Care Quality Commission

N. Notaro Homes Limited

Casa di Lusso

Inspection report

Bower Lane
Bridgwater
Somerset
TA6 4GU

Tel: 01278557100

Date of inspection visit:
03 December 2018
04 December 2018

Date of publication:
07 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 and 4 December 2018, the first day was unannounced.

We last undertook a comprehensive inspection at Casa Di Lusso in October 2017, at this inspection the service was rated 'Requires Improvement'.

We undertook an unannounced focused inspection in June 2018 in response to concerns we had received about the service. At the focused inspection we inspected the service against three of the five questions we ask about services: is the service well led, safe and effective. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received all of the training required to ensure people and staff were safe during incidents and the systems in place to monitor and improve the quality and safety of the service had not been fully effective. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. This was because the provider had not notified the Care Quality Commission and the local authority of safeguarding incidents in line with their legal responsibility.

During this comprehensive inspection we found that improvements had been made, and where improvements were required, the provider had systems in place that identified all except one of the improvements and actions needed.

Casa di Lusso is a purpose built 90 bedded care home specialising in the care of people living with a dementia. At the time of the inspection there were 65 people living at the home. The home is split into eight units all with Italian names, Colosseum, Tuscany, Positano, Pantheon, Pisa, Trevi, Vesuvius and Pompeii.

There was a manager in post who had submitted an application to become the registered manager. The first day of our inspection was the managers first day at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The Quality and Performance manager was responsible for managing the service prior to the manager being in post and they were continuing this through the managers induction.

Some areas of the care plans needed to be improved. Care plans did not always contain enough detail to inform staff on how to support people with all of their needs and preferences. The provider had a plan in place to address this.

People told us they felt safe living at Casa di Lusso, people's relatives also thought they were safe. There were systems in place to analyse and review incidents when they occurred and action was taken following incidents to prevent a reoccurrence.

There were systems in place to protect people from harm and abuse. Staff understood their responsibilities

to keep people safe from harm.

Risks to people were identified and management plans were put in place to reduce risks. People's medicines were managed safely.

We received mixed feedback from people regarding the staffing levels at the home. Staff and relatives told us staffing levels had improved. Our observations were that there were enough staff available to respond to people and meet their needs.

There were systems in place to ensure suitable staff were recruited to the home.

There were systems to protect people from the risk of infection. There were a range of checks in place to ensure the environment and equipment in the home was safe. We found the water temperatures were not being consistently taken, the provider addressed this immediately and confirmed temperatures were within a safe temperature range.

People's rights were protected because the correct procedures were followed where people lacked capacity to make specific decisions for themselves.
The provider had met their responsibilities with regards to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

People's nutritional needs were assessed and their weights were monitored where required. Our observation of the mealtime experience was mixed. People commented positively about the food.

People were supported to access a range of healthcare professionals. The home maintained links with the local community.

Staff had access to a range of training to meet people's needs. Although formal one to one supervision had not been completed consistently staff told us they felt supported. There were plans in place to ensure staff received regular one to one supervision.

People and their relatives spoke positively about the staff supporting them. People told us staff knew them well and treated them with dignity and respect. People were supported to make decisions about their day to day lives.

Relatives told us they were happy with the support they and their family members received at the end of their lives.

There were a range of activities on offer that people could attend if they chose. People and their relatives felt able to raise any concerns with staff. Complaints that were raised, were responded to.

People, their relatives and staff had the opportunity to provide feedback on the service.

Relatives, staff and health professionals commented positively about the management of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People were supported by staff who knew how to recognise and report abuse.

People's medicines were managed safely.

Risks to people were identified and minimised.

There were sufficient staff to meet people's needs. Staff were recruited safely.

People were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff received training to meet people's needs and to keep them safe.

Where decisions were made for people in their best interest, these were completed in line with the Mental Capacity Act 2005.

People saw appropriate health care professionals to meet their specific needs.

People received adequate nutrition and hydration. People were positive about the food, our observation of people's mealtime experience was mixed.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the staff supporting them.

People told us they were supported in a way that promoted their dignity and respect.

People told us staff knew them well.

Is the service responsive?

Requires Improvement

Some areas of the service were not responsive.

People's care plans were not consistently person centred and detailed.

People had access to a range of activities to attend.

People felt confident to raise any concerns with the staff or managers.

Is the service well-led?

Good

The service was well led.

There were effective systems in place to monitor the quality and safety of the service.

People, their relatives and staff spoke positively about the management of the service.

The service had links with the local community.

Care Quality Commission

Casa di Lusso

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.

This inspection was carried out by two inspectors and an expert by experience on the first day and two inspectors and a medicines inspector on the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

When the service was last inspected in June 2018 the service was rated requires improvement.

