Mills Family Limited

Fairlight & Fallowfield

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

This inspection took place on the 22, 23 and 24 November 2017 and was unannounced. Fairlight and Fallowfield is a 'care home'. People in care homes receive accommodation and nursing, or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates up to 55 people, across two joined buildings, one of which focuses on residential care, and the other on nursing care. There were 48 people living at the home at the time of our inspection.

At the last comprehensive inspection in February 2017, we asked the provider to take action to make improvements to address deficiencies in staff training. We conducted a focused inspection of the service in June 2017 to follow up on further issues we had identified during our February 2017 inspection relating to poor risk management, following which we asked the provider to take action to make improvements to address concerns relating to the management of pressure relieving equipment at the service. We also took enforcement action following that inspection, serving a warning notice on the provider and registered manager, requiring them to address concerns we had identified with their systems for monitoring the quality and safety of the service. These actions have all been completed.

At this inspection we found improvement was required because sufficient staff were not always deployed in a way that ensured people received prompt support when required. We found further areas of improvement were required to ensure environmental risks were consistently managed safely at the service, call bell response times were monitored effectively and to ensure notifications were consistently submitted to CQC, where required.

The service did not have a registered manager in post. 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 current service manager was in the process of applying to become the registered manager.

Risks to people had been assessed, and staff acted to manage identified risks safely. People were protected from the risk of abuse, because staff were aware of the types of abuse that could occur and the action to take in reporting any concerns they had. Medicines were stored, recorded and administered to people safely. Staff were aware of the action to take to ensure people were protected from the risk of infection. Staff were also aware to report any accidents or incidents and records showed that any accidents that had occurred at the service had been followed up to reduce the risk of repeat occurrence.

The provider followed safe recruitment practices when employing new staff. Staff received an induction when they started work at the service, and were supported in their roles through a programme of training and regular supervision, which included an annual appraisal of their performance.

People were supported to maintain good health. External healthcare professionals confirmed that staff worked in partnership with them to ensure people received consistent support across different services. People were also supported to maintain a balanced diet and told us they were happy with the layout and decoration of the home. People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

People confirmed staff treated them with care and consideration, and that their privacy and dignity were respected. Staff involved people in day to day decisions about their care. People had care plans in place which reflected their individual needs and preferences. The service offered a range of activities for people to engage in, and we saw plans in place to increase the level of one to one activity support for people who were unable, or did not wish to take part in communal activities. The service provided appropriate care and support to people at the end of their lives.

People and relatives were aware of how to make a complaint and expressed confidence that any issues they raised would be addressed by the manager. The provider had systems in place to gain the views of people about the service with a view to driving service improvements. People, relatives and staff spoke highly of the manager, and told us there service had improved in recent months. Staff were aware of the responsibilities of their roles and told us they worked well as a team, focussing on providing people with good quality care and support.

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.

The manager determined staffing levels based on an assessment of people's needs, but staff were not always deployed in a way which ensured people received prompt support when required.

Risks to people were assessed, and plans were in place to manage identified risks safely, but improvement was required to ensure environmental risks were consistently safely managed.

People were protected from the risk of abuse because staff were aware of the signs to look for and action to take if they suspected abuse had occurred.

Staff were aware to report any accidents and incidents, and senior staff had taken action where accidents had occurred, to reduce the risk of repeat occurrence.

People's medicines were stored, administered and recorded safely.

The provider followed safe recruitment practices.

Staff were aware of the action to take to ensure people were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff received an induction when they started work at the service and received support in their roles through regular training and supervision, including an annual appraisal of their performance.

Staff had assessed people's needs and provided support in line with nationally recognised standards.

People were supported to maintain a balanced diet and told us the living environment met their needs.

Staff sought people's consent when offering them support and

acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) where applicable when people lacked capacity to make decisions for themselves.

People were supported to access a range of healthcare services when needed. Healthcare professionals visiting the service confirmed that staff worked well them to deliver effective, joined up care.

Is the service caring?

