M S Ali

Marine View Rest 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 5 April 2016 and was unannounced.

Marine View Rest Home provides accommodation for nineteen people who need support with their personal care needs. On the day of our inspection there were thirteen people living in the home. One person was living with dementia and another had a neurological condition. The home is a large property, spread over three floors, with a communal lounge and dining room.

The service had a manager who was also the registered provider of the home. A registered provider is a '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.

Risk assessments had been undertaken for most risks. They considered people's needs and abilities as well as hazards in the environment. People were encouraged and enabled to take positive risks. People's independence was not restricted through risk assessments, instead risks were assessed and managed to enable people to be independent. However, not all risks had been assessed. For example, a bed rails risk assessment was not in place to enable the provider to ensure that the least restrictive option had been considered and to ensure that bed rails were the safest method to use. One person used an air mattress to minimise the effects of pressure damage to their skin. However, appropriate mechanisms were not in place to monitor the setting of the mattress to ensure that it was correct and suitable for the person, therefore potentially increasing their risk of skin breakdown. One person administered their own medicine. The provider had not ensured that a risk assessment was in place to identify and mitigate the risks this may have created.

People were positive about the leadership and management of the home. One person told us "The manager listens to me, they are as straight as a dye." There was a positive culture within the home. There was a relaxed, homely and friendly atmosphere which complied with the provider's aims and was embedded in staff's practice. However, there were minimal mechanisms in place to gain feedback to enable the provider to monitor the quality of the service provided and drive improvement. Records had not always been updated to evidence the good practice carried out by staff. For example, care plans were reviewed on a monthly basis but no changes in people's conditions were recorded in the monthly reviews. Staff had taken appropriate action to ensure that people's needs were met but had not documented this to inform other staff of their actions and to ensure that staff were provided with up to date information about the person's care.

The lack of risk assessments for some practices and the insufficient monitoring of equipment to ensure that it continued to meet people's needs meant that some people's safety was potentially at risk. The lack of detail in monthly review records meant that staff were not provided with up to date information on people's conditions. Minimal quality assurance processes did not enable the provider to monitor the quality of the service and take appropriate actions to drive improvement. These are areas in need of improvement.

There were sufficient numbers of staff to ensure people's needs were met and their safety maintained. People were safeguarded from harm. Staff had received training in safeguarding adults at risk, they were aware of the policies and procedures in place in relation to safeguarding and knew how to raise concerns. People felt safe, one person told us "There is always someone around if you need help."

People received their medicines on time and told us that if they were unwell and needed medicines that staff provided these. One person told us "I have a medical condition. They give me medication, I have to wait until it kicks in and then I feel very safe." People were asked for their consent before being offered medicines and were supported appropriately. There were safe systems in place for the storage, administration and disposal of medicines.

People were asked their consent before being supported with anything and were encouraged to make their own decisions, enabling them to live their lives how they chose to. People had access to relevant health professionals to maintain good health. Records confirmed that external health professionals had been consulted to ensure that people were being provided with safe and effective care. People's health needs were assessed and met and they received good health care to maintain their health and well-being.

People could choose what they had to eat and drink and told us that the food was good. For people at risk of malnutrition, appropriate measures had been implemented to ensure they received support from relevant health professionals and that their foods were fortified to increase their calorie intake.
The provider had a complaints policy. People and relatives felt that the provider was approachable and were confident that if they were to raise concerns that these would be listened to and acted upon.

People were treated with dignity, their rights and choices respected. Observations showed people being treated in a respectful and kind manner. People's privacy was maintained. When staff offered assistance to people they did this in a discreet and sensitive way. People confirmed that they were treated with dignity and their privacy maintained. One person told us "They attend to your every need and treat you with dignity and respect."

Staff knew people well. Support was provided to meet people's needs, preferences and interests. There were minimal organised activities. However, people preferred to choose how they spent their time. Some people chose to access the local community and enjoyed visits to friends and local shops. Others preferred to spend time in their rooms reading newspapers, watching television or playing musical instruments. People were able to make suggestions as to how they wanted to spend their time and these were listened to and respected.

