerns they had. This meant that the manager took appropriate steps to help ensure people were protected from harm or any potential abuse.

The provider had a permanent recruitment drive. They were regularly advertising for permanent care staff positions and staff employed had gone through thorough pre-employments checks which included a criminal history check, two references and a full employment history. The manager told us they were carefully selecting applications and interviewed applicants to ensure only the right calibre candidates were employed.

We found that the equipment used in the home, such as wheelchairs, hoists and crash mattresses were clean. There was a cleaning and a maintenance schedule used to ensure all equipment was checked and cleaned regularly in line with the infection control principles. The equipment people used or required had been assessed by an occupational therapist or other appropriate person to help ensure that it was appropriate for people to use. This was an area which had improved since our last inspection.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that people`s consent to care was not always sought and decisions made on behalf of people had not always been made following a best interest process. During this inspection we found that suitable arrangements were in place to ensure that people's consent to care and treatment was obtained in all cases. We also found that the requirements of the Mental Capacity Act 2005 (MCA) were followed.

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 to 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). Senior staff had submitted deprivation of liberty applications to the local authorities for people who had limitations of their freedom in place to keep them safe. Some authorisations were approved some were still waiting for approval; however staff and the manager ensured that these limitations were at least restrictive as possible.

Assessments in relation to people's capacity to consent to care and treatment were completed and regularly relieved. In case people had capacity staff respected their choices and decisions even if it involved a level of risk for the person. For example we found that one person had been assessed by the speech and language therapist (SALT) to use a thickener in their drinks to minimise the risks of fluids getting into the person`s lungs. The person had refused to have their drinks thickened. Staff had informed the relevant health care professionals about the person`s decision, they had discussed and documented the risks with the person to ensure the person could make this decision based on the facts and that they understood the level of risks involved. The person told us, "They [staff] explained the risks to me and I will take the thickener when I think I need it. At present I don't."

People who were assessed as lacking capacity in making decisions had best interest decisions in place. We saw that the manager followed a best interest process and they took into account the views of health and social care professionals as well as family and friends involved in the person`s life. They also challenged families views if they felt decisions were not in the person`s best interest. For example we saw a person who we observed during the previous inspection being restrained for 45 minutes whilst staff were helping them to eat. We were told at that time by staff that it was the person`s family member who had agreed to that practice to ensure the person had enough food and drinks. At this inspection the person`s family member told us they had a discussion with the manager about this practice and they now understood why it was not in the person`s best interest. We saw staff supporting this person in a non-restrictive way. They gave them food and drinks every time they sat down and respected their need to walk around when they wanted too. This meant that staff respected people`s choices and supported them through their decisions.

Staff demonstrated a good understanding of their responsibility under the MCA, and described how they offered simple choices to people day to day to promote their right to choice, independence and freedom. One staff member said, "Even if a person is assessed as lacking capacity it is our [staff] responsibility to give them a choice and ensure we obtain their consent before we deliver care." They continued, "Some people will tell us `No` straight away when we ask them about personal care, but if we [staff] go in with a cup of tea and give them five minutes the `NO` changes to a `Yes`." This approach demonstrated that staff had a good knowledge about people in their care and were able to obtain their consent to the care which was in their best interest.

At the last inspection we found that people were not supported effectively to have a pleasant meal experience. Staff assisting people were standing up talking amongst each other and assisting people in an un-caring way. At this inspection we found significant improvement. Meal times were pleasant and un-rushed. Staff put background music on; tables were presented well with tablecloths, glasses and cutlery. People were offered a visual or verbal choice of food and drink. Staff assisted people to eat sitting next to them at same level. We observed a good level of interaction from staff including physical touch to reassure people.

We saw a person being assisted to eat by a member of staff. The person was sat in a lounge chair, but the staff member got down on their knees so they could assist the person from a comfortable height and angle. Food looked appetising and people were offered second helpings, one person who was not eating was offered an alternative, the staff member told us they knew what the person liked.

However people had different views about the quality of the food provided. Some people told us the food was not always hot enough or cooked to their liking. Choices were offered however they felt these were not appropriate for main meal choices. For example if people didn't like the roast dinner they were offered a sausage roll as alternative. People also gave us examples when they requested an alternative which was on the menu however it was not available when they asked for it. One person told us, "The food is not good at times. It is not enough choice and if it is not appropriate choice for a main meal." Another person said, "There is limited choice at the weekends, alternatives are not always available."