Prior to the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We reviewed other information that we had about the service including safeguarding records, complaints, and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people in the service were living with a dementia and were not able to tell us about their experiences. We therefore spent a lot of time observing the care and support practices in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who used the service and five people's relatives or visitors. We also spoke with 20 members of staff. This included the quality and performance manager, the operations manager, the manager, the deputy manager, activity coordinators, kitchen staff, housekeeping staff, nursing staff and care staff. We also received feedback from a visiting professional.

During the inspection, we looked at eight people's care and support records. We also reviewed records associated with people's care provision such as medicine records and daily care records relating to food and fluid consumption. We reviewed records relating to the management of the service such as the staffing

rotas, incident and accident records, recruitment and training records, meeting minutes, audit reports and action plans.

Good

Is the service safe?

Our findings

At the focused inspection in June 2018 we found the systems in place to protect people from harm needed to be improved. Some people living in the home, due to their specific needs, at times experienced anxiety, and confusion, which could lead to physical and verbal incidents towards other people and staff. We found there was a lack of detailed guidance for staff to follow, to prevent the risk of incidents occurring, or the action to take during incidents. We also found these incidents were not being reviewed and analysed for themes and trends to prevent further incidents from occurring.

During this inspection we found improvements had been made. There were people living at the home who became anxious at times that could lead to incidents occurring. These people had plans in place describing what made them become anxious and the action staff should take.
Where staff had concerns about the intensity and frequency of incidents they had requested health professionals to attend the service and offer advice and guidance on strategies to support people from becoming anxious. Staff told us this had some success in reducing incidents.
For one person there was some confusion from some staff over the action they should take in the event of the person becoming anxious and hitting out. Staff described how they used their hands to prevent the person from hitting them. We discussed this with the quality and performance manager who told us although a health professional had advised this, this action was not something that they would do for people living at the home as it could be viewed as a form of restraint. The quality and performance manager told us they would ensure all staff were made aware of this.

Staff told us although there still were times when people became anxious, which could be difficult at times, the levels of incidents had reduced. One staff member said, "Things have improved since the last inspection, [names of people] are a lot more settled."

There were systems in place to analyse and review incidents when they occurred. Incidents and accidents were documented by care staff and reported to the nurses in charge of the shift. The nurse was responsible for ensuring the quality performance manager or deputy manager was alerted of every incident. The quality and performance manager or deputy manager reviewed each incident and where relevant took action to prevent further incidents occurring. For example, seeking external health professional support or ensuring care plans and risk assessments were updated. The quality and performance manager demonstrated they had identified the cause of anxiety for one person and they were working around ways of reducing the person's anxiety, which had proven to start to have a positive effect.

Incidents and accidents were reported. When incidents did happen, care plans had usually been reviewed to prevent a recurrence. For example, one person had spilt tea on themselves and the plan had been updated to inform staff to give the person warm rather than hot drinks, in a beaker with a lid instead of a normal cup. We found one instance where a care plan had not been updated following an incident, we discussed this with the quality and performance manager who told us they would ensure the care plan was updated with the relevant information.

People told us they felt safe living at Casa Di Lusso. One person told us, "Yes I have people around all the time." Another commented, "Yes, I do feel safe, knowing there is 24/7 care. It's my little haven." Relatives also thought their family members were safe. Comments included, "Yes there is always someone to keep an eye on him", "It's very secure here, you can't get in without a pass" and "Yes, the night staff check on them."

There were systems in place to protect people from harm and abuse. Staff understood their responsibilities to keep people safe from harm. One member of staff said, "If I saw any bruises, I'd report it straight away." Another member of staff said, "We take pictures, document it and report it. It's good that we've got the iPad and can take pictures. It helps us keep people safe."

Staff were also familiar with the term whistleblowing and said they knew how to report concerns about poor standards of care. One member of staff said, "I wouldn't be scared to speak up and report it." Staff also knew they could report their concerns to CQC. One visiting professional said, "I do feel people are safe here."

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. When risks had been identified, plans provided clear guidance for staff. For example, some people were able to move around with mobility aids and these were documented. When staff needed to use equipment to move people safely, this was documented, such as hoist and sling details. We saw staff using this equipment and this was done safely.

Some people were at risk of developing pressure sores. The plans for these people detailed any pressure relieving equipment in use, such as air mattresses and informed staff how often they needed to assist people to change positions. Position change records showed that people generally had their positions changed in line with care plan guidance. There was a process in place to check that air mattresses were set correctly and all the mattresses we looked at were set at people's weights.

Most people told us they were happy with the staff who supported them with their medicines. Comments included, "You can't fault it", "You don't have to worry about it" and "No worries there." One person however commented they had requested pain relief one evening and they did not receive it. We disused this with the quality and performance manager who told us they would look into this.

People were given their medicines safely and in the way prescribed for them. Improvements had been made to the way medicines were managed. Staff recorded when medicines were administered on Medicines Administration Records (MARs). A sample of 20 people's MARs showed that they were given their medicines correctly as prescribed. Staff recorded the administration of non-medicated creams or external preparations on separate care records.

