

Forever Care Ltd

Fairlight Nursing Home

Inspection report

121 Worthing Road
Rustington
Littlehampton
West Sussex
BN16 3LX

Tel: 01903772444

Website: www.fairlightnursinghome.co.uk

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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 8 and 14 August 2017 and was unannounced.

Fairlight Nursing Home is registered to provide accommodation with personal and nursing care for up to 62 people with a variety of needs including those living with dementia. At the time of our inspection, there were 61 people living at the home all of whom were over 65 years of age and had varying needs such as those associated with old age, frailty and dementia. Fairlight Nursing Home has a range of facilities including five lounge- dining rooms. Fairlight Nursing Home has 62 bedrooms all with en-suite facilities. 28 are in the new building and 34 in the old building. The service had well maintained gardens which people could use in warmer weather. The premises were well maintained, clean and brightly decorated.

At the time of the inspection the service did not have a registered manager, but there was manager in post who was in the process of registering with the Commission. Following the inspection the new manager was registered with the Commission. 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 last inspection took place on 16 and 20 February 2017. At that inspection we made a legal requirement as the provider had not followed the procedure for reporting allegations to the local authority safeguarding team. The provider sent us an action plan to say how this legal requirement would be met. At this inspection we found action had been taken to meet this regulation. The registered manager and staff had a good awareness of when allegations of abuse should be reported.

The inspection was prompted by a notification that one of the people who lived at the service was given food of the incorrect consistency. The person choked due to swallowing problems and died. This is being investigated by the coroner and the social services safeguarding team. Since this incident the manager had introduced a number of changes to mitigate the risks of choking for those with swallowing problems. This involved the input of a Speech and Language Therapist (SALT) to advise on the assessment and safety of people who had problems swallowing. A new system of checks when delivering food to people had been introduced. However, we identified additional monitoring was needed to ensure staff took action to prevent people choking on food. We have made a requirement about this.

Checks were made that newly appointed staff were safe to work with people but references were not always obtained from previous employers. We have made a recommendation about this.

At the time of the inspection the service was undergoing a change of management. The new manager had introduced a number of changes and improvements to the service such as reducing the use of agency staff and employing more care staff and registered nursing staff. There were sufficient numbers of staff to meet people's needs. However, deployment of staff during lunch time was an area for development. We have

made a recommend about this.

Medicines were safely managed although we noted guidance regarding a 'when required' medicine for mental health needs was not recorded for one person.

We recognised the positive changes the new manager was making to the service. However, we judged these needed to be sustained and embedded in practice. For example, the service had recruited additional nursing and care staff who would need to be inducted.

People told us they felt safe at the home. Staff were aware of how to report any concerns regarding the safety of people.

Care records showed any risks to people were assessed and there was guidance of how those risks should be managed to prevent any risk of harm.

Since the last inspection the manager had introduced a system for planning and monitoring that staff supervision took place which was at the early stages of implementation. Staff said they felt supported in their work. Staff received a range of relevant training.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). People's capacity to consent to their care and treatment was assessed and applications made to the local authority where people's liberty needed to be restricted for their own safety.

There was a choice of food and people were complimentary about the meals. People were consulted about the food and meal choices.

People's health care needs were assessed, monitored and recorded. Referrals for assessment and treatment were made when needed.

Staff treated people with kindness and respect as well as being patient and gentle. People were able to exercise choice in how they spent their time. Staff took time to consult with people before providing care and showed they cared about the people in the home.

People said they were consulted about their care and care plans were individualised to reflect people's choices and preferences. Each person's needs were comprehensively assessed and included information about people's social and recreational needs. Care plans showed how people's needs were to be met and how staff should support people.

A good standard and range of activities were provided including entertainment and outings. People said they enjoyed the activities.

The complaints procedure was available and people said they know what to do if they had a complaint. People said they had opportunities to express their views or concerns. There was a record to show complaints were looked into and any actions taken as a result of the complaint.

People's views about the quality of the service were sought and the service's management acted in response to issues raised by people. This showed the management of the service was open to suggestions as well as criticism so the standard of care people received improved. The manager was aware of the challenges and improvements which needed to be made and was motivated and enthusiastic. A number of

audits and checks were used to check on the safety and quality of the service. However, these had not been effective in embedding change and improvement in the home, and had not identified some shortfalls that we found at this inspection.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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.

