Pearlcare (Acle) Limited

The Old Rectory Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 and 20 March 2018 and was unannounced.

At our last inspection carried out on 12 December 2016, we found three breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Health and Social Care Act 2008 (Registration) Regulations 2009. Although some improvements had been made within the areas of breaches, some further improvements were needed.

The Old Rectory is a 'care home' for up to 34 people. The home supports older people, many of whom are living with dementia, across two floors. When we inspected, there were 32 people living in the home. There was one room which was being shared by two people. The rooms had en-suite toilets and sinks, and there were other communal bathrooms with showers and baths on each floor.

People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was a registered manager in post. The registered manager at the home had been registered with CQC since September 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected this service on 12 December 2016, and we found three breaches of regulations. We completed this comprehensive inspection to see if the home had been improved in these areas. At the previous inspection in September 2015, we had also asked the provider to take action to make improvements in respect of the quality of care that was provided to people.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of safe, caring, responsive and well-led to at least good. They had not managed to make all the improvements needed to increase the overall rating of the home. Therefore, we remain concerned that the provider has not implemented effective quality assurance systems in a timely manner to ensure full oversight of the areas previously identified as a concern.

There had been improvements in infection control and the home was clean, and the registered manager completed a further risk assessment needed. There were some improvements required to the oversight of infection control within the home to ensure actions were taken when needed.

We found that risks were not always fully mitigated as far as is practicable because not everyone was able to ask for support from staff. This was addressed shortly after the inspection. Risks to people were covered in

their care plans and there was guidance for staff on how to mitigate risk.

The registered manager had overlooked safeguarding notifications which they sent us shortly after the inspection. They sent these immediately after the inspection. We found that improvements were needed in the systems to assess, monitor and improve the service, as some concerns had not been identified by the provider.

There were effective systems in place for the registered manager to observe whether staff had seen people, however these were not always used to full effect to check that people received care according to their care plans. However, there had been a decrease in falls and people were safer since the electronic care planning system allowed the registered manager to have a better oversight of people in the home.

Medicines were administered as prescribed, and the registered manager had taken action when errors were made. Improvements were needed to the care planning around 'as required' (PRN) medicines, and the registered manager completed these immediately. Improvements were required to ensure the safe storage of the sharps box.

Staff had received appropriate training and there were enough of them to meet people's care needs. However, some people reported waiting a longer time for them during certain parts of the day. The dependency tool did not cover all aspects of staffing required, and did not account for people's behavioural needs and the layout of the building.

Care plans were detailed with people's preferences and care needs, with guidance on how staff should support them. However, we found that people were not always supported as per their care plans with their continence needs.

People had access to a good choice of meals and staff supported them to have specialist diets where needed. There was always a drink available to people and we saw that staff recorded when people ate and drank so that the registered manager could maintain oversight of this.

People were supported to participate in a wide range of hobbies and activities within the home and staff were able to spend time with people who preferred to stay in their bedrooms. Staff were caring and kind, and knew people well.

Relatives and people were involved in the planning of care and the registered manager was visible and approachable. There was good leadership in the home and staff were well supported by the registered manager. They worked well together as a team.

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 were not always able to call for assistance from staff because they did not always have access to a call bell.

Systems were in place to protect people from the risk of abuse.

There were enough staff to keep people safe, however there were concerns around the deployment of staff to respond to people's needs.

Medicines were administered as prescribed. Not all prescribed substances and hazardous items were stored securely.

Is the service effective?

Good

The service was effective.

Staff had received enough training to enable them to provide people with effective care.

Staff sought consent in line with the necessary legislation.

People received enough to eat and drink to meet their needs and were supported with specialist diets where needed.

People were supported with their healthcare needs.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and upheld people's privacy and dignity. They knew people well.

People and their relatives were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff did not always deliver care according to people's needs and their care plans.

People had opportunities to participate in activities which reflected their interests, including one to one time with staff.

People and relatives knew how to complain and any raised were dealt with quickly.

Is the service well-led?