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 home was not consistently safe.

Most risk assessments identified potential risks and measures had been taken to minimise these to ensure people's safety. However, some risk assessments had not been completed and had failed to identify potential risks.

Best practice was not consistently being followed. Pressure relieving mattresses were not monitored to ensure that they were suitable and therefore people were at risk of further pressure damage.

There were sufficient numbers of staff to ensure that people were safe. People were cared for by staff that were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

People received their medicines on time, these were dispensed by staff that had received the relevant training and there were safe systems in place for the storing and disposal of medicines.

Is the service effective?

Good

The home was effective.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

People were asked their consent before being supported. The provider was aware of the legislative requirements in relation to gaining consent from people and had worked in accordance with this.

People were happy with the food provided. They were able to choose what they had to eat and drink and were provided with support according to their needs.

Is the service caring?

Good

The home was caring.

People were supported by staff that showed genuine warmth. Positive relationships had developed and there was a friendly, homely atmosphere.

People felt at ease and able to express their needs and views about the care they received and the home itself.

People's privacy was maintained. They were treated with respect and dignity by staff who were compassionate and understanding.

Is the service responsive?

Good

The home was responsive.

People's individuality was respected. They received personalised care and had their needs assessed and met.

People could choose how they spent their time and the interests that they pursued.

People felt comfortable and at ease with staff. They felt able to raise any concerns in an informal way and were confident that they would be listened to.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

People were positive about the leadership and management of the home. However, feedback from people and their relatives was not gained or used to improve the running of the home.

Records were not always updated to show the good practice that staff had undertaken in relation to people's care.

There was a positive culture within the home. There was friendly and relaxed atmosphere and people were at the centre of their care.

Marine View Rest 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 took place on the 5 April 2016 and was unannounced. The inspection team consisted of 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.

On this occasion we did not ask the provider to complete 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. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with six people, two relatives, four members of staff and the provider (who was also the manager.) After the inspection we contacted a professional who visited the home on a regular basis. We reviewed a range of records about people's care and how the service was managed. These included the care records for four people, medicine administration record (MAR) sheets, staff training and support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining areas during the day. We also spent time observing the lunchtime experience people had and the administering of medicines.

The service was last inspected in January 2014 and no areas of concern were noted.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe and that the staff that supported them made them feel this way. Another person told us "Staff are very attentive, this is what contributes to the sense of security." One member of staff told us "We try to provide a safe home from home." However, despite these positive comments, we found areas of practice in need of improvement.

Suitable measures had been taken to ensure that people were safe but their freedom was not unnecessarily restricted. There were generic risk assessments for the environment as well as person-centred risk assessments that were tailored to most people's individual needs and abilities. One person spent most of their time in bed. The provider had installed bed rails on the sides of the person's bed to minimise the risk of the person falling out. Bed rails are implemented for people's safety but do restrict movement. Staff confirmed that the person had consented to the bed rails being in place. However, there was no documentation that confirmed this or any risk assessments in place which considered the risk, what could go wrong and how to eliminate the risk. Bed rail risk assessments should also consider if any least restrictive options have been considered, such as a low profile bed or crash mats.

For the same person, measures had been taken to reduce the risk of pressure damage. The person had been assessed by a district nurse and required the support of an air mattress (inflatable mattress which could protect people from the risk of pressure damage) as they had been assessed as high risk of skin breakdown (pressure ulcers). When receiving care on an air mattress, it is important that the setting of the air mattress matches the person's weight. Otherwise, it may increase the risk of a person sustaining skin breakdown. Staff told us and records showed that the person's skin damage had improved and therefore they no longer needed to be monitored by the district nurse. Records showed that the person had last been visited by the district nurse six months ago. During this visit the district nurse had checked the mattress to ensure that it was in- tact and at the correct setting. However, the mattress had not been checked since this visit to ensure that it remained at the correct setting for the person's weight. The failure to monitor and record the mattress settings could potentially place the person at risk of pressure damage. We have identified these as areas of practice that need improvement.