Changes had been made to mitigate the risks of people choking on food but we found further action was needed.

Staff recruitment procedures needed to be improved as adequate reference checks were not always made.

Sufficient numbers of staff were provided to meet people's needs. However, we have made a recommendation to review deployment of staff at lunchtimes.

Medicines procedures were safe with the exception of a lack of guidance for one person who had a medicine to be administered on a 'when required' basis.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Risks to people were assessed and guidance recorded so staff knew how to reduce risks to people.

Is the service effective?

Good 

The service was effective.

Staff were supported to complete relevant training and had a good knowledge of people's needs.

People's capacity to consent to care and treatment was assessed and staff were aware of the principles and procedures as set out in the Mental Capacity Act 2005 Code of Practice.

People were supported to have a balanced and nutritious diet. Health care needs were monitored. Staff liaised with health care services so people's health was assessed and treatment arranged where needed.

Is the service caring?

Good ●

The service was caring.

People were treated with kindness and dignity by the staff who demonstrated values of compassion and respect for people.

People received support and care which reflected their needs and choices.

People were consulted about their care and their privacy was promoted by staff.

People were supported regarding care at the end of their lives which reflected their wishes.

Is the service responsive?

Good ●

The service was responsive.

People's needs were assessed and reviewed. Care plans were individualised and reflected people's preferences.

A range of activities were provided to people by activities coordinators who were motivated and had the resources to enhance this aspect of people's lives.

The service had a complaints procedure and people knew what to do if they wished to raise a concern.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

Further action was found to be needed regarding supporting people to eat safely.

There were a number of systems for checking and auditing the safety and quality of the service. However, these had not been effective in embedding change and improvement in the home, and had not identified some shortfalls that we found at this inspection.

Improvements to the management of the service had taken place. The manager was motivated to meet the challenges in making changes to the service, which needed time to be embedded.

The provider sought the views of people regarding the quality of

the service and took action to address any concerns or suggestions.

Fairlight 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted by notification of an incident following which a person using the service died. This incident is subject to an investigation as part of the local authority safeguarding procedures which includes the police as well as an inquiry by the coroner's office. As a result of this we did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risks of people choking when eating food. This inspection examined those risks as part of a comprehensive inspection of the service.

The inspection was carried out by two inspectors, one of whom was a Speech and Language Therapist and concentrated on assessing how the service managed people who may be at risk of choking when they ate. An Expert by Experience was also part of the inspection team. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we checked information that we held about the home and the service provider. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. We did not request a Provider Information Return (PIR) to be sent to us as the inspection was brought forward because of concerns raised. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 12 people and six visiting relatives or friends of people who lived at the home. We spoke with seven staff and the registered manager.

We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI) on each of the days we inspected. SOFI is a way of

observing care to help us understand the experiences of people who could not talk with us.

We looked at the care plans and associated records for nine people. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints.

Is the service safe?

Our findings

At the inspection of 16 and 20 February 2017 we found the provider was in breach of Regulation 13 as one person had made a complaint which fell within the definition a safeguarding incident. This was not referred to the safeguarding team for investigation when it should have been. The provider submitted an action plan to confirm all such incidents would be referred to the safeguarding team. Since that inspection the provider has made appropriate referrals to the safeguarding team as well as notifying the Care Quality Commission of these. Staff had a good awareness of safeguarding procedures and knew who to report any concerns or allegations by speaking to their line manager. This requirement is now met.

We looked at the procedures for supporting people who were at risk of choking when eating food. Since an incident of choking where a person was given food of the incorrect consistency, the manager has introduced a number of changes to minimise the risks of this happening again. This included seeking the advice of an NHS Speech and Language Therapist (SALT) which involved the review of people's needs regarding risks of choking when eating. The provider had also sought the advice of an external consultant regarding safety and dietary needs. Staff said there was literature and guidance regarding supporting people to eat safely.