Requires Improvement

The service was not always well led.

At our last two inspections, we have identified that further improvements were required to ensure a consistently good service is delivered. The provider did not always maintain full oversight of the systems in place to monitor and improve the service provided.

Staff were happy working at the home and there was an open culture where staff and people were listened to. The registered manager was visible and approachable.

The Old Rectory Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. Prior to the inspection, the provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters.

As part of our inspection, we spoke with six people using the service, and three relatives. We also spoke with five staff members, including the registered manager, a senior carer, two care staff members and a cook. We obtained feedback from a healthcare professional about the service shortly after the inspection visit. We also looked at four care plans in detail, as well as sections of other care plans, and reviewed a range of records relating to health and safety, and how the service is run.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in December 2016 we found the service was not always safe, and was rated 'Requires improvement' in this area. During this inspection we identified some shortfalls and further improvements were still needed. Whilst improvements had been made in this domain since our last inspection, we found some environmental risks during this inspection.

At our last inspection in December 2016 we found that there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because medicines had not always been managed safely, risks had not always been managed and there were concerns around infection control. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by June 2017. At this inspection in March 2018 we found that improvements had been made. Although we found some concerns related to people's safety, the provider was no longer in breach of this Regulation.

Improvements had been made in respect of infection control, however some further risk assessments were needed. There was one bedroom which was being shared by two people, and risks in relation to infection control had not been assessed. The registered manager stated they would complete these as a matter of priority, which they later confirmed had been done. The service had achieved the rating of five in their latest food hygiene inspection, which is the highest rating awarded. Communal areas were clean, however there were some areas such as shower plugs which required further attention for cleaning, as they had dirt, hair and lime scale stuck in them. The relatives we spoke with told us they felt the home was a lot cleaner since our last inspection. The infection control audits did not always include an action plan, and this would support oversight of improvements in infection control.

Not all people were able to call for assistance from staff when they needed it. This did not demonstrate that risks were always reasonably mitigated. We visited one lounge, which was situated at the end of one corridor. Throughout the two day inspection we saw there were periods of 20 minutes where there were no staff members in this lounge. There were several people sitting in the room who were not able to call for help independently. This was because they had communication difficulties and were not able to reach a call bell, and some were deemed not to have capacity to use a call bell. A relative told us, "I've been here when somebody's needed some help, they might get up, tend to get out of their chairs, and [person] will call the buzzer." One person, whose care plan stated they were at high risk of falls, was sitting in a reclined chair without access to the controls. The inspector asked another person living in the home to press the call bell for the person, as they were asking for help to get up. Staff then came to assist the person. The person who pressed the call bell said they saw staff regularly check the room, and the registered manager assured us that staff checked people in the room at least every half hour.

The falls risk assessment stated that the person sitting in the lounge should have their walking frame within reach, but this had been placed over the other side of the room. This, along with the position staff had placed the chair in, effectively restrained the person. The care plan stated the person must have access to their call bell whilst in their bedroom. There was no care plan in place to guide staff on supporting the

person to call for assistance when in the lounge. We observed that there was no way of calling staff if they needed help, and no care plan in relation to the person consenting to being confined to a chair without a call bell. Only one person could use the call bell in the lounge and they had assumed responsibility for calling staff when someone required assistance in the room. We discussed this with the registered manager as it concerned us that one person living in the home had undertaken this responsibility. The registered manager told us that the person in the chair should have had the chair controls in the chair with them. However, the registered manager did not acknowledge that they may be placed at higher risk of falling as no staff were present in the room, if they repositioned the chair into an upright position and attempted to mobilise. The care plan stated that the person lived with dementia and at times became confused. This presented again a higher risk of the person falling. We were not assured that this was being managed safely. A relative also told us they were concerned at times there were no staff around, as they had seen someone trying to get up who appeared to be at risk of falls. They said they had summoned staff at times. Shortly after our inspection, the registered manager completed a risk assessment for this communal lounge which addressed the issue of people not being able to call for assistance.

