Uniquehelp Limited

Whitstable Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 7 December 2017 and was unannounced.

Whitstable Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the car provided, and both were looked at during this inspection.

Whitstable Nursing Home is registered to accommodate care and support for up to 34 people. At the time of the inspection there were 23 people at the service.

At the previous inspection in October 2016 three breaches of regulation were found. The provider had failed to ensure that care plans reflected people's assessed needs and preferences, failed to maintain accurate care records for each person and failed to ensure that complete information about people's previous employment had been investigated. Following the inspection we asked the provider to complete an action plan to show what they would do and by when to improve the key questions Safe, Responsive and Well Led to at least good. At this inspection improvements had been made and the legal requirements of one of the previous breaches had been met. However, a new breach was identified and there was a continued breach.

The provider had failed to ensure that care plans reflected people's assessed needs and preferences, failed to maintain accurate care records for each person and failed to ensure that complete information about people's previous employment had been investigated. At this inspection improvements had been made and the legal requirements of the previous breaches had been met. However, a new breach was identified.

The service had a registered manager in post. A registered manager is a person who is registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care act 2008 and associated Regulations, about how the service is run.

Potential risks to people's health and welfare had not been consistently assessed and there was not detailed guidance for staff to follow to mitigate the risks to people.

Checks and audits had been completed on the environment, equipment and all areas of the service. The audits had not identified the shortfalls in the risk assessments to keep people safe. In all other audits when shortfalls had been identified, an action plan was put in place and signed off when the action had been completed.

The registered manager met with people before they came to live at the service to ensure staff would be able to meet their needs. The assessment covered all aspects of their physical, mental health and equality needs. People's needs were assessed using best practice guidelines and formed the basis of the person's care plan. Each care plan contained information about the person's life, likes and preferences. The care

plans contained details about how the person liked to be supported.

People had been asked about their end of life wishes and these had been recorded to ensure people's wishes were respected. Staff had received training appropriate to their role, including end of life care. Staff received one to one supervision and appraisal to discuss their role and their training needs. There were sufficient staff on duty to meet people's needs, staff were recruited safely. People's medicines were managed safely and people received their medicines when they needed them.

Staff monitored people's health and people were referred to specialist healthcare professionals when required. Staff supported people to be involved in discussions about their care. People had access to professionals including opticians, chiropodists and dentists when needed to support people to stay as healthy as possible. Staff worked with health and social care professionals to ensure people received the support they needed. People were supported to eat and drink to maintain a balanced diet.

People were protected from abuse and discrimination. Staff knew how to recognise signs of abuse and knew that they should challenge colleagues if people were being discriminated against. Staff knew how to report concerns and felt confident they would be dealt with appropriately. Accidents and incidents had been recorded and analysed, action had been taken to reduce the risk of them happening again.

The building had been adapted to meet people's needs. People were protected from the risk of infection, staff wore protective clothing when required and kept the building and equipment clean.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

Some people knew how to complain, the complaints procedure would benefit from being written in a way that would be more meaningful to people living with dementia. Any complaints received had been investigated and action taken to prevent the incident from happening again. People were encouraged to provide feedback about the quality of the service and any suggestions they may have. These were acted upon by the registered manager and people told us any concerns had been acted on immediately.

People were treated with dignity and respect. Staff had developed caring relationships with people and their relatives. Staff encouraged people to be as independent as possible. People's confidentiality and privacy was promoted by staff. People had access to a variety of activities. The service had links and were involved in the local community.

There was an open and transparent culture within the service. People and relatives knew the registered manager well and told us that they were approachable. Staff told us they felt supported by the registered manager. People and staff attended regular meetings to discuss the service and to give their views and suggestions. The provider asked people for their views regularly on themes of the service throughout the year. Staff survey had been completed and the response from staff had been positive.

The registered manager attended local forums to keep up to date with best practice. Staff understood their roles and responsibilities.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. This meant we could check that appropriate action had been taken. The manager was aware that they needed to inform CQC of important events in a timely manner.

At this inspection two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. You can see what action we have asked the provider to take at the end of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Potential risks to people's health had not been assessed and mitigated; there was not detailed guidance for staff to refer to.

People were protected from the risk of infection.

There were sufficient staff, who had been recruited safely, to meet people's needs,.

People's medicines were managed safely and people received them when they needed them.