The manager told us that mealtimes observations had been completed by a consultant working at the home. The consultant looked at staff interaction with people at mealtimes, the support people received and people's reaction to the food provided. They identified that people were not always happy with the choices available and a food forum was being set up to be led by people with support from staff and relatives. This was still an area in need of improvement.

People were weighed regularly, if it was required, and when there had been issues identified such as weight loss, the staff had sought support and guidance from a dietician. Risk assessments included information to guide staff on how to support people who were at risk of not eating or drinking enough.

People and relatives we spoke with told us that people`s needs were met by staff. All regular visitors and people knew staff by their names. Some people and relatives were disappointed in the high number of agency staff who in their opinion were not as dedicated and knowledgeable as the permanent staff. They told us the difficulties they encountered at times were with agency staff who were not in the home regularly. However, these were minor issues and could be dealt with by contacting another member of staff. One person told us, "They [agency staff] don't always know how we like things done and that can be frustrating at times."

Staff told us the new manager encouraged them to participate in a varied training programme. There were

regular training sessions scheduled for every week and staff names listed who were expected to attend the training sessions. One staff member told us, "The quality of the training has improved, the manager is asking us what training we would like to do or what we need."

There was a comprehensive training schedule for newly employed staff and also refresher training sessions were provided for other staff members. Newly employed staff told us they had induction training before they started working with people. They also shadowed more experienced staff until they felt confident and familiar with the job requirements. Training topics for staff included, manual handling, safeguarding, dementia training, infection control, medication and health and safety. One staff member told us, "New staff are already trained when they come on the units to shadow us. This is really good because they have a good understanding about the job and they only need to learn the practical side."

Staff told us they had annual appraisals of their performance and they received support through bi-monthly one-to-one supervisions. Records confirmed there was a clear structure for supporting and supervising staff. One staff member told us, "We are getting more support now since the new manager came." Another staff member said, "We have now a team leader on each unit in addition to the nurses and the manager is always around when we need them. They [manager] are amazing."

We found that nursing staffs knowledge across the units was not consistent. On one unit the nurse in charge was very knowledgeable about people`s nursing needs and the documentation they were required to complete following treatments they administered. On another unit the nurse in charge was not aware of documentation regarding people`s nursing care and they were limited in their nursing duties due to the lack of training and skills. For example we asked them if any of the people on their unit had wounds and required wound care and dressings. They told us there was nobody on the unit who required this. We observed a person who had two dressings one on their arm and one on their lower leg. The nurse had no knowledge about these. We asked about the wound care plan and they told us they were not aware of any wound care plan. We showed them a blank one and they told us they never saw those documents before and that they were not skilled to apply or change dressings or to take bloods from people. They told us nurses from other units had to do those.

The nurse who applied the dressings for the person recorded in their care plan however they had not initiated a wound care plan or indicated how often the dressings should be changed. The last entry we found that indicated that the dressings had been changed was the 25 April 2016. This was very poor practice as all wounds should be assessed and records kept of measurements, treatment and progress in a clear format so that staff can easily find the information of when dressing changes are required. We were concerned that a nurse in charge on an elderly care unit was unable to do any wound care. We have talked to the manager about this who told us they had already identified this issue and discussed with the provider who agreed to contract a clinical trainer. The clinical trainer will evaluate the competence of the nursing staff and training needs. They will also deliver specialist training to nursing staff and regular updates and re-validation workshops to help ensure that nursing staff acquired the skills required to meet people`s needs. This was an area which required improvement.

People and relatives told us that staff involved health care professionals in people`s care if there was a need for it. We saw evidence in people`s care plans of regular GP visits, occupational health therapist and SALT team involvement in people`s care. People had regular visits from a hairdresser; chiropodist, dentist and optician to ensure their health needs were met.

Good

Is the service caring?