The provider had demonstrated good practice and promoted independence by enabling a person to administer their own medicine. The National Institute for Health and Care Excellence – Managing Medicines in Care Homes, states 'Care home staff should assume that a resident can take and look after their medicines themselves, however, an individual risk assessment should be completed to find out how much support a resident needs to carry on looking after their medicines themselves.' It advises that risk assessments should include the person's choice, if self-administration poses a risk to the person or others, if the person has mental capacity and the dexterity to take their medicines, how the medicines will be stored and how often the risk assessments needs to be reviewed. There was no risk assessment in place for this person. The provider had not taken sufficient measures to ensure the person's safety when taking their medicine. We have identified this as an area of practice that needs improvement.

Risk assessments were based around the person's interests and the activities that they wanted to pursue.

Observations showed people, who were able, leaving the home as and when they chose. Staff told us "People come and go as they want." Another member of staff told us "We do risk assessments to make sure people are as safe as they can be but we don't restrict people." One person, who liked to go out late in the evening and return home in the early hours of the morning, had a risk assessment that had been designed to enable them to continue to do this. Care plan records for the person stated 'I know that I am at risk every time I go out, due to my mobility and because I like to stay out late at night. I am potentially at risk from other people, especially if they've been drinking.' The provider had recognised that the person was able to make their own decisions and had identified and assessed the potential risks, recognised the likelihood of them occurring and identified the measures that needed to be taken to minimise them. To person was encouraged to carry a mobile phone with them as well as a card stating their address and telephone number, in case they needed support to get home.

Care plan records and risk assessments for another person, who smoked, showed that the provider had considered the risks to the person as well as other people. An agreement between the provider and the person had been incorporated into the person's risk assessment to inform staff. It advised staff that the person had agreed to go into the garden to smoke and had agreed that staff would store their cigarettes and lighter so as to remind them not to smoke in their room or in the building. Smoke detectors were installed in the person's room as well as a sign stating 'no-smoking' to further remind the person and safeguard people.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked with the Disclosure and Barring Service (DBS) and their employment history gained. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Identity and security checks had been completed and their employment history gained.

There were sufficient staff to ensure that people were safe and cared for. People told us there were enough staff on duty to meet their needs and observations confirmed this. One member of staff told us "There are enough staff, everybody has fixed shifts but we do move them around for holidays and sick leave." Another member of staff told us "There aren't many residents at the moment so we don't need as much staff, but that would go up if we get more residents." The provider did not use a formal dependency tool to assess the staffing levels to meet people's needs. Instead, ongoing informal assessments were undertaken to identify people's needs and inform the support and number of staff required to meet people's needs. A relative told us "My relative is safe and secure because there is always someone here and that gives them a sense of security."

When people required assistance staff responded in a timely manner. People had access to call bells in their rooms so that they could call for assistance if needed. People told us that staff responded to the call bells quickly. Observations and records confirmed this. People confirmed that staff were always there if they needed help or support. One person told us "There is always someone around if you need help." Another person told us "If I need help here, they come right away." Accidents and incidents that had occurred were recorded and action had been taken to reduce the risk of the accident occurring again, for example risk assessments had been updated to reflect changes in people's needs or support requirements.

Staff had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were safeguarding adults at risk policies and procedures. These were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being. One member of staff told us "I would speak to a colleague if they weren't treating someone well, but I'd still report them to the manager." Another member

of staff told us "I'd go to the CQC if my manager didn't do something about it (an incidence of abuse)." Staff confirmed to us that the manager operated an 'open door' policy and that they felt able to share any concerns they had in confidence.

People were assisted to take their medicines by staff that had undertaken the necessary training. Observations of people being supported with their medicines showed that they were asked for their consent. Safe procedures were followed when medicines were being dispensed. For example, people's identity was confirmed prior to the medicine being dispensed. People were also supported to have their medicines one at a time to ensure that mistakes were minimised and that the correct person received the correct medicine. People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the provider's policy for the administration of 'as and when' required medicines. People confirmed that if they were experiencing pain that staff would offer them pain relief. One person, who was able, had chosen to administer their own medicine.