Some people were prescribed medicines to be given 'when required' and for some people there were protocols to guide staff as to when doses may need to be given. For example, we saw a protocol for someone prescribed a sedative medicine if needed for anxiety. There were clear guidelines for staff to make sure doses were only given appropriately. However, for another person, the care plan lacked personalised details about when the medicine should be administered.

There were suitable arrangements for ordering, receiving, storing and disposal of medicines, including medicines needing extra security. Storage temperatures were monitored to make sure that medicines were safe and effective. However, we found that open pots of thickening powder for adding to drinks were being kept in an unlocked kitchen cupboard in a public area of the home. Staff told us they would address this issue straight away.

There was a policy and system in place so that some non-prescription medicines were available to treat people's minor symptoms in a timely way if needed.

There were systems for checking and auditing medicines. The deputy manager completed daily checks to make sure no medicines had been missed, and monthly medicines audits were completed. These had identified some areas for improvement such as the detail provided for staff on some 'when required' medicines. The supplying pharmacy also undertook regular audits and advisory visits. Their latest report didn't identify any areas of concern and concluded that there had been improvements in medicines management.

Staff received updated medicines training and had been checked to make sure they were competent to give medicines safely. There were detailed policies and procedures, and information to guide staff on looking after medicines.

The provider had procedures in place to ensure that only suitable staff were recruited. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with adults. Staff confirmed these checks were completed before they were able to start work.

We looked at five staff files. In four of these we saw that all necessary checks had been carried out prior to employment. In one staff file, we saw there was no record of a DBS check, no references, no identification checks, no application form and no interview notes. We discussed this to the quality manager who said they were confident the checks had been carried out and would address the gaps in the staff file. Following the inspection, they confirmed the checks had been carried out and were now in the staff members file.

We received mixed feedback from people and relatives regarding the staffing levels in the home. Some people thought staff were rushed, whilst others commented staffing had improved. Comments from people included, "There are not always enough, especially in the mornings when everyone is getting up", "Sometimes when I ring the bell it's a long time before it gets answered", "There are not enough a lot have left", "Sometimes they seem more rushed than others" and "No I don't think there are enough, but it's getting better." Comments from relatives included, "It's improving" and "They have had a high turnover of staff but it is settling down."

We discussed the staffing levels with the quality and performance manager who told us staffing levels were kept under review each day. They confirmed although some of the units had reduced the number of people living on them, the staffing levels had remained the same. They explained that on occasions when staff unexpectedly did not turn up to work, when they were sick for example, this was covered with staff from an agency, additional staff such as supervisors, activity officers and the deputy manager or themselves when required.

During the inspection we observed there were enough staff available to meet people's needs. Staff were visible and did not appear to be rushed. Most staff felt there were enough staff available on each shift. Comments included, "Staffing levels are fine", "Staffing levels have improved", "There are enough staff" and "I think staffing levels are ok." An agency member of staff said, "Most of the time when I come here, there's enough staff." Some staff said they felt there was enough of them on duty when staffing levels were met, but that when staff went off sick they felt "Under pressure." Another commented at times they felt staffing was

short. They said, "A while ago two staff called in sick and we couldn't find cover for both, we were short by one staff."

Staff had been trained to prevent the spread of infection. There was personal protective equipment such as gloves and aprons available and we saw that staff used these. One member of staff said, "All of the PPE is in the cupboard. I know when to use it because I've been trained." A relative told us, "They always use gloves and aprons when giving personal care." All the people and relatives we spoke with commented positively about the cleanliness of the home. The environment was visibly clean and there were no odours.

There were a range of checks carried out to ensure the environment remained safe. These included, a fire risk assessment, testing of the fire alarm system, personal emergency evacuation plans, electrical testing, equipment safety checks, gas safety checks and water system checks. Although an external company had completed checks on the water system in line with their schedule, we found the home had not completed their own regular checks on the water temperatures to ensure they remained within a safe range. We discussed this with the operations manager who confirmed all of the water outlets included a thermostatic mixer value that prevented the water from reaching a temperature that would scald a person. They confirmed these had been regularly serviced. They also arranged for all of the water temperatures to be checked during the inspection and confirmed these were within a safe temperature range.

Good

Is the service effective?

Our findings

At our last inspection in June 2018 we found that training to safeguard staff and meet the needs of some people at the service had not been provided. Staff told us they had not received any training in relation to supporting people at times when they were anxious, which could lead to them displaying aggression towards other people and staff.

During this inspection although not all staff had completed this training, they had all been enrolled onto a course. The quality manager explained that following our last inspection they had focused on health professionals offering support and guidance to staff to support people when they became anxious. They also said they had spent time researching suitable training for staff to meet the needs of the people they supported, and that they had sources suitable training and all staff were now enrolled. Staff told us they would benefit from this training.