People were protected from abuse, and discrimination.

The registered manager had made improvements following incidents and accidents.

Is the service effective?

Good

The service was effective.

People's needs were assessed and care planned using best practice guidelines.

The building had been adapted to meet people's needs.

Staff received training appropriate to their role and supervision and appraisal to discuss their personal development.

People were supported to eat and drink enough to maintain a balanced diet.

Staff monitored people's health and worked with other health professionals to meet their needs.

People had access to healthcare services and support.

Staff understood and worked within the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion.

People were supported to be as independent as possible.

People's privacy and dignity was promoted and respected.

Staff encouraged people to express their views and be involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care in line with their preferences and choices.

People were supported to be involved in activities.

People knew how to complain and felt that any concerns would be dealt with immediately.

People were asked about their end of life wishes these were recorded and respected.

Is the service well-led?

Requires Improvement

The service was not always well led.

Checks and audits were completed on equipment and all areas within the service. However, shortfalls found at this inspection had not been identified.

There was an open and transparent culture within the service.

Staff and people told us the registered manager was approachable.

People, relatives and staff were asked to give feedback about the service.

Staff understood their roles and responsibilities.

Whitstable Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 December 2017 and was unannounced. The inspection was carried out by three 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.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service. We looked at notifications received by CQC. A notification is information about important events which the provider is required to tell us about by law, like death or serious injury.

We looked around areas of the service, and talked to 15 people who live at the service. Conversations took place in people's rooms and the main communal areas. We did not use the Short Observational Framework (SOFI) as people were able to talk with us and tell us about their experiences. SOFI is a way of observing care to help us understand the experience of people who cannot talk to us.

We reviewed records including four care plans and risk assessments. We looked at a range of other records, staff rotas, medicines records and quality assurance surveys and audits.

We talked with six relatives who were visiting people, the registered manager, area manager, three care staff, one nurse and kitchen staff.

Whitstable Nursing Home was last inspected in October 2016 and three breaches of regulation were found at this inspection.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe living at the service. One person told us, "If I use my call bell, I always know someone will come to me and that makes me feel safe." A relative told us, "My loved one is safe and well cared for."

Potential risks to people's health and welfare had not been consistently assessed and there was not always detailed guidance for staff to follow to mitigate risks. For example, one person had been diagnosed with epilepsy. There was no care plan or risk assessment to give staff guidance about how to recognise if the person was having a seizure, how to support them during a seizure and when to call for medical assistance. There was no record of when or if the person had experienced seizures since admission to the service. Staff told us they had seen the person experience seizures and how they had supported the person. All the staff were consistent in how they would support the person during a seizure. However, the service used agency staff who may not know the person and how to support them, there was a risk that the person would not receive safe and effective care. Following the inspection, the provider sent us a copy of the care plan they had put in place to give staff guidance about how to support the person.

In some care plans the information was contradictory, placing people at risk of not consistently receiving the correct support. One person's care plan stated that they could change their position in bed and were able to sit out in a chair. The moving and handling risk assessment stated the person could not sit out of bed and needed support to move. The risk assessment did not contain detailed guidance on the equipment to be used to support the person. During the inspection we observed staff preparing to support the person to move and they explained how they supported the person and why.

Another person had a urinary catheter in situ; a catheter is a tube that drains urine from the bladder. The care plan did not give staff detailed guidance on how to keep the catheter free from obstruction and reduce the risk of infection, following best practice guidance. Staff told us how they would maintain the catheter; this was not consistent. Some staff told us that they would remove the urine drainage bag daily from the catheter, infection control guidance states that this should only be done weekly. Although the person had not had any urine infections there was a risk that the person would not receive safe, effective care due to the practices in place at the time of our inspection. Following the inspection the provider sent us a copy of the catheter care plan now in place with detailed guidance.

The provider had failed to assess the risks to people's health and safety, doing all that is reasonably practicable to mitigate risks to people receiving care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection, we found that staff had not always been recruited safely; staff's previous employment history had not always been fully investigated. At this inspection, improvements had been made. We found that staff files had been audited and any missing or insufficient information had been sought and verified. New staff recruited to the service had been recruited safely. The registered manager had completed all required pre-employment checks including a full employment history and any gaps had been investigated.

Each person had a proof of identity with a photo. Disclosure and Barring Service (DBS) criminal records checks were completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Nurses Personal Identification Number was checked to ensure they were registered to practice.