We gathered mixed feedback about staffing levels. One person told us, "It's the early part of the morning and after tea in the evening that the staff are busy. [Staff] take me to my room to go to the toilet, and I have to wait." Another person referred to lunch time, "Mealtimes, people who need help, sometimes they have to wait because they haven't got enough staff – it would be a help if there were more staff, definitely." An additional person said, "The [staff] say we'll be with you in 10 minutes, but it can be 20 minutes." Another person told us that there were less staff available at weekends. Staff told us they felt there were enough staff to keep people safe. The registered manager advised that any unplanned absence of staff was covered by existing staff, the deputy manager or registered manager.

It was not clear that the tool used to calculate the numbers of staff required to meet people's dependency needs was fully effective. We found that staff were not always available and present within communal areas of the home. The dependency tool specified that one person living in the home had high needs, which did not reflect what we found when looking at their care plan and making observations. There were four people who required two staff to mobilise living in the home. There were four care staff and a senior on shift during the day. This indicated that if two of these people needed support at the same time, then a third person may have to wait some time for assistance. Furthermore, the dependency tool did not effectively take into account the layout of the home or people's behavioural support needs. There were two floors, and downstairs had a total of four separate communal seating areas, two of which were regularly used by people with different needs. There were also rooms situated along three different corridors downstairs.

We concluded that there were enough staff to keep people safe, however there were not enough staff deployed throughout the home effectively to be fully responsive to people's needs. Improvements were needed in how staff were deployed due to the layout of the home, which meant that at times people were left unattended. The rota reflected the staffing levels we had seen during our inspection and what we had been told about the planned staffing levels. Although we received mixed feedback about staffing levels, we observed staff responding promptly to people's call bells throughout the inspection.

Some risks to people were mitigated. For example, risks associated with people at risk of losing weight, choking or developing a pressure ulcer were mitigated by staff. People were weighed regularly and we saw that when they were at risk of not eating enough, staff had provided diets that helped them put on weight. There was clear guidance for staff within people's care plans about supporting them with risks to their health and safety. A healthcare professional told us they had observed safe manual handling within the home.

The registered manager kept a good oversight of health and safety incidents within the home. The electronic care planning system allowed for this as it transformed data into tables where any trends in incidents could be easily spotted. The registered manager had ensured staff took further action where needed, either to make referrals or to further mitigate risks to people where practicable. The registered manager confirmed to us that the number of falls in the home had decreased since they used the electronic care planning system which meant he could ensure people were checked regularly.

Medicines were administered as prescribed. One person told us, "I have to have certain medicines and I find they are very good here". We looked at all of the medicines administration records (MAR). We checked some stock levels and found that the correct amount had been given. However, the wrong date had been written on the stock count on the MAR so it took some time to establish what stock there should be. We brought this to the senior carer's attention. They told us that the registered manager had already taken action with regards to a staff member who had made mistakes with the MAR and medicines administration. We saw that medicines which carried a higher risk were accurately administered and recorded.

Where people had been prescribed medicines for 'as required' use (PRN), there was not always up to date accurate information available to staff to guide them under what circumstances it was appropriate for people to have these medicines. For some people, there was not enough information written in the care plans to establish how staff would know they needed a PRN medicine. For example, one member of staff described how one person, who was living with dementia and had communication problems, behaved if they were in pain. This information was not in the care plan. Therefore we could not be assured that people always had PRN medicines administered as they required.

The paper PRN protocols remained in a folder in the medicines room. These were out of date and contained inaccurate information. For example, one maximum dose specified on the paper PRN protocol was different to that stated on the MAR. This presented a risk that staff could administer it incorrectly. The PRN protocols were not kept with the MAR, so staff did not have the relevant information in front of them when completing the medicine rounds. The registered manager stated they would update all PRN protocols and replace them back into the MAR, rather than solely in the electronic care plan. They confirmed they had completed this shortly after the inspection.