People and their relatives told us they thought staff had the right skills and knowledge to undertake their roles. One person commented, "Yes they do, they have to use the hoist for me. They know what they are doing." Other comments included, "I think they do" and "I'm never in any doubt that they do." One relative told us, "It's improved definitely. I think it's better now there is a team leader to supervise the unit."

Staff said they had been trained to carry out their roles. Staff completed an induction prior to working unsupervised. One member of staff said, "My induction was a week long, lots of training and working alongside another member of staff. The training gave me some knowledge, but working 'hands on' really helped me to be more confident." Another commented, "I had a week's training on induction, it included shadowing staff and was enough to do the job." The induction was linked to the Care Certificate. The Care Certificate standards are recognised nationally to help ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support.

Staff commented positively about the training they received and said they had access to additional training to meet the needs of people. One staff member told us, "I have never worked for a company that has offered so much, I've done a team leading course, I've been offered an end of life diploma, they also offer lots of one-day courses."

Nurses told us they had access to professional development in order to meet their professional registration requirements. One nurse said, "We've had quite a lot [of training] lately. I've done end of life training at the local hospice and pressure ulcer management. I'm improving my skills all the time." Some staff had been allocated 'champion' roles, in areas such as medicines, dementia, nutrition and care plans. The deputy manager told us, "The dementia champion did a memory tree for people and brings in a reminiscence paper for staff to read with people. The champions help keep staff up to date. They put articles up in the staff room."

Records demonstrated staff received training in subjects such as; moving and handling, infection control, fire, person centred care, first aid, nutrition and hydration, dementia and equality and diversity.

Although staff told us they felt supported in their role, they had not always had formal supervision meetings with a line manager. This is an opportunity for staff to discuss their performance and any additional support they might need. The quality and performance manager explained how they had implemented a supervision plan for the coming months which would ensure all staff had one to one meetings. They said, "I have had to prioritise. I've spent lots of time out on the floor with staff supporting them in an informal way. They have lots of opportunity to speak with me - staff are often in and out of my office during the day." Staff comments included, "Yes, I feel supported. I had a supervision a few weeks ago" and "Yes, I do feel supported. When I raised something a while ago, [quality and performance manager] responded and resolved it very quickly. I feel confident to speak up if I need more support."

People and their relatives were positive about the meals they received. One person told us, "The food is pretty good. They are always coming around with food." Other comments included; "Very good, food well cooked", "There is good choice", "They will always get you alternative", The food is very good. I can choose if I want to stay in my room or come to the dining room" and "I like what I get, there is always a choice. The meals are well presented." Comments from relatives included, "There are plenty of alternatives to choose from", "I have eaten here and I can recommend it", "I have booked for Christmas lunch. It's very good" and "It's really good, I can't fault it. You let the chef know if you want something. The other day he kept a curry back for dad as we were out. Dad loves a curry."

People were supported to have enough to eat and drink. People's preferences for what they liked to eat and drink had not always been recorded in care plans. However, the chef had details of this and when we spoke with staff they demonstrated they knew people's preferences. The chef had a list of people's likes, dislikes, and dietary needs and they told us any changes to these were communicated to them by the staff team.

People's nutritional needs were assessed and when required, specialist advice was sought. For example, some people with swallowing difficulties were reviewed by the speech and language team, (SALT). SALT advice was included within the care plans and detailed when people needed to be provided with specialist diets and thickened fluids. People's weights were monitored. When people lost weight, advice was sought from the GP. We looked at the plan for one person who was receiving their diet via percutaneous endoscopic gastrostomy (PEG). This feeding tube is placed directly into the stomach. The feed regime was detailed as well as informing staff how to care for the tube itself.

Some people were having their food and fluid intake monitored. The electronic recording system in place meant there was real time information available to show how much people had eaten and drunk. Monitoring records we looked at showed that people had either met or exceeded their daily targets. When people refused a drink or food, staff had documented this. One member of staff said, "The new [recording] system is great. It means I can see at a glance if people have had enough to drink and if they haven't, we can act on it straight away." We saw that people were regularly offered drinks and snacks throughout the day. On one occasion we heard one member of staff say to another, "We need to make sure [person's name] gets lots to drink this afternoon. They didn't have much this morning."

The lunchtime experience was variable. People were offered a choice of main meals, but were not always offered a choice of vegetables; instead everyone was given all the vegetables available. Although dining tables were laid and people were offered drinks, there were no condiments available on the tables and people were not asked if they wanted them. One member of staff told us, "We do have salt and pepper, but we can't use it because the stoppers have gone missing." When we discussed this with the quality and performance manager, replacement condiments were ordered.

Our observations of staff supporting people during their meal was mixed. We saw positive examples of

permanent staff sat with people whilst assisting them and interacting in a positive manner. We saw staff ask people, "Is it nice, it smells lovely." People were asked if they would like to sit up for lunch or stay in their rooms or chairs in the lounge area. One relative told us, "One staff member showed exceptional skills when assisting [name of relative] with a meal, such patience and ability. They also go to tremendous trouble to give them what they like, even down to their preferred type of sherry."