Regular checks had been completed on the environment and equipment used, these were carried out within the required frequencies, to ensure people were safe. The maintenance staff carried out regular checks on the equipment, such fire alarms and wheelchairs, any shortfalls were rectified. Environmental risk assessments had been completed and action taken to mitigate risks to people. There was a business continuity plan in place which contained details of how the service should respond in an emergency situation. Each person had a personal emergency evacuation plan (PEEP), these gave details of the persons physical and communication needs, to support them to be evacuated safely.

Staff understood their responsibility to report accidents and incidents and we saw evidence that staff recorded and reported accidents. We reviewed accident and incident records, these had been audited by the registered manager and analysed monthly by the provider to identify any trends that were occurring. When a pattern had been identified action was taken to investigate and reduce the risk of it happening again. For example, one person was falling frequently, a falls tracker was put in place and the person was referred to the falls clinic. The tracker meant staff could support the person at times when they were most likely to fall. Any learning from incidents and accidents was shared with the staff team at staff meetings and at handover meetings. The registered manager shared records of accidents and incidents with professionals involved in people's care for example, physiotherapists and care managers to help review people's care.

There were sufficient staff on duty. There were vacancies for care staff at the time of the inspection; the service used agency staff to cover these positions. Regular agency staff were used who people knew and were included on the rota. All nurses were permanently employed by the service so no temporary or agency nurses were used. Rotas showed that the registered manager always managed to ensure that staffing levels were in line with the number they had identified as needing to maintain people's safety. The provider used a dependency tool to identify how many staff were required to support people safely. The tool was updated at least monthly. Staff told us that staffing numbers changed according to the needs and number of people living at the service.

People were protected from the risks of abuse and discrimination. Staff knew what to do if they suspected incidents of abuse. Staff told us they were confident that any concerns would be dealt with by the registered manager quickly and appropriately. Staff had received training in safeguarding processes and this was discussed with them at supervision. The registered manager understood their responsibility in reporting incidents to the local safeguarding team and had reported incidents as required. People were encouraged to raise any concerns about safety with a staff member or the registered manager or with their relatives. Meetings were held for people and their relatives and the registered manager gave everyone their contact details so they contact them with any concerns. Staff told us how they promoted people's differences and how they supported them with their choices and preferences, for example some people were wearing jewellery and staff ensured that people had what they wanted on their table. People who mobilised using a wheelchair were able to access bathrooms and there was specialist to enable them to use the bath safely. Staff understood their responsibilities to challenge people who discriminated against people and had training in equality and diversity.

People's medicines were managed safely by nurses, who updated their practice regularly by attending training and reflective practice. Staff recorded the temperature of the room and fridge where medicines were stored; to make sure it was within safe limits. There were appropriate arrangements for ordering,

administering and disposing of medicines, in line with best practice, staff followed these and there were records to support this for example, medicines were ordered in advance and checked into the service to ensure that medicines were always available. Medicines Administration Records (MAR) had been completed and checked at the end of each shift to ensure people had received their medicines as prescribed. The MAR were completed accurately with no gaps giving a clear record of what medicines had been administered by whom, to whom and when. Medicine records were checked as part of the provider's audits so that any gaps or errors could be followed up.

Some people were prescribed medicines on an 'as and when' basis for example pain relief medicine and to manage behaviour. At the time of the inspection there was no one requiring medicines to manage their behaviour.. There was There were guidelines in place for staff to follow about when to give the medicines and how much should be given. Some medicines required special storage and additional records to be maintained and these were accurately completed. Staff asked people how they would like to receive their medicines and if they wanted to self-administer when they moved in. People had requested staff to administer their medicines and this was recorded in their care plan. There was guidance about how people liked to take their medicines on their medicines records. We observed nurses administering medicines to people in line with their care plan. People's medicines were reviewed by their GP when required to check they were still needed and suitable. We observed people receiving their medicines in a person centred way for example, staff went to each person with a drink and supported the person to sit up in their bed and take the medicine in their own time.

The provider had a policy on preventing infection and any spread of infection. Staff followed this policy and could tell us about how they would reduce the spread of any infection including the use of 'barrier nursing' which reduces the risks of infection spreading. There were cleaning schedules that domestic staff followed and this included kitchen staff. The service was clean and hygienic and smelled fresh. There were sufficient domestic staff employed to maintain the standard of cleaning required. Care staff wore protective clothing such as gloves and aprons when required and disposed of soiled linen appropriately to minimise the risk of cross infection.