Good

The service was caring.

Staff treated people with care and kindness.

People's privacy and dignity were respected by staff.

Staff involved people to make decisions about the support they received.

Is the service responsive?

Good

The service was responsive.

People were supported by staff in line with the guidance in their care plans which reflected their individual needs and preferences.

People were supported to take part in a range of activities and to maintain the relationships that were important to them.

The provider had a complaints policy and procedure in place. People knew how to make a complaint and expressed confidence that any issues they raised would be dealt with appropriately.

People received appropriate end of life care and support.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to the provider's systems for monitoring the quality and safety of the service people received. However, further improvement was required because call bell response times were not monitored effectively.

There was no registered manager in post. The current manager was in the process of applying to become the registered

manager. They understood the responsibilities of the role, including the events that required them to submit a notification to CQC. However, improvement was required to ensure notifications were consistently submitted where required, in line with regulatory requirements.

People, relatives and staff told us the manager was a positive influence who provided effective support and drove improvements at the service.

The service worked in partnership with other agencies where required.

Staff were aware of the responsibilities of their roles and spoke positively about the way in which they worked as a team.

The provider had systems in place to seek feedback from people about the service with a view to driving improvements.

Fairlight & Fallowfield

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 brought forward due to information of concern shared with the Commission by relatives of two people who had been living at the service, about the quality of the care their loved ones had received.

This inspection took place on the 22, 23 and 24 November 2017 and was unannounced. The inspection team consisted of one inspector, a specialist advisor, specialising in nursing care, and an Expert by Experience on the first day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection was completed by one inspector who returned to the service on the second and third days.

Prior to the inspection we reviewed the information we held about the service. This included details of the complaints shared with the commission by relatives of people who had lived, as well as notifications received from the provider about deaths, accidents and safeguarding allegations. A notification is information about important events that the provider is required to send us by law. We also received feedback from a local authority commissioning team and a social worker who had recently had involvement with people living at the service. We used this information to help inform our inspection planning.

Due to our decision to bring the inspection date forward, the provider was not able to complete a 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 took this into account when we inspected the service and made the judgements in this report.

During the inspection we spoke with 22 people, eight relatives and a visiting healthcare professional from the local hospice to gain their views of the service. We also spoke with a community nurse who visited the service on a regular basis by telephone following our inspection, to seek their feedback. We also spent time observing the support staff provided to people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk

with us.

We spoke with 14 staff, including the service manager, residential unit manager, clinical lead, two nursing staff, the head of housekeeping and the senior activity co-ordinator. We also looked at records, including eight people's care plans, five staff recruitment records, staff training and supervision records, and other records relating to the management of the home, including Medication Administration Records (MARs), audits, and minutes from staff and residents meetings.

Requires Improvement

Is the service safe?

Our findings

People and relatives had mixed views about the staffing levels at the service. One person told us, "A member of staff will come if I need help; I use my call bell." Another person said, "The staff are always in a rush they cannot come and sit with me." A relative commented, "They've employed more staff recently which is an improvement, but it depends on who is on duty and what time of day it is, as sometimes it can be very busy."

The manager explained that staffing levels were determined based on an assessment of people's needs, using a dependency tool. Records showed that this had led to a recent increase in the number of staff on duty during the day. The manager also confirmed that they had successfully recruited new staff to vacant posts at the service which had recently led to a reduction in the level of agency staff being used. Records we received confirmed this, and we noted that actual staffing levels reflected the planned allocation.

However, improvement was required because one relative told us, "[Their loved one] can wait five or ten minutes before anyone comes to answer the call bell." We tested call bell response times during our inspection and found that it took staff nine minutes to respond on one occasion, despite a staff member remotely confirming their intention to attend very shortly after the bell sounded. We also reviewed a sample of call bell response data and found examples of people waiting between eight and 12 minutes before staff responded to them. This placed people at risk of not receiving the support they required in a timely manner.