We saw that where people had topical creams prescribed, body maps were in place to provide staff with guidance on where to apply the creams which would help ensure they applied the creams to the correct area. However, the creams were not always stored securely, presenting a risk to some people living in the home of ingestion or inappropriate use. For example, where two people shared an en-suite, who had variable capacity due to living with dementia, there were two prescribed topical medicines left out in the en-suite. This had not been risk assessed appropriately. We also saw prescribed creams left unsecured in another person's room. This posed a risk that people living with dementia may ingest or otherwise use these inappropriately. The registered manager told us they had ordered lockable cabinets for these the following day. During the administration of medicines at lunch time, the staff member left the doors of the medicine cabinet open whilst walking round and administering individual medicines. This presented a risk of inappropriate use if a person took something from the trolley. We also noted that the sharps disposal box was being stored on a high shelf above head level. The policy stated this should be kept at hip level, and it presented significant risk if it fell from this height.

The MAR front sheets did not all contain the correct information. Whilst they contained information such as allergy information and a current photograph of the person, we saw the Do Not Resuscitate (DNAR) information on the front sheet was not always accurate. The information about whether it was appropriate to resuscitate someone if needed was not always correct. Therefore there was a risk that Cardio Pulmonary

Resuscitation may not be carried out in accordance with the clinician's assessment and people's wishes. The registered manager rewrote the front sheets immediately when we brought this to their attention.

Systems were in place to reduce the risk of people experiencing abuse. All of the people we spoke with told us they felt safe living in the home. Staff had received training in safeguarding adults. They were able to demonstrate to us that they understood what constituted abuse. They were clear on the correct reporting procedures if they suspected that any abuse had taken place. The registered manager had reported any safeguarding concerns to the local authority and had fully investigated them, with action taken as appropriate. For example, when there was an incident between people living in the home which could cause harm, the registered manager had reported this to safeguarding and where appropriate, sought further advice from other healthcare professionals.

We looked at three staff employment records to see what checks had been completed prior to them working within the home. The registered manager had checked with the Disclosure and Barring Service that the staff member was deemed safe to work with people living in the home. Staff had also given references before being employed.

Good

Is the service effective?

Our findings

During our last inspection in December 2016 we found the service was effective, and was rated 'Good' in this area. During this inspection we found that the service remained effective.

The registered manager completed full assessments of people's individual needs before they started using the service. This meant that the resulting care plans were able to reflect people's needs holistically. The areas covered in the assessment included their physical, mental, social needs and future plans.

People told us they felt staff were well trained. One person said, "I always feel confident with the staff". They were referring to their recent use of a stand aid to move instead of a hoist, as they had managed to increase their mobility. Staff told us about the training they received, and the registered manager told us about improvements they were making to the training to include more classroom-based work. The staff received computer-based training in safeguarding, mental capacity and dementia. We received mixed views from them about how effective the training was. Two staff we spoke with felt that the face to face training they received, for example in first aid and manual handling, was more helpful. The staff were organised, calm and capable throughout our inspection, and we observed competent care being delivered.

Staff received regular one to one supervision meetings which provided them with the opportunity to discuss their work, receive feedback on their practice and identify any further training needs they had. New staff underwent an induction period and shadowed more experienced staff for a period of time until they were confident to work with people. New staff were supported to undergo a qualification in care, the Care Certificate.

Staff supported people to have enough to eat, and choose what they wanted. A family member confirmed, "[Person] had a banana, cornflakes and three rounds of toast for their breakfast, they're eating well now". Staff supported people to have the appropriate diet and have healthy balanced meals. We spoke with the cook who had good knowledge of people's needs within the home. This included how to prepare meals for specific diets, such as fortified with extra calories, diabetic and soft or fork-mashable diets.

The meal time we observed was positive. However, we did observe that people received their medicines whilst at the dinner table. This could disrupt their meal and create additional congestion in the room. One person said, "I get my tablets regular, they do come during your meal, but they have to do that otherwise people wouldn't get them".