We spoke to a Speech and Language Therapist (SALT) from the NHS community health team. They said they had visited the service twice in July 2017 to assess the procedures for supporting those at risk of choking when eating. The SALT said they had observed people were not adequately supervised at meal times and arrangements were not made so people could always eat comfortably. This included a period of more than 45 minutes where there were no staff in one of the dining rooms to monitor people at lunch time when people needed some degree of support. We were told that they observed that food was not always cut up into small enough pieces for people to eat. Some people were prescribed a thickening fluid to help them swallow but the SALT said they had observed these were not always mixed to the right consistency. This meant measures designed to help people swallow were not always followed. The SALT provided a report to the provider about this and the manager had taken action to address the concerns raised. However, we found further action was needed to ensure people were always safely supported when there was a risk of choking.

The system of preparing, serving and supporting people to eat was reviewed on both days of the inspection. We spent time tracking meals from the time they were served in the kitchen to the point people ate them. The chef and registered manager explained that a new system of checks and recording had been introduced to ensure people got the correct food. This involved a system whereby the dietary needs of people were displayed in the kitchen, which kitchen staff used to plate up meals. Plate covers were used which had the name of the person so staff would give them the correct meal. There was also a system of colour coded trays for people who needed to have fluid thickeners. We saw food was served which matched the details recorded in care plans regarding consistency such as whether it was pureed or mashed. Care records also showed people were referred to a SALT when there as a risk of choking on food.

We observed meals being given to people in the dining rooms over two days which covered four meal times. People were given meals with the correct consistency such as pureed or fork mashable food. People were

supported to eat and were supervised by care staff although we noted two exceptions to this. Two people's care plan said they needed to be supervised by staff as they were at risk of choking were not always monitored by staff on the first day of the inspection. Both these people were observed to cough repeatedly when eating but staff did not check if these people were safe. At one point a member of the inspection team raised the issue of a person coughing whilst eating with a member of the care staff team but the staff member did not check if the person was in any difficulty. A registered nurse said care staff should have informed them when this occurred but had not. This showed staff did not always follow procedures to check people were safe when they coughed whilst eating food. Other staff we spoke with said they were aware of the system for checking people received the correct food and told us which people on the unit they worked in needed special diets to prevent choking. On the second day of the inspection we observed people were monitored during the meal time and that no one coughed whilst eating. Staff checked on these people and assisted them to eat.

We also noted that when staff made a record of the food they gave to someone the record did not always specify the consistency of the food. Following the inspection the manager confirmed that since the inspection visit additional checks had been put in place to ensure people were safe from choking when eating. This involved periodic visual checks and observation by a member of the service's management team that staff were following the correct procedures regarding staff supporting people to eat. The manager had also introduced a care plan guidance document in each person's bedroom so staff can check the food people should have.

The provider had not done all that was reasonably practical to mitigate the risks of people choking when eating. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment procedures were followed and included a Disclosure and Barring Service (DBS). DBS maintains a list of those people who are considered not 'fit' to work in a care setting. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC). Two references were obtained but we identified these did not always include the most recent or current employer where these were health and social care organisations. For example, one staff member's references were both personal references where the staff member had previously worked in a health and social care setting. The provider's recruitment procedure did not specify that references needed to be sought from previous employers. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 specify that reference checks should be made with previous employers where the staff member has worked in a health and social care setting. We recommend the provider's staff recruitment policy is updated to reflect the guidance in the regulations and that the policy is followed when recruiting staff.

The staffing levels were the same as at the last inspection when there were 60 people at the home; at this inspection there were 61 people. The service operated with between three and four registered general nurses (RGNs) and eleven care staff between the hours of 8am and 2pm. From 2pm to 8pm there were two RGNs and 10 care staff. The staff duty roster reflected the provision of these staffing levels. These staff were deployed between the four units of the home.

People and their relatives were critical about the deployment of staff in the service. People raised issues about the consistency of the staff team and the numbers of staff. For example, one person said, "At times there is not enough staff. They use a lot of agency people and continuity is a problem, they're very nice people, but it is a problem." Another person said of the use of agency staff, "I know they try to get the same ones but we often have new ones and they don't know what's what. The regulars have to do more and end up being rushed and it's me that is left sitting on the commode while they go off to help someone else and

take a while to come back." Staff said there were enough staff so they could safely look after people, but were also critical of the high use of agency staff.