We raised this issue with the manager and provider and they investigated our concerns. They identified an issue with the call bell system which they told us could be addressed with an update which would alert staff to delayed attendance even if a staff member had accepted the call remotely. They told us they would look to update the system, although we were unable to check on the outcome of this at the time of our inspection.

The service followed safe recruitment practices. Records showed that staff completed application forms when applying for their roles which included details about their education and employment history. We noted that the provider had explored reasons for any gaps in employment with staff. Staff files also contained confirmation of checks having been made on identification, criminal records checks, references and confirmation of right to work in the UK, where this was applicable. We also noted that checks had been made on the professional registration of nursing staff. These checks helped ensure staff were of good character and suitable for the roles they were applying for.

At our last focused inspection we found a breach of regulations because pressure relieving equipment used was not safe for use. Following that inspection, the previous registered manager wrote to us to tell us the action they had taken to address this issue. At this inspection we found equipment used to support people was regularly maintained to ensure it was safe and fit for use, and action had been taken to address any identified issues. For example, records showed a castor on a mobile hoist used to transfer people at the service had recently broken and we confirmed that this had been replaced.

However, improvement was required to ensure environmental risks were safely managed. On the first day of

our inspection, we noted that doors to areas which should be kept secure were not always locked. For example, we found the doors to a sluice and maintenance room which opened directly onto a short flight of concrete steps were not locked, placing people at risk if they attempted to access these areas. We raised these concerns with the manager who ensured the maintenance room was secured and arranged for a replacement lock to be put on the sluice room door to prevent people from accessing these areas.

Risks to people had been assessed and we saw guidance was in place for staff on how to support people safely. People had risk assessments in place which covered areas including mobility, falls, skin integrity and malnutrition. These were reviewed on a regular basis to ensure they remained reflective of people's current needs.

Action had been taken by staff to manage identified risks. For example, where people' skin integrity had been identified as an area of risk, we saw pressure relieving equipment was in place, and records showed that staff had supported people to reposition in line with the guidance in their risk assessments. In another example, we saw referrals had been made for people to a dietician where they had been identified as being a risk of malnutrition, and records showed their weights and food and fluid intake were monitored by staff. Clinical staff also discussed people's food and fluid intake during handover meetings between shifts, to ensure all staff were kept up to date about the support people required.

There were procedures in place to deal with emergencies. People had personal emergency evacuation plans (PEEPs) in place which gave guidance to staff and the emergency services on the support they required to evacuate from the service safely. Records showed that regular checks were made on fire safety equipment, including the fire alarm, and that staff took part in periodic fire drills. Staff we spoke with were aware of the provider's procedures in the event of a fire or medical emergency.

The provider had systems in place to protect people from the risk of infection. Regular checks were made on the cleanliness of the service and we noted that the service was clean, with domestic staff carrying out cleaning duties throughout the time of our inspection. Records also showed the service had a contract in place with an external service provider to carry out periodic deep cleans. Staff were aware of the need to use personal protective equipment when supporting people, in order to reduce the risk of spreading infections, and people told us staff used equipment such as disposable gloves when supporting them. The management team conducted regular infection control audits to ensure safe practice. We noted that hand sanitiser was only available in communal bathrooms, and not readily available in other areas where people were supported. We raised this issue with the manager who told us they would look at options to provide staff with person hand sanitizer.

People's medicines were managed safely. Medicines were stored in locked trolleys which were securely stored in clinical rooms when not in use. Regular checks were made of the temperatures of storage areas, including medicines stored in medicines refrigerators, were required in order to ensure they remained effective for use. Staff responsible for medicines administration had received training and a competency assessment to ensure they supported people with their medicines safely. The provider had systems in place for the receiving and disposal of medicines to ensure the service did not hold onto excess amounts of medicine stocks.

People told us they received appropriate support from staff to take their medicines. One person said, "They give me my tablets; no problems." Another person told us, "The staff help me with my medication. They're very good; they've just given me my eye drops." People had medicine administration records (MARs) in place which included a recent photograph and details of any known allergies, to help reduce the risks associated with medicines administration. We reviewed a sample of people's MARs and found them to be up to date

and accurate, confirming that people received their medicines as prescribed.