Our findings

People and relatives praised the staff at the home. They told us that staff attitude had changed and that the home was a happy place. One person said, "Staff are nice and patient." Another person said, "I cannot believe the change in attitude staff had recently. They [staff] seem happy and we are happy." Relatives also commented how significant the improvements were in staff morale and that this made staff more relaxed patient and kind towards people. One relative told us, "Very good and caring staff." Another relative said, "I can't praise them [staff] enough. It's improved so much. The place has really come alive"

On the day of the inspection, we observed staff giving care and assistance to people. They were kind and caring in their approach to people. Staff were smiling and showed respect when talking to people and visitors. Staff were open and courteous towards the inspection team and approached us to tell us about people in their care. One staff member told us about a person who we heard shouting from their bedroom. They told us, "[Person] is lovely. Time to time they will shout because they want to know if we [staff] are around." We saw during the day staff went in the person`s room just to give reassurance and let them know they were around.

Staff told us they were enjoying their work and they were fond of the people in their care. One staff member told us, "I love working here, when I go home I know I have done the best I can to make a difference." Another staff member said, "I love coming to work because of the people here, I am proud of what I do, we work really well as a team."

People and relatives told us they were involved in the planning and reviews of the care and support they needed. We saw that care plans were updated and where people had capacity to do so they signed their care plan. For example we saw that the manager had a discussion with a person about their care plan. The person read the care plan and asked the manager to change the plan where they felt it did not entirely reflect their preferences. We saw that they signed their care plan when this had been done.

Where people lacked capacity the care plans were done in their best interest and in consultation with family or relevant representatives. One relative told us, "[Person] is very complex but they [staff] cope very well, I am involved in [person's] care."

People were encouraged and supported to maintain and develop relationships that were important to them, both at the home and with family and friends. For example, we saw that staff welcomed visitors and facilitated visits by ensuring visitors had somewhere to sit, they were offered drinks and a quiet place to talk if they wanted. One relative told us, "I like coming here, it is a happy place, and I feel very welcome."

Care files and other information about people's medical histories and personal information was kept securely and people's confidentiality was maintained.

Requires Improvement

Is the service responsive?

Our findings

People`s care plans were detailed, up to date and provided good information for staff about how to meet their needs, such as maintaining safety, personal care, eating and drinking. However, personal information about people's preferences, dislikes and preferred routines was not consistently clear or detailed enough. The manager told us that they started working closely with families and people to capture more details about people`s likes and dislikes and preferences to incorporate these in people`s care.

At the last inspection four people out of ten we spoke with told us they were bored most of the time and there was nothing for them to do all day. At this inspection we found that most of the people were engaged in some activities around the home. Staff were chatting with people, music was playing, we saw people reading books and magazines and people singing. We saw posters advertising musical entertainments and a pat dog visit.

On the day of the inspection we saw the activity coordinator encouraged people to go outside into the garden to enjoy the sunshine. We saw people outside enjoying tea and coffee with staff and family members. One relative told us, "Staff try hard with activities but sometimes is difficult to engage people. I am pleased they take [person] out in the garden." We observed a `telling stories` session where people shared funny stories from their life. People were engaged and were laughing about funny stories from when they were young.

We talked to a person who told us about the music they liked to listen to. They told us that the manager helped them pursue their passion for music and gave them a lift to a nearby town to buy new speakers. However, we found that the activities were mainly suitable for people who were able to sit or move around. People who could not leave their rooms had limited activities offered to them. The activity coordinators visited them at most twice a week for a couple of minutes chat. We asked a team leader why where so many people being cared for in bed and if this was their choice or if they had a medical condition which prevented them from being out. They told us some people were unable to get out of bed, however they agreed that more work was needed in order to motivate people who were able to get out of bed. They told us they had started a project for people in their bedrooms most of the time to find out what they would like to do and organise activities around this to motivate them to join in.

Where people could verbalise their likes and dislikes we saw their bedrooms were personalised with items they liked, photographs, books, music players. However people without active support from close relatives did not appear to have any personalisation of their rooms, walls were bare, no personal items to trigger memories. This was an area in need of improvement.

At the last inspection we found that complaints had been recorded however there was no evidence that they had been responded to or thoroughly investigated. At this inspection we found that after the inspection on the 14 and 15 January 2016 there was one formal complaint received, however before the new manager has started at the service. The complaint was recorded but there was no evidence that the provider has responded or investigated the allegations. We asked the manger to follow this up and update us about the

outcome of this complaint however we did not receive this information.

People and their relatives told us they knew how to complain however since the new manager had started they only had to mention their concern and they dealt with the problem. One person told us, "My only complaint would be the state of the pond outside." The manager told us they asked the provider to take care of this matter so people could enjoy watching the fish in the pond.