Each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. One person told us that they had medicine for their health condition, they told us "I have a condition that I take medicine for, the staff give me medicine sometimes and I have to wait until it kicks in, then I feel very safe."

Good

Is the service effective?

Our findings

People told us that the care they received was effective, that staff were good at their jobs and that they were happy with the care that was provided. When asked if the service from staff was effective, one person told us "The Staff are great, they're here twenty-five hours a day!"

Most staff had worked at the home for many years. The provider had introduced the Care Certificate for new members of staff. The Care Certificate is a set of standards that social care and health workers should work in accordance with. It is the new minimum standards that should be covered as part of the induction training of new care workers. Staff had undertaken essential training such as safeguarding and health and safety, as well as training that was specific to the needs of the people they were supporting. For example, pressure area care, oral health and principles of dementia care. Observations and people's feedback confirmed that the skills and knowledge of staff had a positive impact on people's experiences.

An external professional, who provided training for staff, told us "Often during training I would inform the staff of changes that may have occurred, documentation requirements that have changed or changes in guidance and legislation. The Management team always appeared to take on board what I had said and made plans to implement the changes. For example, person-centred care plans. The attendance at the training sessions are very good, most sessions have full attendance by all staff, as well as the manager." Records and staff confirmed that they kept their knowledge and skills up to date by undertaking training. One member of staff told us "We don't even have to ask, it is organised for us by the manager and we do it."

People were cared for by staff that had access to regular support and guidance. The provider used an external organisation to conduct regular supervisions and appraisals. The provider explained that this had been arranged to ensure that staff felt able to talk openly and freely during their supervision meetings. Regular meetings took place between the provider and the external organisation to ensure that the provider was aware of any issues that they needed to address. Staff felt well supported and told us that the system worked well. One member of staff told us "It's good because I can say what I want in confidence. It's better that we can speak to someone not involved day to day." Another member of staff told us "The person who supervises us meets with the manager on a regular basis to deal with issues. It's done in confidence and they never say who said what, it works really well."

Staff handover meetings provided an opportunity for staff who had been working during the previous shift to provide information about people's needs to staff working during the following shift. Observations confirmed that information related to the needs of people was passed onto staff and they were made aware of any changes in people's condition or needs. Staff told us that these meetings were helpful to them as it provided them with information so that they could ensure that people's care was consistent and effective. Observations showed that information was passed on effectively. For example, one person had experienced pain and had been supported to have some pain relief earlier in the day. This information was provided to the member of staff coming on shift and they were informed what time the person could have some more pain relief, if they should need it. This ensured that staff that worked with people were aware of their current needs and were therefore able to provide effective, consistent care.

People's communication needs had been assessed and met. One person's care plan informed staff of the person's preferred communication methods, as due to their neurological condition they had difficulties communicating. These included ensuring that staff faced the person so that they could lip read, it also advised staff to be patient when the person was trying to communicate their needs. Observations confirmed that staff were aware of this person's needs and they were able to interpret their communication effectively. They explained their actions before offering any support and ensured that they faced the person when communicating with them. Staff also demonstrated patience and enabled the person time to express themselves and communicate their needs. People were encouraged to communicate with one another. Observations in the dining room and communal lounge showed that people enjoyed having conversations with one another. Staff encouraged this by engaging in conversations with people about their interests and their plans for the day, contributing to a friendly and relaxed atmosphere.

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).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. People living at the home all had capacity to make decisions. Staff had completed training on MCA and DoLS and showed a good understanding of the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. One member of staff told us "It's about knowing our residents, we have one person living with dementia who is still safe to go out alone. They might say "I'm going out" without knowing it's pouring down outside. We'd suggest that they wait for an hour and they are okay with that. In that way we're not restricting them but we're keeping them safe."