There was guidance in place for staff on how to support people with any medicines which had been prescribed for them to take 'as required'. We observed staff supporting people to take their medicines and noted that they communicated clearly with people, explaining what they were doing and giving people sufficient time to take their medicines at their own pace. We also noted that staff offered people their 'as required' medicines appropriately, in line with the guidance in their records. For example one staff member checked to see of one person was in any pain before offering them pain relief medication which had been prescribed for them to take when needed.

People were protected from the risk of abuse. The provider had safeguarding procedures in place and we saw guidance in place and available to people, relatives and staff on identifying and reporting any potential abuse. Staff had received training in safeguarding adults. They were aware of the types of abuse that could occur and knew to report any suspected abuse. They were also aware of the provider's whistle blowing policy and told us they felt confident to use this, if needed. One staff member said, "I would report any safeguarding concerns to the manager or head office, but if they didn't act, I'd speak to social services or CQC."

Records showed that the manager had followed the provider's safeguarding procedures in reporting any concerns to the local authority safeguarding team where they had been identified. Prior to our inspection we also spoke with a social worker who had investigated a recent allegation. They confirmed the manager had worked with them in an open and transparent manner during the investigation, providing further information promptly where required in order to complete the investigation. The also confirmed the outcome of the investigation concluded that there was no evidence to substantiate the concerns that had been raised.

Staff were aware of their responsibilities to report any accidents, incidents or near misses at the service. The manager maintained a log of accidents and incidents and we saw examples of staff having acted to reduce the risk of repeat occurrence in order to keep people safe. For example, records showed one person's medicines had been reviewed by a GP following a recent fall, and another person who had suffered multiple falls had been referred to a falls clinic for specialist advice.

Good

Is the service effective?

Our findings

At our previous comprehensive inspection we found a breach of regulations because staff were not always up to date with mandatory training. At this inspection we found that the provider had addressed this, in line with their action plan.

People and relatives told us they considered staff to be competent in the way in which they provided support. One person said, "I've no concerns about the way staff have supported me. They have to hoist me, which I was anxious about at the start, but they know what they're doing." A relative told us, "The staff really understand. They take so much care they know exactly what to do; they're very professional."

Staff told us they completed an induction when starting work for the service, which included a period of orientation, time spent familiarising themselves with policies and procedures and time shadowing more experienced colleagues. Staff with no experience of providing care were also required to complete the Care Certificate during their first months of employment. The Care Certificate is a nationally recognised set of standards for staff working in health and social care.

Staff also completed training in a range of areas considered mandatory by the provider. This included training in infection control, safeguarding, equality and diversity, health and safety, moving and handling, and first aid. This training was periodically refreshed to ensure staff remained up to date with best practice. For example, we noted that training was scheduled for the upcoming month for staff who required fire safety refresher training, and clinical training was scheduled for nursing staff in areas including catheterisation, ear syringing and phlebotomy. Records also showed that staff were supported to sign up to undertake relevant health and social care qualifications, such as diploma courses, where they wished to further develop their knowledge and skills.

Staff told us the training they received gave them the necessary skills to perform their roles. One staff member said, "The training has given me a lot of confidence in the way I work with the residents." Another staff member said, "The training has been helpful; I feel I know what I need to do when taking care of the residents." We observed staff support people competently during our inspection, for example, when supporting people to transfer between a wheelchair and armchair using a hoist.

Records showed that staff were also supported in their roles through regular supervision and an annual appraisal of their performance. One staff member told us, "I meet with my manager regularly for supervision. It gives me an opportunity to feed back about my views on the role, and any concerns I have, as well as enabling my manager to confirm what's expected of me." Another staff member said, "Supervision is helpful as a way to remind us of good practice."