There were twenty people present, seated around five tables in groups of four. The room was bright and blinds were partially closed due to strong sunlight entering the room. Tables were dressed with linen table cloths, placemats and floral decorations. Condiments were present as were menus, which were unobtrusive and benefited from clear descriptions of the day's choices for all three meals. Drinks had been served to people prior to service commencing, and appropriate music was playing quietly in the background. Staff asked people if they would like to wear a cotton clothes protector, and some people chose to use the paper napkins provided.

We observed that everyone had a drink available to them throughout the day. One person told us, "[Staff] are always bringing me drinks, they do remind me [to drink], yes often". Staff also logged on the electronic records when people had a drink so that the registered manager could readily oversee this information.

Everyone we spoke with was positive about the food served. One person said, "Yes, the food is excellent here, it really is". Another confirmed, "Oh it's lovely food, you get a variety." We spoke with the staff in the kitchen and found they were familiar with each person's dietary needs and preferences. They said if people did not like what was on offer, they were happy to make something different for them. They also made a variety of snacks suitable for people with diabetes so they did not miss out. We saw that a variety of snacks were available throughout the day.

People had good access to healthcare services. One person told us, "They [doctors] come here on a regular basis and are extremely helpful. I know the doctor, and the staff respond, absolutely." Another person said, "The physiotherapist comes once a week, helps with my exercises." A relative said that they felt people were well-supported to attend healthcare, saying, "[Deputy manager] in the office is very good, always helpful. [Deputy manager] keeps all your appointments." A healthcare professional told us that they had visited and found the staff needed more guidance on administering a cream to someone. They said they explained how this should be done, and when they returned staff had taken the information on board, communicated it to other staff and followed their recommendations.

The registered manager told us the service aimed to work with other organisations, and kept regular contact with people's social workers and other health teams where appropriate. During our inspection we saw that the deputy manager communicated well with healthcare professionals who were called in following an emergency.

The environment was made suitable for people, and there were further improvement plans in place. The ambient light throughout the home appeared adequate and there were no dark areas. Floors were level and no trip hazards were encountered and equipment was stored appropriately. Stairways were secured at the top by way of full length keypad operated gates and the lift was freely available for people to use. There were individual door signs which supported people to find their bedrooms and to navigate their way around the home. The smaller of the two lounge areas in use was at the end of the building, and whilst this provided a compact and pleasant seating area in itself, it was somewhat removed from the main body of the home, leaving people and staff with a logistical difficulty.

We assessed whether the service was complaint with the Mental Capacity Act 2005 (MCA). The 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.

There were thorough care plans in place to guide staff on supporting people to make decisions where their capacity was variable. The mental capacity assessments carried out were decision specific, and records showed that people were involved in decisions about their care. We observed many examples of staff asking people for consent.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). There was one person in the home who was deprived of their liberty, and we saw that the least restrictive method was used.

We had one question about a person who was effectively restrained in the chair because they did not have the controls. The registered manager told us this was an oversight and they would ensure the person had the controls in the future.

Good

Is the service caring?

Our findings

During our last inspection in December 2016 we found the service was not always caring, and was rated 'Requires Improvement' in this area. During this inspection we identified some shortfalls and found that improvements were still needed in this area.

We received complimentary feedback about the staff in the home. One person told us, "Absolutely top care, they're kind and thoughtful here." They added, "They made me feel wanted, welcome." A relative confirmed, "The staff all seem very amicable, always very positive."

It was clear that staff built positive relationships with people. A person said to us that they enjoyed speaking with staff, telling us, "Talking to people, it keeps your life going." People felt comfortable to speak with staff, one saying, "I think it's how the people [staff] talk to you, if you tell them there's something wrong they'll soon sort it out for you." One person said staff made them feel more secure going out, saying, "They will always supply me with a helper to go to the hospital, they insist on it, literally." A healthcare professional told us that when they visited the service they found that staff knew people well, including about their personal histories and preferences.

During our inspection, staff were relaxed and friendly, and there was good communication taking place. We observed many positive interactions throughout the day and it was clear that staff knew people well. On one occasion we heard staff adapting their communication accordingly to speak with a person who was disorientated due to living with dementia.