People's health needs were met. People received support from healthcare professionals when required, these included GPs, chiropodists, consultants, district nurses, opticians and social workers. People told us that if they were unwell, staff recognised this and they were able to see a Doctor. One person told us "I can't reach my toes so the chiropodist comes to cut my nails on a regular basis and I go to the opticians if I need to." One person, who spent most of their time in bed, had a history of pressure sores. Records showed that the person had been visited by a district nurse and had received appropriate treatment. Another person, who had lost weight in the past, had received support from a dietician. The person had been provided with a nutritional plan, which included the fortifying of food to increase calorie intake. Staff had supported the person to follow this and as a result the person's weight had increased and they no longer needed to follow the nutritional advice.

People were happy with the quantity and choice of food available. One person told us "The food is very good, we can choose from a menu, I like everything." A relative also agreed that the food was good and that that their relative enjoyed it. People could choose where they ate their meals, most choosing to eat in the main dining room whilst others preferred to stay in their rooms. People had a positive dining experience, we observed people engaging in conversations with one another over their lunch. Food was presented nicely and people were asked if they'd like condiments to season and flavour their food. One person preferred to eat their meal at a different time to other people. The provider had respected this. The person was able to eat their meal at their preferred time, they did not like the choice of meal and requested an alternative. Staff asked the person what they wanted to eat and this was prepared for them. Care plan records for one person

stated that the person required a glass of juice when they had their meals to assist them to digest food. Observations confirmed that they received this. Another person was supported to have their lunch whilst they were in bed. Staff supported the person appropriately, ensuring the person was positioned in such a way to aid digestion. They explained what the meal was and demonstrated patience, enabling the person to eat at their preferred pace.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Observations of people being supported by staff showed genuine warmth and compassion. People told us that they were happy with the support provided by staff and that they were well cared for. One person told us "The staff are as good as gold."

There was a friendly, relaxed and homely atmosphere. People appeared to be happy and were cared for by staff that appeared to know their needs and interests well. Observations showed that genuine relationships had been developed and there was a kind and caring rapport between people and staff. Staff were observed asking people how they were, how their day had been and how they were feeling. One member of staff confirmed that staff knew people well. They told us "This is their home, we know the people really well, most of the staff have been here years." In a card sent to staff by a relative, it stated 'Thank you for the kindness, care and attention you showed my relative, it gave me peace of mind knowing they were looked after."

People told us that staff treated them with kindness and that they chose the home because of this. One person told us "Before I came here to live I was a painter and decorator. I painted every care home in this area, so I know this is the best. I am so pleased I came here." Another person told us about the efforts staff made when there were special occasions or celebrations. They told us "They are very caring. On my birthday they asked people to go to the lounge and we had a cake and a tea party." A professional who visited the home told us "I have witnessed staff interacting with people, they have always had a friendly, caring manner, appropriate to the person."

People's differences were respected. Staff adapted their support and approach to ensure people were treated equally, yet had their differences respected. People of different ages and abilities lived at the home. The provider ensured that each person was treated as an individual and that they were able to live their life how they chose to. For example, one person, who was younger than other people who lived in the home, was encouraged to maintain their social life. The person liked to go out in the evenings and meet friends and would often return to the home in the early hours of the morning. The provider respected this person's right and ensured that they adapted their support and the environment to accommodate this. For example, care plan records for this person showed that the person was able to choose what time they came home and that staff who were working during the night would be aware that the person was out and would ensure that lights were left on to ensure the person could find their room once they returned.

One person's care plan records contained information about their sexuality. The person had been encouraged to discuss this, if this is what they wanted, and had been advised that staff were there to support the person if they needed it. Another person told us that they sometimes liked to have an alcoholic drink. They told us that they respected the attitudes of the manager and staff as they were aware that their religious beliefs differed from their own. They told us "I'm able to have a drink, I really respect that as I know that their religion does not condone this, however I am still able to have a drink when I want one."

People were treated with respect. They were involved in their care and told us that staff listened to them. The provider's aim was to create a homely atmosphere, rather than an institutionalised feel. Staff told us

that regular resident meetings did not take place, that feedback from people had shown that people preferred a more informal approach to making their thoughts and opinions known. People and observations confirmed this. Observations showed that people felt comfortable and able to raise any issues or suggestions, that there was a culture that ensured people felt at ease. One person told us "If I'm not happy about anything or I want anything to change I can talk to any of them, they listen to me. The manager is as straight as a dye." Care plan records showed that people had been consulted about their care and the support that they required. When people required additional support to voice their opinions and needs, appropriate referrals to other professionals, such as social workers, had been made.