Staff told us there were regular meetings held where they discussed the changes implemented by the manager. One staff member said, "The manager has a consistent approach to everything. They keep us in the loop and discuss changes. It is clearer now what are our responsibilities and what we need to do."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found concerns in relation to safe care and treatment, staffing, safeguarding people, consent, privacy and dignity, person-centred care, meeting nutritional and hydration, receiving and acting on complaints, and governance. At the time of this inspection visit we saw evidence that the newly appointed manager had made significant improvements. People who used the service, staff and relatives spoke consistently highly of the manager. Staff told us that the manager worked alongside them and gave valuable guidance and support.

When we spoke with the manager they demonstrated a good knowledge of the service and the areas that still required improvements and explained their vision and plans to address these areas. However, the systems required to sustain and continue the improvements were not sufficiently developed to make sure that the quality of service was maintained and risks to people managed. The manager explained to us that they regularly worked excessive hours to make sure that people were safe and receiving good quality care whilst the systems to monitor, support and manage the quality of the service were being developed. However, following our inspection visit we were informed that the manager had left the service and the provider informed us of the temporary arrangements that they had put in place to manage the service.
At the last inspection we found that people's care records had been reviewed by staff regularly, however the information contained in them was not detailed enough around people`s mental capacity, mobility needs or person centred care. Daily care records were not completed accurately with unexplained gaps in observation records.

At this inspection we found that care plans had been updated and the information was up to date and reflected people`s current care needs. Work was being done by the manager and staff in completing `This is me` document for every person with person centred information about their past history, likes and dislikes. We found that observation charts for people such as food and fluid charts had been completed correctly for day time; however we still noted gaps in night time recording. For example, one person had one to one care during the day and staff completed the fluid balance charts every time they offered the person a drink. We reviewed the fluid charts for five days and found that after tea time there were no records of fluids given. The total amount of fluids taken by the person over a 24 hour period was not totalled by staff. This was evidence of poor recording and an area in need of improvement.

The last inspection also identified that there were no effective systems in place to monitor staff competence and skills to carry out the tasks required of them, and as a result we had seen staff practice that had placed people at risk of harm. At this inspection we found that staff competencies were monitored by care team leaders, deputy manager, clinical lead and the manager. The training provided was done by an external training provider and staff told us the quality of the training had improved. The manager had identified the lack of skills and experience the nursing staff had and they discussed with the provider the need of a clinical trainer position to ensure a qualified and competent person was provided to improve this.

The manager delegated auditing responsibilities to the deputy manager, clinical lead and team leaders to ensure they were empowered and accountable for the audits they done. For example the deputy manager

was responsible for auditing medicines. The clinical lead was responsible to audit care plans. We saw that team leaders delegated simple audits and checks to staff working on the units. For example we observed a staff member in the morning checking the airflow mattresses people used to check that they were at the correct settings and in good working order. We heard the staff member report to the team leader that all checks had been done and that for one person they had adjusted the settings after checking the person`s weight and recommendations of the mattress settings. We found notes and recordings done in care plans by the manager following their own assessments and audits carried out on the units. This practice ensured that staff and members of the management team worked collaboratively to meet people`s needs and help keep people safe at all times.

People, staff and visitors spoke highly about the new manager. They told us since the manager had worked at the home care practices had improved, people were safe and staff morale had improved which made the home a `happy place`. One relative told us, "[Manager] really cares. They care about relatives as well as residents. They were so good when [person] was in hospital." Another relative said, "I met the manager and I am quite impressed. They really care for people." A staff member told us, "[Manager] is amazing, they are very different to previous managers we had. They are visible on the units and always around when we need them." Another staff member said, "The manager is like a breath of fresh air; they are here for the residents and often works the floor. They are very supportive. "

We observed the manager walking around the units, talking to people, staff and visitors. We found that despite the short period they had been manager in the home they had a very good knowledge about people`s needs. They were supportive towards staff and practiced an open door policy. One staff member told us, "[Name of the Manager] told us their door is always open, however they are never in their office. We don`t have to go to ask anything, they will be on the floor with us so we can ask for guidance and help when we need it." Another staff member told us, "I really like [Named new manager] they really made a difference, very easy to talk to. They really care about the residents." We found that this practice motivated staff and made them feel acknowledged and valued by the new manager.