Good

Is the service effective?

Our findings

People and relatives told us that they had choices and staff contacted healthcare professionals when they needed it. One relative told us, "They often ask my opinion and what my loved one would like to add or change on the menu." One person told us, "They are sharp on calling the doctor when I need them."

Before coming to live at the service the registered manager met with the person and their relatives to complete an assessment to check that the staff had the skills and knowledge to be able to support the person. The assessment covered all aspects of the support the person needed including their physical and mental health and social needs and wishes. People were asked about any specific needs they had around culture, religion and sexuality. The assessment was then used to form the basis of the person's care plan. The registered manager understood that people needed to be assessed in line with guidance from the National Institute of Clinical Excellence (NICE) which states that risks to people's health and welfare such as skin damage, falls and malnutrition should be assessed using a recognised tool. Each person had a risk assessment for nutrition and skin integrity. The area manager explained that currently the service used a recognised tool to assess the risk to people's skin integrity. However, the local hospital had changed their assessment tool and to ensure that effective assessment was continued the service would be changing to use the same tool.

People received care from staff that knew them and had been received training appropriate to their role. Staff completed an induction when they started working at the service. This included working with experienced staff to learn about people's choices and preferences. New staff were mentored and their competency in each area of their role was signed off by their mentor or the registered manager. We observed staff using equipment to move people safely following guidelines set out in people's care plans. Agency staff received an induction about the service's emergency procedures and about people living at the service when they started. Agency staff received a written information for them to refer to and a verbal handover from staff. The registered manager told us that they tried to ensure that regular agency staff were used so that they knew people and people knew them.

All staff had received training in areas such as infection control, safeguarding and moving and handling people. In addition, there were specific areas of training that nurses were required to complete such as syringe driver and catheterisation. There was a nursing competency framework in place for nurses to complete which covered key areas such as wound care, catheter care and pressure area care. Nurses were assessed for their competence in medicines management. The registered manager recorded when each nurse had demonstrated they were competent in each area.

Staff told us that they felt supported by the registered manager. Staff received regular supervision and an annual appraisal. Staff were able to give their feedback and reflect on their performance as well as receive comments from the registered manager. Both parties signed the supervision and appraisal forms to confirm that they were an accurate record of the discussions.

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 much 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 interests and as least restrictive as possible.

Staff understood their responsibilities under MCA. We observed staff asking people what they wanted to eat and drink and how they wanted to spend their time. Staff spoke confidently about how they promoted people's choice and how people should be treated as individuals. People's capacity had been assessed, some people had Lasting Power of Attorneys in place, and this was recorded in their care plan. Best interest decision discussions had been held involving people who knew the person well and recorded when people were unable to make their own decisions.

People can only be deprived of their liberty so that they can receive care and treatment when it 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. We checked to make sure the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of the inspection, authorisations that had been granted were being adhered to.

People were supported to eat and drink enough to maintain a balanced diet. People told us they enjoyed the food and that there was plenty of choice. They were happy with the times they received their meals and they were able to ask for snacks at any time. For example one person requested ice cream in the morning, staff brought them a bowl of their favourite ice cream. There was a menu in the dining room including pictures of the meals. The cook told us there was a four weekly menu that changed with the seasons. People were asked what they wanted on the menu at resident meetings and this was incorporated into the menu. Most people chose to eat on their bedrooms and we saw that staff supported people in their rooms if they needed support to eat and drink. Others chose to eat in the dining area, the lunchtime meal was served hot and the atmosphere was relaxed and a social occasion, people were given the time and support they needed.

The cook was aware of people's different dietary needs; they were able to tell us about people's dislikes and their favourites. The cook understood about the different types of diets people may need, during the lunchtime meal, we observed that some people had pureed meals as recommended by health professionals. People were supported to eat their meals, when required by staff. When people were not eating and drinking well, staff recorded this on food and fluid charts, so that staff knew that these people needed to be encouraged to eat and drink between meals. Extra calories were added to meals when people needed to gain or maintain their weight, for example, by adding cheese or cream. Extra fluids were given to people who may be at risk of becoming dehydrated and this was recorded and totalled each day with a goal amount for the individual. The provider's audits included checks of the food and fluid charts and of people's individual eating and drinking needs to make sure people were getting the right support.