The manager informed us there had been a high use of agency staff due to vacancies with 170 hours of agency staff per day from a total of 462. The manager was aware that people who lived at the service had raised concerns at resident's meetings and in surveys about the high use of agency staff and the problems of consistency this created. As a response to this, the manager and provider had taken action to restructure the staff team and to recruit additional staff. At the time of the inspection there were four vacancies for care staff and we were told that these would be filled by new staff during the month of August. Following the inspection the manager confirmed four new care staff had started work in August 2017 and a further eight care staff were due to start work. The home was fully staffed for day care staff but still needed to recruit for night time shifts as well as registered nurses posts in order that agency staff would not have to be used. The manager confirmed there was an ongoing process of recruiting more staff. Staff also recognised that additional staff had been recruited and that further staff were due to start work which meant the situation was improving. In addition to this a head of care and a clinical lead were appointed, both of whom were supernumerary to the care and registered nursing staff. Following the inspection, the manager told us a dependency assessment tool was to be introduced to assist in determining staffing levels. We judged the service had sufficient numbers of staff at the time of the inspection. However, in view of the comments about the deployment of staff during lunch time we recommend that the provision of adequate staff at meal times is kept under review.

We looked at the service's procedures for the handling, storage and administration of medicines. RGNs handled and administered medicines. A record of each person's prescribed medicines was maintained on a medicines electronic recording system. Training was provided to staff in using the electronic medicines records. Staff completed a record when they administered medicines to people. Stocks of medicines also indicated medicines were administered as prescribed. People confirmed they were supported to take their medicines and that they were satisfied with this. Medicines were stored in people's bedrooms in a locked cabinet.

Where people had 'when required' medicine prescribed for specific occasional symptoms the medicines records included the reason the medicine may be needed. However, we noted one person who had 'when required' medicine for mental health symptoms did not have care plan guidance about when this should be given. Medicines records showed it had been administered on different occasions when the person was agitated, anxious, verbally aggressive, or had shouted. There was no guidance about this so staff would know what to do or if they should try any other calming techniques or ways to divert the person from this behaviour. This was also found to be an issue at the last inspection. Following this inspection the registered manager said 'when required' medicines procedures would be reviewed. This is an area which needs to be improved.

Every person and relative we spoke with said they considered the service a safe place. For example, one person said, "I feel very safe here. The staff are very good. They knock on the door before they come in and they're all really kind, some of course are better than others. I've no complaints at all." Another person told us, "Yes, I feel very safe here, personally and my belongings. I've been here a couple of years and I'm happy knowing someone is looking out for me." A relative also said they considered the service was safe, "We never wanted to find our relative in here but a safe environment and nursing care is needed and we are happy that relative is receiving that here." The people we spoke with appeared relaxed in the company of staff. People also said they would not be afraid to speak up if they felt unsafe.

Risks to people were assessed and recorded. There were corresponding care plans so staff had guidance on

how to support people to reduce the risk of injury or harm. These included the risks of falls, the risk of pressure areas developing and risks when moving people. Risk assessments and care plans gave staff clear guidance on how to support people to mobilise safely. Where people were assessed as being at risk of developing pressure areas on their skin there was a care plan of the action being taken to reduce this such as by the use of air mattresses and action to ensure people were assisted to move at regular intervals. Charts showed people were repositioned at regular intervals when in bed and as set out in care plans. Risk assessments were reviewed on a regular basis to ensure they were still accurate and reflected the current risks.

Checks were made by suitably qualified persons of equipment such as the gas heating, electrical wiring, fire safety equipment fire alarms, hoists, passenger lifts and electrical appliances. Each person had a personal evacuation plan so staff knew what to do to support people to evacuate the premises. Staff received fire safety training and fire drills took place. Temperature controls were in place to prevent any possible scalding from hot water, and the temperature of water was also checked. The procedures for the prevention of Legionella were checked. Radiators had covers on them to prevent any possible burns to people. A risk assessment of the garden identified the pond needed to be covered to prevent anyone falling in. Following the inspection the registered manager said arrangements were being made for a grill to be installed over the pond.