On one unit although there was a relaxed atmosphere during lunch, there was a lack of staff interaction with people during the meal. Where an agency worker was observed to be standing over one person whilst supporting them and not interacting, permanent staff requested they sit beside the person rather than stand over them.

Senior staff completed mealtime observations on each unit, this was to ensure the mealtime experience was positive and to identify any concerns. The observations covered the environment, assistance given by staff, staff interaction, safe practices being followed, choices and the pace of the mealtime. Comments were recorded for each of the areas covered. The records we viewed demonstrated people had received a positive mealtime experience.

People had access to ongoing healthcare. A visiting health professional spoke positively of the improvements for how the service communicated with them. They told us, "It's so much more organised now. We get calls that are specific to what the problem is, actions already taken and the nurses tell us what they think. It's far more detailed" and "I'm very impressed with the communication." One nurse told us, "One GP comes weekly for complex care reviews and people's own GP's come out for acute problems. If we need a doctor to come and see someone in between routine visits, we can call them." An agency nurse confirmed this and told us, "I know I can ring the out of hours team for advice if I need to." Records showed people had also been reviewed by the rehabilitation team, SALT and an occupational therapist.

The building was light and airy and there was signage available to enable people to orientate themselves to the bathroom and toilet. People's rooms had memory boxes outside so they could relate to something that would remind them that it was their room. There were lots of communal areas for people to use and different seating areas available. There were also different areas away from the units where people could spend their time. These included, an American room which was designed similar to an American diner, this was used for activities and social gatherings, a cinema room, hair salon and café area. There was secure outside space for people to access with a play area for people's relatives to use and a greenhouse, which we were told was used in the summer to grow a range of plants.

One agency nurse said, "I think the layout here really works well. It means the care staff can really focus on the residents." Staff told us activities were offered in areas away from the communal lounges and we saw this. The activities co-ordinator said, "Doing activities away from units is so much better. It means that people really can choose whether to take part or not."

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's capacity to consent to aspects of their care had been assessed where they were thought to lack capacity to make specific decisions. For example, where people required bed rails, consent to photographs being taken and consent to personal care. Some of the documentation relating to the assessments had

been archived and was not on people's current care records. Following the inspection, the quality and performance manager sent us information to evidence this.

The deputy manager told us one person with bed rails and a room sensor had capacity to consent but there were no signed consent forms in place. They said the person had arrived from another care home where the rails and sensor had been in use, and that the paperwork in relation to this had been archived. However, the person had not signed to consent to their use at this service. The deputy manager said they would address this.

Some of the capacity assessments required further information to determine how the best interest decision was reached. For example, one person had been assessed for their capacity to consent to personal care. Staff had assessed the person as lacking capacity and a best interest decision meeting had been held. The documentation for this stated the person often refused personal care; however, on the same form staff had written the person did not communicate in any way. It was therefore unclear how the person was refusing personal care because staff had not documented this or why the best interest decision was needed. We discussed this with the deputy manager who said mental capacity assessments and best interest decision documentation would be reviewed for all people who needed them.

People told us staff asked their consent before supporting them. One person told us, "They always ask if I would like a shower or a wash." We consistently heard staff seek people's consent prior to supporting them. For example, at lunchtime, we heard staff ask one person, "Hello, [person's name]. Would you like to come and sit at the table for lunch?" On another occasion staff asked one person, "Do you want me to help you walk to your bedroom?" Staff demonstrated they understood the need to gain people's consent to care and to offer people choices regardless of their mental capacity. One member of staff said, "I always give people time to make a decision. And I offer people choices, like what time they want to get up, what they want to wear." One health professional said, "The staff here were recently very good when working through some best interest decisions for one person."

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service kept a record of all DoLS applications and authorisations and they were meeting the legal requirements.

Good

Is the service caring?

Our findings

People and their relatives told us staff were kind and caring. One person told us, "They are very nice caring staff." Other comments included; "You can't fault them", "Yes, they are very friendly", "They always support me and are ready to talk to me" and "The staff are kind." Comments from relatives included. "Oh yes. I haven't met one who isn't caring yet" and "They are caring, he has no worry's and it's like a weight has been lifted."

We heard and saw lots of positive interactions between people and staff. The atmosphere was relaxed and friendly. We saw staff greet people in an affectionate way and people responded well to this. For example, on one occasion a person was walking with a member of staff and another member of staff said, ""Hello [person's name], don't you look fabulous today?" The person laughed and said thank you. On other occasions we saw staff say, "How are you? You look lovely" and "Let's pull your blanket up around you or you will feel the cold."

On one occasion we saw a member of staff gently wake one person who had fallen asleep in their chair. The member of staff said, "Don't forget your cup of tea." When the same person stood up later and went to walk to the kitchen area with their cup, but without their mobility aid the same member of staff went over to them and said, "Let me take that [cup] for you, then you can use your frame properly."