People were treated with dignity and their privacy maintained. In the provider's statement of purpose it stated 'We give help in intimate situations as discreetly as possibly." Observations confirmed this and showed staff treating people with dignity and respect. For example, when staff were supporting one person, who spent most of their time in bed, they ensured that the person was treated with dignity when providing assistance with their personal hygiene and when supporting them to eat and drink. One person told us "They attend to your every need and treat you with dignity and respect."

People confirmed that staff respected their privacy and our observations confirmed this. Staff knocked on people's doors and waited for a reply before entering people's rooms. They asked people what they needed support with and explained their actions. One person told us "They knock on the door and ask for your consent before they do what is required." Staff told us that this was something that they always respected. One member of staff told us "We always knock before we go into people's rooms."

In the provider's statement of purpose, it stated 'The home is aware that people give up a great deal of their independence when entering a group living situation. We can help by maximising the abilities of the person to retain self-care and independence and carrying out tasks unaided.' This was embedded in practice. People were encouraged and enabled to be as independent as they wanted to be. Care plan records for one person stated '(The person) is able to maintain an independent lifestyle. They are aware that their circumstances will change in the future, however is encouraged to be as independent as possible and maintain a good quality of life, which they are still in control of.' Observations confirmed that the person was encouraged to be as independent as possible. The person was able to access the community whenever they chose to, enjoying accessing shops and visiting friends. Observation of other people showed that they too were able to access the community whenever they chose to, enjoying walks along the seafront and visits to local shops.

People who were unable to leave the home, due to their abilities, were still able to be independent. Care plan records for one person stated that the person needed assistance with getting in and out of the shower, however could maintain their personal hygiene themselves. Daily care records showed that the person had been supported to get in and out of the shower and this was further confirmed by the person. Care records for another person stated that the person was able to use the stair lift to get down the stairs but that they needed to have a walking frame near to the stair lift so that it was ready for them to use. Observations showed that staff had positioned the person's walking frame by the stair lift, enabling the person to independently travel down the stairs and then walk around the ground floor of the home without staff assistance. People confirmed that they were able to be independent. One person told us "They use their common sense, they do things for you, but let you do it yourself, if you are capable." Another person told us "I can go out alone, when I first moved in I had to be accompanied, but now they know I am safe." A relative told us how staff enabled their loved one to still be independent. They told us "They can take control of situations and make choices themselves."

Good

Is the service responsive?

Our findings

People were cared for in a person-centred way. Care was adapted to meet people's needs and preferences and staff ensured that people were at the centre of the care being delivered. Staff told us that they knew each person and what they liked to do. One member of staff told us "We know the residents so well. We know their routines, likes and dislikes etc. Some people like to go out, others like their meals at certain times. We fit around them."

On admission to the home each person had their individual health and social needs assessed and individual care plans were devised to meet people's needs. People confirmed that they had been involved in the development of their care plans and that they contained information that was important to them. Each care plan was specific to the needs of the person and was person-centred. It contained information about the person's likes and dislikes, their interests and hobbies and their past employment history. This enabled staff to have an understanding of the person's life before they moved into the home. Staff explained that they found the care plans useful when providing support to people. People's care was regularly reviewed and any changes to the delivery of care were made as a result. For example, one person had been assessed by a dietician and was being supported to follow a nutritional plan. Care records showed that due to being supported to follow the plan and by regularly monitoring the person's weight, staff were able to recognise that the person's weight had increased and therefore the nutritional plan no longer needed to be followed and was discontinued.

Observations confirmed that people were treated as individuals and received personalised care according to their needs and preferences. For example, one person's care plan contained information on the type of films the person liked to watch. These included films starring Humphrey Bogart or John Wayne. The person told us that they enjoyed watching these films and that staff supported them to put on the films so that they could watch them in their room. Another person's care plan stated that the person liked to read the newspaper each day. The provider had ensured that the person had a daily newspaper and observations showed the person spending time in their room enjoying reading this.