Is the service effective?

Our findings

People and their relatives said the care staff and registered nurses provided a good standard of care. People said some staff were exceptionally experienced and deserved commendation for the standard of their work. The common feedback from people was that all the staff were attentive and cared for them. Comments included the following: "I couldn't wish for better staff. They do everything for me." Another person said, "The nurses and care assistants are wonderful. I have to be supported in everything I do otherwise I collapse. I get all the support I need. I'm not rushed and that's important because I can't." Relatives were also positive about the skills of staff. For example a relative said, "This is all new to me but I can see how well the staff are treating my [relative]. It is very difficult when you have to find care and there is worry and guilt but it helps that I am kept informed and I can see for myself when I visit how patient and respectful everyone is."

The previous inspection report identified that whilst staff said they felt supported in their work regular supervision had not taken place and had not met the provider's own policy of four supervision sessions per year. The new manager had implemented a system of supervision which included detailed plans of when individual staff would be supervised and by whom. We saw records that supervision and appraisals had taken place for care staff and registered nurses. The manager had just implemented the new system of supervision so some staff and registered nurses had yet to receive supervision under the new system. Staff said they received a one to one supervision with a line manager and one staff member said they had not yet had supervision in 2017 but knew they would be getting it soon.

Staff confirmed they received training which they said was of a good standard. This included training which was considered mandatory such as, health and safety, moving and handling, dementia care, fire safety, first aid, nutrition, pressure area care, first aid, infection control, nutrition and falls prevention. Registered nurses had completed training on subjects such as medicines procedures, record keeping, the administration of insulin, wound care and catheterisation. The service had a staff member who was a specialist in palliative end of life care.

Eleven of the 35 care staff were trained to National Vocational Qualification level 2 or above or in the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The registered manager had introduced a system of induction for newly appointed staff. New staff enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers stick to in their daily working life. It is the new minimum standard that should be covered as part of induction training of new care workers.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

There were policies and procedures regarding the Mental Capacity Act 2005 and the associated Code of Practice. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). An assessment tool was used for determining if people had capacity to consent to their care and treatment. The manager had a good understanding and experience of the MCA. Where people did not have capacity to consent to their care and treatment there was a record of multi-agency 'best interests' meetings where decisions were made about people and as advised in the MCA Code of Practice. Twenty four people were subject to a DoLS authorisation. Where people had capacity to consent to their care and treatment records showed they were fully involved in any decisions about their care.

People told us they liked the food and said there was a choice of meals. For example, one person said, "The food is smashing, really brilliant, lovely and hot and we get a varied menu." Another person said, "I cannot fault the food. If you were to go to some fancy hotel you could not do better. I have never had any food I do not like; we get a good choice and good portions. I'm a nuisance to cater for as I'm diabetic but they do it, they look after me." A third person said, "I'm what you would probably call a finicky eater but the food is very good indeed. I recommend it." People also said their dietary needs were addressed; for example one person said, "I've got diabetes but they're all good at making sure I don't eat anything I shouldn't. I'd take a cake if I could but they won't let me, they do make me special desserts and I get diabetic biscuits with my tea so I don't feel too hard done by."

People were asked in advance what they would like to eat. We observed the midday meal in three of the dining rooms and for some of the people who ate in their bedrooms. There was a choice of food for people. Staff knew people's needs and preferences regarding food. The meal looked appetising and was presented well. Drinks were provided at meal times and were available for people in their rooms. We noted there was a delay of 36 minutes in the serving of the dessert on one occasion and people became slightly restless. The care staff on duty said this was not unusual. Whilst this did not have a significant impact on people it is an area which could be improved on.

Snacks and hot drinks were also provided in the morning and afternoon. These included homemade cakes which people were complimentary about. Specialist diets were catered for such those for people with diabetes. There was a record for the kitchen staff about people's likes and dislikes for food as well as any specialist dietary requirements.