People and their relatives were involved in their care and kept informed. One family member told us, "I know if anything's wrong, [staff]'ll be on the phone to me straight away." Another relative confirmed to us that the registered manager had included them in discussions about their family member's care. The registered manager told us that people, where they were able, chose their key workers. We saw that information about relatives involved in people's care, and whether they had any Power of Attorney for health and welfare, was included in people's care plans.

The relatives we spoke with told us they always felt welcome and could visit any time. One said, "I can have a meal if I want, they always offer me a drink." The registered manager told us they had a flat available for relatives to stay in if they required, for example if their family member was in poor health or if they had travelled far.

The practices within the home largely promoted people's dignity and privacy. However, we noticed that the lunchtime medicines round was taking place in the main dining room where people were seated. It meant that people were being given their medicines in a communal environment and it was not clear that this was their choice. This may disrupt people's meals.

We saw that during the mealtime, staff supported people to be as independent as possible and only provided support to them when required. This was then carried out in a dignified and discreet manner. One

person stated that they enjoyed being as independent as possible, "If they think I'm overdoing it they very politely remind me of my [back] problem and they do try and help me with that". Another person told us, "I usually go down, we go for a walk, into the village. I did at first [using wheelchair], but now I've got this [walking frame], my legs feel a lot better. [Staff] encourage me, tell me I look well." This demonstrated that staff supported people to maintain independence whilst providing reassurance and support when needed.

There was one shared room where we were concerned that the environment did not always uphold the people's dignity because the curtain did not come across fully to protect the person's dignity. The registered manager stated they would replace this following the inspection.

People felt respected by staff, one person said, "I think [staff] do respect me, they do respect what I say, they will listen." The people we spoke with confirmed that staff supported them with their privacy and dignity, for example, by ensuring they were covered properly when going to use a communal bathroom. Staff confirmed they supported people with their personal care behind closed doors. We observed people's privacy being respected whereby staff always knocked on doors prior to entering people's bedrooms. We also observed a member of staff knocking, despite the person's bedroom door being open.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection in December 2016 we found the service was not always responsive, and was rated 'Requires improvement' in this area. Prior to that inspection in 2015, it was also rated 'Requires Improvement' in this area. During this inspection we identified that further improvements were still needed to ensure that people received person-centred care.

At the last inspection, lack of suitable activities and responsiveness to individual needs resulted in a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements would be made by June 2017. At this inspection we found that there was no longer a breach of this Regulation, but that further improvements were still needed to ensure that people received care according to their care plans.

Some people confirmed they chose how they wanted to be supported. One person said, "I always have a shower, I have had a bath but I prefer a shower." A relative confirmed, "It's [person's] choice." People got up and went to bed when they wanted. One person confirmed, "I always get up at half-past eight, they don't make you get up." However, we concluded that people did not always receive the level of care that was planned for them. This was because we looked at records of people being supported to use the toilet and receive personal care. This included managing people's continence needs. Staff did not always deliver this support according to people's care plans. For example, one person who required the assistance of two staff to use the toilet. Their care plan stated they should be offered this opportunity throughout the day. However, they had only been offered this assistance first thing in the morning and last thing at night, according to the records. This was also reflected in four more people's care plans we looked at. For one person, the care plan guided staff to ensure they encouraged the person to be supported to use the toilet in their best interests. There was no evidence that staff delivered this support. Prior to the inspection in summer of 2017, we had also received a complaint around people not regularly being supported to use the toilet through the day, therefore not being supported with their continence needs. This meant people could be subjected to unnecessary discomfort and embarrassment. The registered manager said they had not identified this issue.

We gathered information about whether people and families felt the care provided was fully individualised. One person told us, "[Staff] all seem particularly observant about people's needs". A relative told us, "They replace [person's] hearing aid batteries if I'm not here. What has been good is that they've noticed that their hearing aid batteries are not working."