Senior staff conducted an assessment of people's needs before they moved into the home to ensure they could be met. These assessments included consideration of support people needed in a range of areas, taking into account, their physical and mental health, as well as any social, spiritual and cultural support they required. The manager explained that assessment information was used to help develop people's care

plans and risk assessments, taking into account their views and preferences using nationally recognised tools and standards. Records we reviewed confirmed this. For example, we saw examples of risk assessment tools which were based on nationally recognised standards, such as the Malnutrition Universal Screening Tool used to assess the risk of malnutrition, or Waterlow scale used to assess risks to people's skin integrity.

People were supported to maintain a balanced diet. We received mixed feedback about the meals on offer at the service. One person told us, "The food is very good; good portions and staff are always offering us drinks." Another person said, "The food is not too bad. I do like having a choice and they [staff] show me every day the options I can have. There are always plenty of drinks; hot tea or coffee, or juice. We always have a jug of water in our rooms." However a third person commented, "No I do not like the food, it's always the same sort of stuff."

People's care plans contained an assessment of their nutritional needs. This included information about the food and drink preferences, as well details of any food allergies or specific dietary requirements they had such as requiring a fortified diet due to being at risk of malnutrition. This information was also on display in the kitchen to ensure people's meals were prepared in line with their assessed needs.

Records showed that professional advice had been sought where risks associated with eating and drinking had been identified. For example, one person was at risk of choking and guidance had been put in place by a Speech and Language Therapist on how their food and drink should be prepared, and how they should be positioned when eating or drinking. Staff we spoke with were aware of this guidance and confirmed they supported the person accordingly.

Staff told us people were welcome to eat where they wished. Some ate in communal dining rooms whilst others ate in their rooms or in one of the lounge areas. The atmosphere in the dining areas was relaxed and friendly, with staff on hand to support people where required. We observed examples of staff supporting people with their meals on a one to one basis, giving people time and encouragement to eat at their own pace. We noted one person requesting a change to the meal they had chosen, which staff catered for promptly. People's independence at mealtimes was also promoted through the use of equipment such as plate guards.

People were supported to maintain good health. One person told us, "If I need to see the doctor, the staff arrange it; there's one that visits every week." Another person said, "I have the physio coming to see me tomorrow. You can book an appointment with the optician, but mine are OK at the moment." People had access to a range of external healthcare services when needed, including a GP, community nurse, speech and language therapist, dentist and optician. We saw that staff made notes about any health concerns they had identified in the people living they supported which were shared with the GP during their regular visits so they could consider the most appropriate course of treatment.

Staff worked to ensure people received co-ordinated care when moving between different services. People's health appointments were diarised so staff were aware of any support people needed to attend, and could plan accordingly. For example, one person had a hospital appointment on one of the days of our inspection which was noted in the communication book, and we observed staff contacting the hospital to arrange appropriate transportation. We also spoke with a community nurse who regularly visited who told us staff kept them well informed about people's conditions and made prompt and appropriate referrals to them.

People told us they were comfortable living at the service and that it met their needs. Whilst the décor in some areas was old, the provider was in the process of working through a programme of improvements. One person said, "We were told we were welcome to bring in any decorations or furniture we wanted keep

with us when we moved in." Another person showed us pictures they had put up on their bedroom walls to personalise the space. People also spoke positively about the gardens surrounding the service which they told us they enjoyed, and we saw that these were well maintained.

Staff told us they only provided people with support with their consent. One staff member said, "We can't force people to do things they don't want to. We can try and encourage them, but it's their decision." Another staff member said, "If someone didn't want me to help them, I have to respect their wishes. For example, if someone didn't want to have a wash, I can't make them, but would ask them again later to see if they'd changed their mind."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether 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.

Staff demonstrated an understanding how the MCA applied to their roles in supporting people at the home and told us they supported people to make decisions for themselves wherever possible. They were also aware of the process to follow to ensure specific decisions were made in people's best interests, where they lacked capacity to make the decision for themselves. People's care plans included records of mental capacity assessments having been conducted, and best interests decisions having been made for more significant decisions such as the use of bed rails, in line with the requirements of the MCA.