Where needed, people's nutritional needs were assessed using a malnutrition universal screening tool (MUST). People were referred to their GP if the MUST identified them as being at risk of malnutrition. People's weight was monitored to assess any changes. A care plan was devised regarding the support people needed for food and drink. People told us they were referred to health services when needed. Relatives also confirmed staff referred people for health care services such as the GP or chiropody services. Care records included details about each person's medical history and the monitoring of health care needs.

People said the staff made arrangements for them to have checks and treatment from health care professionals. For example, one person said, "I have to be a bit careful as I'm a diabetic; they take good care of me here though. Last week I had a bit of a cold, they had the doctor out to me within hours. There is no problem seeing the doctor, they do all the organising here – just mention it and it's as good as done. Another person said, "There is no problem seeing a doctor here. The doctor would be in quickly. The nursing staff are very good. The chiropodist comes in regularly and if I needed to see a dentist I'd only have to ask for it to be organised." Care records showed health needs such as breathing and circulation as well as dental

and oral health care were checked.

Is the service caring?

Our findings

People told us staff treated them well. For example, one person said, "Staff are gold star. They are lovely, caring staff and they make me feel quite special." A relative said, "The staff are excellent, I visit regularly and I see how patient they are." People said they had good relationships with the staff and that they laughed and joked together.

We observed staff treated people with kindness and respect. Staff spoke to people calmly and made good eye contact with them. We observed where an agency staff member stood over a person they were helping to eat that a more senior staff member instructed the agency staff not to do this and to sit and make eye contact with the person. For all our other observations of staff interacting with people we saw staff made good eye contact, lowered themselves to the same level as the person and spoke politely to people. Where people were distressed or upset staff provided support and reassurance which had a positive outcome for people. Staff were skilled and patient in gently assisting people who became distracted when eating their lunch. Staff communicated well with people and showed warmth towards them. Staff were cheerful and friendly with people. Staff who arranged activities for people also took part in the lunch and chatted to people about history and topical events; these interactions were of a very good standard and made people feel they mattered.

Staff demonstrated values of compassion and respect for people. Staff said they treated the people in the home as if they were members of their own family or how they would like to be treated themselves. For example, one staff member said they, "Treat people equally as you would like to be treated yourself...with respect, dignity and compassion. As a whole people are treated this way." Another staff member said, "I can't work if I don't love them. I love to work with people with dementia."

Staff stressed the importance of providing care which reflected people's needs and preferences. People said they were consulted about their care. Each person's care plan showed people's preferences were assessed and included in how care was provided. Emotional and mental health needs were assessed and there was guidance for staff to follow if these needs increased.

Independence was promoted and people confirmed they were supported to maintain their own daily living skills. Care plans included details about which aspects of personal care people could do for themselves and where staff needed to provide support.

People told us staff respected their privacy and dignity by always knocking on their bedroom door before entering. We observed staff knocked on people's bedroom doors and waited for a response before entering. People said they were able to choose if they wanted care from male or female care staff.

Arrangements were in place to ensure people were supported to have a dignified and comfortable death. The service had a RGN whose job title was Palliative Care Coordinator, which involved taking a lead role in end of life care. The RGN had completed training in end of life care. Registered nurses said they had also received training in end of life care from a local hospice trainer. People who were nearing the end of their

lives had care plans for this which reflected their preferences and changing needs.

Is the service responsive?

Our findings

People and their relatives said the staff met their care needs. People said they were asked how they wanted to be helped and were able to say what their preferences were. People also said they attended a good range of activities. For example, one person said, "I only go out of my room if there's something on that interests me, just like you would at home, and this is my home. There's plenty going on if I want to join in but my room is comfortable, I have all I need and I'm never lonely as someone always pops in with a cuppa, or just a nod to check all is well."

There was a comprehensive system for assessing people's needs before and following admission to the service. This included a pre admission assessment which covered a range of care needs such as mobility, medicines, communication, continence, medical history and social and recreational needs. Following admission, further assessments of need were completed. Care plans were recorded to show how care needs were to be met. We saw moving and handling care plans were of a good standard and included details of the numbers of staff needed to support someone as well as the guidance for staff on how to support or supervise people when they moved. There were assessments of the risks of pressure areas developing and the action staff needed to take. Personal care needs were assessed and care plans gave guidance to staff on how to support people with personal hygiene. The care planning system included people's goals regarding personal care, such as where they can complete tasks themselves. Mental health and emotional needs were assessed. Records regarding mental health needs were of a good standard and included details of how to communicate with people. Care records showed needs were reassessed and care plans updated where needed. We noted one person's care plan regarding the management of distress and 'as required' medicine needed more information which is included in the Safe section of this report.