Staff monitored people's physical and mental health and took prompt action when they noticed any changes by reporting changes to the nurse on duty. Nurses were responsible for people's day to day nursing needs; they referred to healthcare professionals such as specialist wound care nurses when needed. People's weight was recorded monthly or more often if the person was at risk of weight loss. People were referred by the nurses to specialist healthcare professionals such as the dietician and speech and language therapist, when required. Guidance from healthcare professionals was recorded and followed by staff to keep people as healthy as possible for example people were given supplement drinks. People told us that they received regular visits from the optician, chiropodist and dentist if needed. People were encouraged to

lead healthier lives by walking around the building as much as possible, staff supported them to have preventative healthcare such as flu vaccinations.

The registered manager and staff worked with other professionals to ensure people had the support they needed, this included care managers who were sent regular updates and were involved in review meetings and GP's who were called when people were unwell. As well as this staff had the contact details of other professionals including physiotherapist and speech and language therapists who had been involved in assessing people's swallowing needs.

Whitstable Nursing Home is a large converted house with a garden. The building had been adapted to meet people's needs including the installation of a lift and specialist equipment. People were able to move around the building. There were separate rooms where people could meet with their relatives privately and where activities could take place. People were able to access the garden when they wanted; there were ramps into the garden. The building was clean and well maintained, large coloured signs were used to identify the toilets and other rooms to help people find their way around. Maintenance work was continuous to improve people's surroundings and to meet people's changing needs.

Good

Is the service caring?

Our findings

People and relatives told us staff were kind and caring. One relative told us, "If they come in while we are here they always pull a screen around and are so gentle and caring. They always knock before entering." One person told us, "They are fabulous the staff here. I really cannot fault them."

Staff knew people well and spoke with them in a kind and compassionate way. There were strong relationships between people and staff. Staff told us that they made sure people were able to have as much control as possible over their lives. People were encouraged to take part in discussions about their health care. During the inspection, the GP visited several people, the staff ensured that people were part of the discussion and agreed to any treatment.

Staff knew people well and their backgrounds. Staff spoke with people about their lives and people who were important to them. People told us staff supported them in the way they preferred and enabled them to be as independent as possible. People were supported to move around the service as independently as possible. We observed staff supporting people to walk around the corridors with mobility aids such as walking frames. Staff were patient with people and allowed them to go at their own pace. They talked with people as they walked around and reassured them and reminded them to use their equipment.

People were encouraged to decorate their rooms with personal items such as photos and ornaments that are important to them. Relatives told us they were able to visit whenever they wanted and were always made to feel welcome. Visitors were able to enjoy meals with people, this was important to relatives as they were able to enjoy that time with their loved ones. Visitors brought in their dogs regularly, people found this to be comforting as many of them had owned pets previously.

People told us and we observed, staff knocking on people's doors and waiting to be invited in before entering. Staff told us and people confirmed that they maintained people's dignity by closing the curtains and covering them when providing personal care. People told us and we observed staff respond to people's needs in a timely manner, for example staff gave people drinks when they requested and responded to call bells quickly. Staff spent time talking to people to find out what they wanted and explained how they were going to meet this.

Staff spoke with people in an appropriate way, explaining what they were doing and reassuring people as they supported them. Staff were patient with people giving them time to respond to questions and express themselves. They were discreet when supporting people to leave the lounge and use the bathroom. Staff kept people's personal and confidential information about them and their needs secure to protect their privacy and confidentiality.

People's religious beliefs were discussed and recorded to enable staff to support people. The local vicar held a monthly service that people were able to attend if they wished.

Some people were unable to express their views about their care, so staff ensured that decisions were made

involving people who were important to them including their family and friends. Some people had nominated a person to represent them, however, some people had not. When this was the case, staff knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. Information was provided in a way that was more meaningful people living with dementia to help people make decisions and be involved. For example, some information was available in picture format.

Good

Is the service responsive?

Our findings

Relatives told us that they were involved in their loved ones care. One relative told us, "We have been fully involved in planning my relative's care every step of the way and we are kept fully updated with any changes or slight alterations to their care." People told us they were asked about how they would like their needs met and this had been added to their care plan.