The care plans recorded information about the person's likes, dislikes, aspirations and their care needs. Care plans were person centred and detailed enough for the staff to understand how to deliver care to people in a way that met their needs and without discrimination. Staff supported people in ways that reflected their wishes.

We observed that people in their bedrooms had call bells present and located within their reach. This meant

they were able to ask for assistance if needed. The registered manager had a system whereby they monitored on the electronic care plan if someone had not been seen for half an hour or more. This meant they could ensure that people were checked regularly. However, it was important that they maintained oversight of the quality of interactions and ensured people were being offered care as per their care plan.

There were person-centred, individualised care plans in place for when people were reaching the end of their lives. This included information about what was important to people at this time, such as family members who they wanted to be involved and whether they would want to go to hospital or stay at the home. There was computer-based end of life training provided to care staff.

People were supported to engage in activities and follow their interests. One person said, "I go into the town, a member of staff comes with me, go to the local café, and the pub." Another person felt that the activities on offer provided an opportunity to build friendships with other people in the home. A staff member said, "The village chapel has a regular weekly meeting that some people attend." A relative said, "[Registered manager] came to see us, spoke to us about [person's] past, a very nice touch really." We saw in people's care plans that there was detail about their past, their families, hobbies and interests. During our first day of inspection, we saw that people were decorating cakes in the afternoon and were engaged in this activity. In the afternoon further activities took place including percussion instruments and games.

One person told us they enjoyed seeing singers visiting, "We've got one coming during the week, we didn't used to have that, and I join in. I enjoy it." One person said they enjoyed gardening, "I'm still very keen on the outdoors, gardening, flowers, birds. [Staff] do find time." One staff member said, "We have raised beds [in the garden] where we all do herbs and flowers, some people have got them in their bedrooms. There's a competition for who can grow the tallest sunflower, with prizes." They added, "We have entertainment, sometimes twice a week, several times a month, talks, wildlife, singers, we have a lot more people coming in, birds of prey last week. People were animated. " One person told us they had thoroughly enjoyed the birds of prey visiting. We saw that a staff member was allocated to carry out activities, including on a one to one basis, with people throughout the home, when the activities coordinator was not working.

Other craft based activities included card making, flower arranging, cooking and baking, cake decorating, arts and crafts and decorating walking frames. Entertainment included card games, table top games, quoits, connect 4, bingo, movies, singers, quizzes and dog petting. There were also keep fit exercises, nails and pampering and one to one sessions twice a week.

People were able to choose where to sit within the home, or whether they wished to stay in their bedrooms. One person told us, "Sometimes [staff] take us outside, the staff push us in our chairs. In the summer you can sit out there and have your dinner, [staff] were with us all the while." Another said, "I didn't feel like going down today, [staff] respected that, when I said I couldn't get going, [staff] help as much as they can."

People were kept informed of any changes to the service. One person said, "About once a month we have a meeting in the large lounge, they keep you informed of what's happening." Another said, "We had a letter, telling us what's going on." This demonstrated to us good communication between the service and people living there.

There was a complaints process in place, however people we spoke with told us they felt comfortable to approach the registered manager with any concerns. People and relatives confirmed that any complaints were resolved and action was taken.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection in December 2016 we found the service was not always well-led, and was rated 'Requires Improvement' in this area. During this inspection we identified some shortfalls and although there had been improvements to the quality assurance processes, further improvements were still needed.

At our last inspection in December 2016, we identified five incidents that had not been reported to us, resulting in a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009. At this inspection we found the registered manager had overlooked some notifications to CQC which they were required to send us. These help us to maintain oversight of services. These were incidents that they had reported to safeguarding. The registered manager then sent them to us in retrospect and created a new checklist to ensure these were notified to us. We saw that the appropriate action had otherwise been taken with regard to these referrals. As the registered manager sent them to us immediately following the inspection, and had taken other necessary steps, we concluded they were no longer in breach of this Regulation. They also confirmed that they created a new checklist for safeguarding referrals which included ensuring CQC were informed.