The service provided a good range of activities to meet people's social and recreational needs. People and their relatives said there were a range of activities both in the home and outside. For example, one person said of the activities, "They've even come in, in their own time, and organised cheese and wine parties, we're very lucky." The service employed two activities coordinators and we saw there was a good system of informing people what activities were provided. We observed the activities staff discussing a forthcoming play which people would be involved in. People were supported by staff to access community facilities such as the shops, pubs or cafes. People were able to use the service's mini bus for outings. We observed an activities coordinator talking to someone who lived with dementia. The staff member was skilled in interacting with the person to find out what they wanted to do.

People and their relatives said they were aware of the complaints procedure and said they knew what to do if they had a concern. For example, one person said, "I'm an easy person to satisfy but if things are going wrong I can speak up."

The records of complaints were detailed and showed any issue raised was looked into and that the complainant was satisfied with the outcome of the investigation.

Is the service well-led?

Our findings

Since the inspection in February 2017 there has been a change of manager. People and staff were positive about the new manager. For example, one person said, "I've been here a couple of years and this new manager seems very nice indeed, she actually comes round and speaks to us. She's trying to stabilise the ship and keep the good agency staff and find more permanent ones." Another resident said, "The new manager is very good, very attentive and listens. She is more a people person." Other people and their relatives said the manager had been round to speak to them individually. People confirmed they felt able to approach the manager. People said the staff seemed happier at work since the manager had been in post. Staff said the manager was making improvements at the service. However, we found that the service was not consistently Well-Led.

The provider and manager used a number of audits and checks regarding the quality and safety of the service which were carried out on a monthly, three monthly and annually. The audits included accidents, incidents and falls, wound care, catering, infection control and call bell response times. The manager said she would be introducing changes so that the recording of accidents included an analysis so that any trends could be identified. However, we identified issues that had not been picked up in the quality audits, which needed addressing by the management in order that people received safe care at all times. These included written procedures for 'when required' medicines for one person, which was also raised at the last inspection. Despite improvements being made to ensure people were supported to eat safely we found this was not always the case during the inspection. Additional monitoring was needed to ensure that staff were aware of the advice from the SALT team, and recognised and acted when people coughed whilst eating. Whilst new staff had been recruited the service still had staff vacancies and newly appointed staff would need time to complete their induction. This was an area that requires improvement.

The provider sought the views of people and their relatives by the use of surveys and meetings. We saw records of surveys for 2016 when people described the service as good or excellent, with friendly staff who were "always smiling," but that cleanliness was variable. Residents' and relatives' meetings took place. Records of a meeting in June 2017 showed people raised issues such as language issues regarding agency staff, response times when people used their call points, the menu plans and drinks. There was a record to show these were looked into and addressed showing that the home's management were open to suggestions and to criticism which were acted on to improve the service for people. The manager had taken action to address the agency staffing issues by recruiting more staff, including a head of care, nursing staff and care staff and was aware of how the language issues of staff from overseas had affected people.

Staff meetings took place and staff said these enabled them to discuss and communicate issues about the service. Daily shift handover meetings were held and staff said this was useful in being able to discuss and update the staff team about people's care needs. Staff were positive about changes being made by the manager. For example, a registered nurse said they felt comfortable approaching the manager with any work or personal issues and that they were listened to. This staff member said, "Whatever we raise or ask, which is reasonable, we get whether it's training or personal support."

The manager was aware of the challenges she faced in improving the service. For example, new care planning tools were to be introduced so staff had access to care plan summaries in people's rooms. The manager had also made changes so communication with registered nurses was better. We noted the manager was motivated, enthusiastic and able to recognise where changes needed to be made.

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
Treatment of disease, disorder or injury	The provider had not taken sufficient action to mitigate the risks to service user who were identified as being at risk of choking on food. Regulation 12 (2) (b)