At the last inspection, the care plans did not reflect people's assessed needs and preferences. At this inspection, improvements had been made. Care plans contained details of people's preferences including their likes and dislikes. One person's care plan explained how they liked their meals; they liked a small meal on a big plate and for it to be cut up. Staff followed this guidance. Other care plans included the assistance people needed with their meals and how staff should assist them. There was information for staff about when people liked to get up and go to bed. Care plans included clear information about how nurses managed all areas of people's care needs including managing wounds that people had.

Staff told us how they supported people. They spoke confidently about people's likes and preferences. We observed staff supporting people in a person centred way, in that they tailored their support to each individual. Staff altered how they supported people, they understood how people communicated, especially those who used non-verbal communication or were hard of hearing. Staff adjusted their posture so people could hear them better. They used pictures and showed people objects so they were able to choose. Staff explained about one person's behaviour and how they were nervous about meeting new people, they reassured the person by touching their arm and maintaining eye contact with them. Some people were able to use call bells to alert staff if they needed something. Staff checked people who were not able to use the call bell to ensure they had all they needed and these checks were recorded.

People were given the opportunity to take part in activities. There was a section in the care plan that detailed what people enjoyed and whether they enjoyed spending time by themselves or with other people. This was compiled by the activities organiser who was employed to lead activities. People were encouraged to make suggestions about what activities they would like and these suggestions had been added to the activities on offer including crosswords. External entertainers including singers visited regularly, as often as people wanted. The activities available included quizzes, puzzles, movies and pamper sessions. People who wanted to spend time in their rooms had one to one sessions, chatting about the subjects they enjoyed and their life before coming to live at the service. People told us they enjoyed the activities, one person told us, "There is usually an activity to join in but there's always an option of doing a quiet puzzle or magazine."

The provider had a complaints policy in place which was displayed on the main notice board in the entrance area of the home. The policy set out how to raise a complaint and who to contact if people were not satisfied with the response. People that we spoke to told us that they would speak to the registered manager or nurse if they had a complaint and that their complaints had always been dealt with. There was no accessible version of the policy available, such as pictorial, to help people living with dementia understand the complaints policy. This was an area for improvement.

The service had received four complaints in the last 12 months. We reviewed two of these and each complaint had been investigated and statements taken from people involved. Immediate action had been taken and this was recorded with the findings from the investigation and any further actions identified were recorded. Where staff were involved in complaints, this had been discussed with them and further training had been arranged for them to improve practice.

Some people and relatives told us they knew how to complain. They were confident that any concerns they had would be dealt with immediately by the registered manager.

Each person had been asked about their end of life wishes and their wishes had been recorded. Some people had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) in place, which was kept at the front of their care plan so it would not be overlooked. Nursing staff had received training in using specialist equipment to ensure that people received end of life medicines, to keep them comfortable. If required, people were referred to specialist palliative services for additional support. We observed that medicines required to support people at the end of life were at the service, were stored safely and were available when needed. Staff monitored people, they recognised when people were becoming frail and liaised with the GP to ensure that people received the care and support they needed. The GP reviewed people's medicines to ensure that they remained appropriate. Some people had completed an advanced care plan that detailed the care and support the person required and whether they wanted to be admitted to hospital or not. Staff, the person's GP and family were aware of the advanced care plans, helping to ensure that people's wishes were respected. Staff reviewed the care plans regularly to ensure that this still reflected people's wishes. Staff were aware and the care plan had information on people's cultural and spiritual needs regarding their end of life care. Staff told us that if relatives wanted to stay with their loved ones this would be arranged.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us they thought the service was well led. One relative told us, "The manager is always open and happy to assist." Another told us, "The manager is great and responds quickly to any queries."

At the last inspection, the provider had not maintained accurate records for each person. At this inspection some improvements had been made in the documentation relating to people's care support preferences. However, further improvements were needed as potential risks had not been consistently assessed and recorded for each person. Audits that had been completed on the care plans had not identified the shortfalls identified at this inspection. For example, for one person who was living with epilepsy, there were no guidelines for staff to follow about what a seizure might look like and what action to take. The risks to the person had not been identified, assessed and mitigated. Other records about people's care relating to catheter care and moving around were contradictory or lacked detail.