At the last inspection we found that there were not fully effective systems in place to oversee the quality of the service. This had resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan that detailed the improvements they planned to make. They told us these improvements were made by June 2017. We found that the improvements they planned had been made, including records relating to staff and people living in the home. However we found during this inspection that further improvements were needed to the governance systems in place. The provider remained in breach of this Regulation.

The registered manager carried out regular audits, for example health and safety, medicines and infection control. In some areas where they had identified concerns, these could be improved with associated action plans with dates to be achieved. We found that although the audits picked up areas for improvement, these were not always acted on in a timely way. We saw that the last medicines audit had been completed on 9 March 2018, and the discrepancies we found on the front sheets had not been identified and acted upon. We therefore concluded that the audit was not fully effective.

The registered manager maintained an oversight of people's care through their use of the electronic care records. They were able to gain quick access to the records and see whether people had received care, and oversee a period of time, for example care delivered over the last week. The system also allowed this for oversight of staff members. Whilst this was useful for the registered manager to take action if they had concerns, there was a great deal of information on the system. The registered manager had not identified that people were not always being offered support to use the toilet regularly. For another person, there was a seven day break in the records where they had not had their hair washed or received oral care, which was not in line with their care plan.

We are concerned about the track record of the service prior to this inspection, as the provider was in breach

of Regulations over the last two inspections in September 2015 and December 2016. Although there have been improvements, some areas where we found some concerns have been raised prior to this inspection. For example, we had some concerns about staffing levels where the service had breached Regulation in 2015, because there were not enough staff. The inspection carried out in 2016, although the Regulation was met, we had mixed feedback regarding staffing levels. At this inspection we still had mixed findings about staffing levels.

At our inspection in September 2015, we asked the provider to make improvements to ensure that people's preferences about how they wished to be cared for were met. These were not fully met when we inspected again in December 2016 and the provider was in breach of a Regulation. Although the provider is no longer in breach of Regulation at this inspection, there remain concerns around people not always receiving fully person centred care.

At our inspection in September 2015, we asked the provider to make improvements to the systems in place to monitor the service. They remained in breach of this in our inspection in December 2016. Where issues had been identified, clear and specific actions had not always been notated. Although there were improvements, not all of the concerns we identified were picked up by the provider and acted upon, during this inspection.

The provider's audits of the service had not identified that the service remained in breach due to not sending the appropriate notifications through, nor that there were remaining concerns in the aforementioned areas.

We remain concerned about the provider's ability to maintain effective oversight, support the registered manager properly, and build and sustain a good service.

The above concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was good leadership in the home and the staff team worked well together. One person told us, "The staff are excellent – organised." The deputy manager supported staff with their roles, and the regional manager visited the service regularly. This created a positive support network for the staff team as a whole.

Without exception, we received highly complementary feedback about the registered manager. One person told us, "[Registered manager] is a very approachable chap, if you had a problem you could approach him easily." Another said, "Oh yes, absolutely, the boss is a gentleman, a very nice man, anything that I feel I need or require I can go and see him and he will always help me if he can." One relative told us they felt the home had significantly improved under the present manager, who had been in post since Summer 2017. Another relative told us, "I think they're well led, well organised. [Staff] all seem to know what they're doing." Staff also confirmed to us they found the registered manager approachable and supportive.

People told us they felt their views were acted upon, one saying, "I have made suggestions and [staff] are always trying to help." Another relative confirmed to us that the registered manager at times checked that they were happy with the service when they saw them visiting.

Without exception people told us the manager was visible throughout the home. "The office door is always open, [registered manager] always says 'Hi' as you walk down the corridor." One relative said, "The [registered manager] is here, virtually every time I've been here. He's very sort of 'hands-on." We saw that the registered manager knew people well, and they were able to tell us in detail about everyone living in the

home. We also observed that they maintained positive caring interactions with people and assisted staff to support people effectively. The registered manager told us they had come in to support staff in cases where an unexpected event occurred, including during the night.