There were minimal organised activities. However, people were able to choose how they spent their time. Some people preferred to spend time in their rooms, watching television or reading, whilst others, who were more independent, preferred to go out for walks or visit local shops or friends. One person told us "I can come and go as I please." The provider minimised the risk of social isolation for people that spent time in their rooms. Observations showed staff spending time with people, enjoying conversations about their interests or the views from their windows. One person, who spent most of their day in bed, had their bed positioned opposite the window as they enjoyed watching the children play in the park and the views of the sea. Observations showed staff spending time with the person talking about the view and the pigeons that the person had seen. The person appeared to really enjoy this conversation and confirmed that they liked to watch the pigeons from their window. Relatives told us that their loved ones were happy living in the home. One relative told us "I come and take my relative out once a month but they are happy enough to remain at the rest home and go out when they want. They have a nice room, they think of it as home and potter in the back garden tending to the pot plants."

People were able to have choice in all aspects of their lives. Observations showed that people were fully involved in decisions that affected their lives. For example, people were able to choose what they had to eat and drink, where they spent their time, if they had male or female carers and what clothes they wore. People told us that it was a "home from home" and that staff supported them to live their lives in the way that they chose to.

The provider had a complaints policy. There had been no complaints since the previous inspection. People told us that they would speak to the manager if they ever had any concerns and that they felt comfortable raising any issues or concerns with all staff. The provider had listened to people's feedback. For example, feedback from people had indicated that they disliked formal resident meetings and that instead they preferred to make their needs and wishes known as and when they had anything to discuss. The provider had listed to this and residents meetings did not take place, instead people felt able to approach the staff and the provider when they needed to discuss anything and were confident that they would be listened to and changes made as a result. One person told us "I can't remember having a residents meeting but the manager is very approachable at all times."

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff felt that the home was well-led. There was a small management team that consisted of the provider, (who was also the manager of the home), a deputy manager and senior care assistants. One person told us "The manager and the staff are very approachable at all times." However, despite people's positive comments, we found areas of practice in need of improvement.

Observations and records of care plans showed that staff were aware of people's needs and had taken relevant measures to meet these. For example, one person's care plan showed that they had received relevant support from a district nurse, the person had received a course of treatment, had access to relevant resources and their health had improved as a result. Another person's care plan record showed that they had received relevant support from the GP and a dietician to address their gradual weight loss. The person had been advised to follow a nutritional plan and staff had supported the person to follow this. As a result the person's weight had increased. However, monthly care plan reviews for these people failed to recognise that the treatment plans had been successful and therefore the recommended treatment be discontinued. Staff were aware of people's changing needs, however, documentation failed to record the good practice undertaken by staff. We have identified this as an area of practice that needs improvement.

People told us that the manager was approachable and listened to concerns and comments that they made. There were some mechanisms in place to audit and monitor practice. For example, audits of medicines management and infection control. However, there were no mechanisms in place to gain people's feedback on a regular basis and effectively assess, monitor and improve quality and safety. We recommend the provider refers to reputable guidance and good practice in implementing a quality assurance system with regards to adult social care residential services.

There was a friendly, comfortable and homely atmosphere in the home. The provider's aims stated 'Our aim is to provide good quality care for all service users. To provide a homely environment which is safe, secure, comfortable and above all enjoyable to people.' Staff had a strong understanding of the provider's aims and confirmed that they implemented the provider's aims when supporting people. One member of staff told us "We try to give people a good quality of life." Observations and people confirmed that they were comfortable and that the home felt like 'their home.'

People and staff spoke highly of the manager, explaining that nothing was too much trouble. Staff told us that they felt well supported and observations showed positive interactions between the provider and staff. The manager appeared to know people well, taking time to speak to people, ensuring that they were happy and asking if there was anything they needed. This contributed to the friendly and relaxed culture of the home.

The provider was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. The provider worked closely with external health care professionals such as the GP and district nurses to ensure that people's needs were met and that

the staff team were following best practice guidance.