One health professional said, "There are very compassionate care assistants here." An agency nurse told us, "One time I worked here and someone had died. A team leader came on duty and was told the person had died. They were distraught and that showed me the staff really do care."

One person using the service spoke English as their second language and one member of staff told us they had been learning the person's first language so that they could communicate more with them. We saw them doing this and the person responded in a positive way, they smiled and engaged with the member of staff.

People told us staff knew them well. One person told us, "Yes I think so. I rely on them to do what needs to be done. I'm happy with that." Other comments included, "I have a routine that has just evolved. They know that" and "Because they come in regularly, I know them, and they know me now." Relatives also commented that staff knew their family member well. Comments included, "They know and they understand his ways", "Yes they know him" and "[Name of relatives] favourite place is the Virgin Islands, the carers know this, I've observed carers talking to them about it and making it a topic of conversation."

Staff spoke positively about the people they supported; they demonstrated empathy and were able to tell us about people's likes, dislikes and what was important to them. For example, staff told us about people's family members, routines and items that were important to them.

People were involved in day to day decisions about their care and support and staff respected their wishes. One person told us, "I tell them and they do it." A relative told us, "They give him choice. He can be difficult,

but they take it in their stride."

Every person we spoke with felt they were treated with respect and staff protected their dignity. Comments from people included. "Staff always knock on the door before entering", "They will close my door or pull the curtains if I am having a wash", "They speak to me kindly", "They are always polite", "There is a very high standard of care" and "They keep me covered when I am on the bedpan."

Staff understood the need to respect people's privacy and dignity. We saw that butterflies were placed on people's bedroom doors to indicate personal care was taking place and that people should not enter. One member of staff said, "If someone is on the toilet, I close the door and tell them I'll wait outside until they've finished. I close curtains, keep people covered up, knock on doors. Basically, I treat them how I would want to be treated." Another staff member said, "Staff hold the same morals, we are respectful and treat people as if they were your family member." One person told us, "It's like a family here. It's just like my sister coming into help me."

Senior staff completed dignity spot checks. This involved them completing observations and recording the outcome. Areas covered included, knocking on doors, closing curtains when conducting personal care, confidentiality when discussing people and responding to requests. Any areas for follow up with the staff member were recorded on the spot check forms.

Staff spoke highly of their roles. One member of staff said, "I make a difference. I make sure people live the best lives they can." Another said, "I know I do a good job. I go home and I know I've made a difference. Like when [person's name] dances and laughs with me, that sticks in my head."

People's visitors could visit the service when they chose, there were no restrictions and they were made to feel welcome by the staff. One person told us, "My whole family comes in. We always feel welcomed. The grandchildren play out in the play area or go and see the animals. It's so relaxed." A relative told us, "I come in at least three times a week. If I can't make it, I ring in and I know the message will be passed on to dad."

The service kept a record of compliments they received. We reviewed a file that contained written feedback to the service to express their thanks. Comments included, "Thank you for all you did to look after mum when she was with you for respite, we greatly appreciate your expertise and kindness to mum and all", "I wanted to thank you for making [name] so welcome. Without a doubt, all the staff I came across were so wonderful, professional, and so very kind and welcoming to both of us. Since spending a week with you [names] walking has improved so much" and "Thanks for the caring, looking after and kindness you showed my mum whilst she spent her last few weeks with you." Feedback from a visiting professional included, "The residents are well cared for, settled and happy and I have heard very positive feedback from residents and their families."

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them. Some areas of the care plans needed to be improved. Care plans were person centred in places, but this was not seen consistently. Although some of the plans detailed people's choices and preferences for how they wanted to be supported, this was not evident in all the plans we looked at. For example, personal hygiene plans did not always detail people's preferred toiletries, how they liked to dress or whether gentlemen preferred a wet or dry shave. In one plan we looked at staff had documented, "Ensure [they] look smart" but there was no information for staff on what smart meant to the person. Although staff knew people well, this information would not be available to unfamiliar staff.

Although wound care plans were clear, the plans had not always been followed in full by staff. For example, in one person's wound plan the guidance for staff was to photograph the wound each time the dressing was changed. However, records showed this had not always happened because on four consecutive wound dressing changes no photograph had been taken.
In one person's plan it was documented that the person could become anxious if their set routine was not followed, but the routine was not documented. Additionally, the plan stated that if the person became anxious that staff should request help from the staff the person preferred. But the plan did not include details of which staff these were. Although staff knew this, the information would not be available to unfamiliar staff.

Communication plans did not always provide enough information for staff on how to effectively communicate with people. For example, in one person's plan it was documented, "It can be difficult for someone who does not know [person's name] well to understand what [they] are saying." The guidance for staff was limited to "Always face [them] when speaking to [them], listen actively to what [they] are saying by nodding your head or repeating the key words." The person's first language was not English and although they could speak it, staff had documented the person's accent meant it could be difficult to understand them. Although one member of staff told us they had been learning the person's language, there were no communication aids in place such as a list of simple phrases that staff might use to support communication with the person and enable them to make choices.