The registered manager carried out audits on a monthly basis covering areas including infection control, pressure sore management and catering. Actions were identified and if necessary, an action plan was developed with timescales and signed off when completed by the area manager who visited regularly to check on the progress of any action plans. Checking records was part of the audits. The audits had not identified shortfalls in the records found at the inspection.

Although some improvements had been made since the last inspection, this is the second consecutive rating of 'Requires Improvement.' CQC will continue to monitor the service to check that the quality of the service is assessed, monitored and improved and that improvements are embedded into practice and sustained.

The provider had failed to assess, monitor and mitigate risks, maintain accurate and complete records, assess, monitor and improve the quality of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager carried out weekly audits which covered checking people looked comfortable and had drinks within reach. They also observed staff completing tasks such as moving and handling people and checked the environment was well maintained. Any shortfalls identified were documented and actions recorded such as speaking with staff, delegating to nursing staff and discussing areas for improvement during handovers and at team meetings. Accidents, incidents and any complaints were reviewed each month by the registered manager and then by the provider to check if any lessons could be learned and if practice could be improved. Any learning was shared with the staff at staff meetings and one to one meetings.

The provider carried out a monthly assurance check of the service which covered a large number of areas. If any areas of concern were identified, actions were set out at the end of the audit. The provider carried out a follow up visit to check on the progress of any actions as a result. For example, the provider gave the registered manager tools to support them with making improvements such as a care plan audit form and a

Mental Capacity Act assessment form.

People were asked for their views on the service. The provider had carried out themed surveys such as around food and about people's experience when they spent time in their bedrooms to understand how people felt and ensure that their preferences were being respected. People had responded positively to the questions asked and any ideas or suggestions for improvement had been taken forward for example one person told us that they had mentioned that the television was too loud and this had been acted on straight away.

People and their relatives were invited to attend meetings every two to three months. People were given updates on the service and any changes happening and were also able to raise any concerns and ask questions. Action plans were developed following meetings to keep track of what had been raised and actions were signed off when completed such as arranging for a long table for Christmas dinner so that everyone was able to sit together. The registered manager confirmed that they had purchased a table that they would use.

Staff attended meetings every two to three months. Staff were reminded about key issues and given updates on topics such as continence care, food and fluid interventions and communication. Staff were able to give their views and opinions on the service. Staff attended daily handovers where the registered manager and nurses ensured staff were aware of any changes or informed of any incidents they needed to be aware of. The registered manager addressed any concerns they had involving staff immediately and reminded other staff their responsibilities.

A staff survey had been carried out and the results were analysed. Staff were asked about how they felt about certain areas such as whether there were enough staff, whether staff felt supported and whether staff felt they received enough training. Responses were mainly positive and staff told us that the feedback about staffing levels had been acknowledged and improvements made.

The area manager told us about working groups that they had started with other homes that the provider owned. These were designed to develop policies and procedures and promote best practice, for example, how to improve dementia awareness. The registered manager attended local forums such as forums held by Clinical Nurse Specialists to keep up to date with best practice.

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

There was an open and transparent culture within the service. The registered manager told us that they had an open door policy. They worked some shifts with staff so that they had an understanding of the role of the care staff. Staff told us that they felt supported by the registered manager and were comfortable to speak to them about any concerns they may have. The registered manager worked with other agencies such as the local safeguarding authority and commissioning groups to ensure that people are protected and receiving the care and support they need. The registered manager ensured that information was shared with relevant agencies under the information sharing guidelines, in an open and transparent way.

People and relatives told us that the registered manager was visible within the service. Each month people nominated a member of staff for 'Dignity Star', this was a member of staff that people felt had gone 'above and beyond'. In October, people had nominated the registered manager, for their help and hard work. The

registered manager told us their vision for the service was that everybody felt part of a loving family and this was promoted by the staff team. The registered manager discussed the vision for the service at staff meetings and spent time with people and staff to ensure that the values of the service were promoted.

The service invited the local community to engage with the service and held a fete in the summer. The local mayor attended the summer fete. The registered manager had organised for children from the local school to sing carols as part of the Christmas celebrations.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. This enabled CQC to check that appropriate action had been taken. The registered manager was aware that they needed to inform CQC of important events in a timely manner and had done this.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on a notice board and on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to assess the risks to people's health and safety, doing all that is reasonably practicable to mitigate risks to people receiving care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to assess, monitor and mitigate risks, maintain accurate and complete records, assess, monitor and improve the quality of the service.