Other plans provided more detail for staff. For example, one person's plan informed staff the person could shout out to staff and the reasons for why the person might do this were listed. In another person's plan it was written that their communication was limited and could be "muddled." Staff were guided to ask yes and no questions and allow the person time to respond.

Some of the care staff said they had read people's care plans and some had not. Some of the staff we spoke with were familiar with people's needs and others less so. One member of staff said, "People's Preferences? | don't know them because I'm always moving around. It's sad. I do read the care plans but it's difficult." Another member of staff said, "I always work on this unit so I know the residents and their families really well. It's good for continuity." Another said, "I sit with people and chat to them. That's' the best way to find out about them."

The care plans had been transferred onto a computerised system. This included people's specific needs and a flagging system for when a specific task was due. For example, if a person required repositioning or if they had not met their specific hydration target. Senior staff and nurses were able to monitor an overview of what was occurring on each shift. The quality and performance manager also had 24-hour access to monitor what was happening in the home.
Staff told is they thought the system was an improvement on the previous paper system.

People and relatives had the opportunity to be involved in the care plans, care plans recorded where aspects of people's plans were discussed with them and included the persons response to this. One person told us, "If something changes we do it." Other comments included, "We just do it as we go along" and "When I first came in I think we went over everything." One relative told us, "If I have a question about her care I sit down with the staff and discuss what's best for mum."

Relatives told us they were happy with the support they and their family members received at the end of their lives. One relative commented, "They were marvellous when my father was dying. They supported me and explained what may happen as he was dying." Other comments from relatives included, "When dad died staff were amazing. They supported me and mum and never left her alone for long" and "Both my parents were here, but dad died a few months ago. We had discussed end of life with staff and they helped me through a very difficult time. They supported me and talked me through each step. They were always available, answered my questions, always at the end of a phone. They have looked after mum as well throughout."

There were end of life plans in place but these did not always detail people's choices and preferences for how they wanted to be cared for at the end of their lives. For example, in one person's plan it was written, "Family have agreed [resuscitation order] and not for hospital admission." There was nothing documented about the person's spiritual or special wishes.

However, another person's end of life plan did include this detail. Despite this, a health professional said, "End of life care here is so good. Staff understand the need to talk to families and set expectations" and "One person died here recently and the staff were great and really did personalise [their] care."

People had access to a range of activities and some people told us they chose to attend them, whilst others did not. One person commented, "I enjoy watching the children play when they come in," Other comments included; "I don't go, I know they exist. Not my cup of tea", "We sit out in the garden and watch the children. Its lovely to see them", "I like going out in the mini-bus", "I like the arts and crafts" and "No, I don't join in. I don't want to. I know they exist." A relative told us, "They always tell dad what's going on."

The home employed three activity coordinators over seven days a week. Activities included trips out to garden centres and places of interest as well as meals out. The home had its own animal barn and surrounding fields where there were a range of animals kept that people could visit. Activities were also arranged in the home such as painting, nail care, knitting, cooking, carpet boules, bean bags, puzzles, film shows twice a week in the cinema and one to ones with people.

During the inspection children from a local nursery visited to help people make some hats. The activities co-ordinator told us, "We do see smiles and more interaction from people when the children are here. But it's people's choice, they don't have to come if they don't want to." We saw that people from different units attended the activities together. When people were unable to attend or chose not to, there was the option of one to one time with the activities team. The co-ordinator told us, "We [the team] have different skills and strengths so we pool our ideas and try to accommodate what people want."

People and their relatives told us they if they had any complaints or concerns they would speak to staff or their family members. Comments from people included; "I would talk to any of the staff', "I would go to the reception", "I would speak to the leader of the unit" and "I could speak to any of them. They are all approachable." Comments from relatives included, "If its personal, I ask to speak to the manager or member of staff privately. It's all about communication. It's not what's right or wrong but what is best for mum", "It depends what it was about. First it would be the unit lead and then the manager", "I would speak to the manager, [name of quality and performance manager] is very approachable and she listens", "Things have improved here in the last 6 months. The [quality and performance] manager is very approachable", "I have raised concerns with the manager and staff and I have always been happy with how it was handled. It's more about discussions about the best way forward for mum, rather than complaints" and "I did make complaints prior to this new manager. Haven't made any since she's been here as its improving."

Records demonstrated there had been 17 complaints since our last inspection and these had been responded to by the management of the service.

Good

Is the service well-led?

Our findings

At our last inspection in June 2018 we found the governance systems used to monitor and improve the quality and safety of the service were not fully effective. During this inspection we found improvements had been made.

There were a range of systems in place to monitor the quality of the service. These included audits that covered areas such as medicines, incidents and accidents, infection control, health and safety, nutrition and wounds. The systems in place were identifying where there were shortfalls in the service such as more detailed protocols for when people required as and when medicines and action required following incidents. The computer system identified where there were shortfalls in detailed information in the care plans.

The health and safety audit had not identified that the water temperatures had not been regularly tested. The maintenance person thought an external company carried this out. The quality and performance manager told us they would ensure this would be monitored as part of their health and safety audit.

The provider had recently arranged for an external moving and handling trainer to visit the service and complete an audit and observations on practice within the home. This involved them reviewing equipment in place and observing staff undertake tasks. A recommendation report had been completed as part of the audit which the quality and performance manager was in the process of implementing.

There was not a registered manager in post. The quality and performance manager had been managing the service since June 2018, following the previous manager leaving the service. The provider has recruited a new manager and the first day of our inspection was their first day in their new role. The quality and performance manager was continuing to oversee the service whilst the new manager was completing their induction.

The quality and performance manager kept their skills and knowledge up to date by memberships and subscriptions to specific forums, groups and websites, they worked with local hospices and managers and attended conferences. They also ran a south west governance leads group. They described how they shared their learning with the providers managers and staff at Casa di Lusso.

People and their relatives commented positively about the quality and performance manager and the improvements that had been made since they had started managing the service. One person told us, "The [quality and performance] manager is very approachable and she listens." Another commented, "Things have improved here in the last six months. The [quality and performance] manager is very approachable."

There was also unanimous positive feedback from staff about the quality and performance manager. Staff comments included, "[Quality and performance manager] has tried really, really hard to make things better," "[Quality and performance manager is good. It feels like [they've] got our back" and "[Quality and performance manager] has tried to do so much for the home, and been really positive." One member of staff

said, "They've been like a breath of fresh air."

Following our last inspection, the quality and performance manager had implemented an action plan to identify where improvements were required in the service. Staff told us they felt involved in the improvement plan. One member of staff said, "We've had staff meetings and been encouraged to speak up and get involved." Another said, "[Quality and performance manager] has driven the changes here but has involved us. We've had more staff meetings and been asked what we need. We do feel involved." One member of staff said, "The way we do things has been changing continuously. We've improved a lot." Another member of staff commented, "All the bad press, it just makes me want to prove them wrong. It really does feel like we're moving in the right direction."

The quality and performance manager maintained a regular presence in the home and they visited each of the units to monitor standards and ensure they were visible and available to people, relatives and staff. They described how they had spent time with the senior staff and nurses supporting them to raise and discuss any concerns and ideas to resolve these. The quality and performance manager had a good knowledge of the people who lived at the home and the staff who supported them.

When asked if they thought the home was well led one person told us, "Definitely, no worries about that." Other comments included; "Yes, it's pretty good" and "Yes, everything goes like clockwork." Comments from relatives included, "There has been a huge improvement" and "I feel they are on the right route now."

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "You are able to speak up, it's an opportunity to say what you want, I do feel listened to." Another commented, "Team meetings are held every month, I feel able to speak up and I feel listened to. There is good communication with the [quality and performance] manager and deputy manager." Meeting minutes demonstrated meetings were held at different times of the day to enable as many staff as possible to attend. They were used to discuss items such as, confidentiality, staffing, plans for staff supervisions, updating care records, training and the environment.

People and their relatives told us there was a good atmosphere in the home and staff appeared happy in their roles. One person told us, "They [staff] seem happy. I hear them laughing and joking." Other comments from people included, "I don't hear them moaning", "They seem to be happy. I don't hear any moans and groans, they just get on with it" and "They are always smiling and laughing." Staff commented positively about working at Casa Di Lusso and the current staff team.

The home maintained links with the local community such as; the local school, the local college, hospice, churches, volunteers. The quality and performance manager told us they had arranged for a WI group to come to the home for a meeting.

There were a range of systems in place for people and their relatives to give feedback on the service. This included a survey covering areas such as the staff, the environment, activities, cleanliness, the meals and safety. We reviewed the results of the latest survey competed in November 2018, the majority of the feedback was positive. Where comments were made, regarding activities for example, the quality and performance manager told us they would address these and feedback via the next residents and relatives meeting.

Resident and relative's meetings were also held to enable people to discuss matters relevant to the home. People and their relatives told us they felt listened to. On person told us, "I attend residents' meetings. I have the minutes. Everyone can have their say. For example, they ask if you are satisfied with the food or any

suggestions for activities. They will change things if they can." Other comments included, "I have only been once, so I just listened but very informative. Let's you know what's going on" and "My daughter goes and tells me what happened." Comments from relatives included, "They are very useful. It's an opportunity to raise any concerns, it doesn't matter how trivial. You get feedback about what's going on", "At the residents meeting someone suggested different food and they have put it on the menu. They do listen" and "I brought up a concern and they acted on it." We reviewed the minutes of the latest residents meeting and saw items discussed included, the menus and any suggestions, activities and a general discussion about the home. Relatives meetings included discussions regarding staffing arrangements, the environment, activities and menus.