The management team were also aware of the process for seeking authorisation to deprive people of their liberty where this was in their best interests under the DoLS and records showed that they had submitted DoLS authorisation requests to the relevant local authorities. We saw appropriate authorisations in place where DoLS assessments had been completed and found that any conditions placed by local authorities had been met.

Good

Is the service caring?

Our findings

People and relatives told us that staff were caring and considerate in the way in which they worked. One person said, "I'm looked after here; nothing is too much [for the staff]. They do care for me." Another person told us, "I'm well looked after by the staff. They show me a great degree of kindness." A relative commented, "The staff have been excellent; nothing has been too much trouble."

Staff we spoke with knew the people they supported well. They were aware of people's interests, likes and dislikes, as well as their family backgrounds and which relatives visited them on a regular basis. It was clear from the conversations staff held with people that this information helped them develop caring relationships. For example, we observed staff talking to people about upcoming family visits, or engaging people in meaningful conversations about their interests, and noted that people responded to these discussions positively.

We observed caring interactions between staff and people throughout the time of our inspection. Staff regularly checked on people's well-being to ensure they were happy and comfortable. For example, we heard one staff member checking to see if a person was warm enough, before going to get another layer of clothing for them from their room. Staff also moved promptly to offer reassurance to people when they showed signs of confusion or anxiety, spending time with them in friendly conversation in order to relax them.

People were involved in decisions about their care and support. Staff told us that they spoke to people about their preferences in the way they received support and followed their guidance. They were aware of people's individual communication needs. For example a staff member we spoke with explained how they made sure they used short clear sentences and didn't ask open questions when speaking with one person, as this maximised their ability to make choices about their care. One person told us, "Staff don't rush me when we speak; I can be slow to reply, but they give me the time I need to answer." We also saw information available to people on the use of advocacy services. Senior staff confirmed that one person had been referred to this service, but had chosen not to engage with them when they met.

Staff treated people with dignity and respected their privacy. One person told us, "Staff respect my privacy; they don't disturb me unnecessarily." A relative said, "I've not seen any issues around privacy when I've visited. The staff put a 'do not disturb' sign on the door when they're helping [their loved one] to wash, so if I arrive and see that, I know not to go in." A staff member told us, "I always make sure the bedroom or bathroom door is closed if I'm helping someone to wash or dress, and I make sure I keep them covered as much as possible so they don't feel uncomfortable when undressed." We also observed staff knocking on people's bedroom doors and waiting for a response before entering their rooms, and speaking with people in a friendly but respectful manner throughout the time of our inspection.

Staff were also aware of the importance of keeping information about people confidential. One staff member said, "I make sure any discussions I have about the resident's needs are held in private and we always try to be discreet when offering people support with personal care." We noted that whilst people's

care records on the nursing side of the home were stored discreetly, they were not kept secure and could potentially be accessed by visitors. We raised this issue with the manager who arranged for the records to be moved into a lockable filing cabinet during our inspection. People's records in the residential side of the home were stored in an office which staff told us was locked when not in use.

Good

Is the service responsive?

Our findings

People told us they received personalised care that met their needs and preferences. One person told us, "[The staff] are thoughtful, and know what I like." Another person said, "They [staff] always ask me about the things I would like them to do. I told them I used to love having strawberries every night at home and now they bring me strawberries every night before I go to bed."

Staff had developed care plans for people which were based on an assessment of their needs. Care plans considered the support people required in a range of areas relevant to people's daily lives, including personal hygiene, eating and drinking, mobility, continence, communication, and any night time support requirements. They included information about people's life histories, likes and dislikes, and the things that were important to them, as well as their preferences in the way in which they were cared for.

People and relatives, where appropriate, were involved in the planning of their care. One person told us, "We've talked about the things I need help with and the things I'd like the staff to do for me." Another person said, "We've discussed my care. They [staff] would make changes if I wanted something to be done differently." A relative said, "The staff here have spent a lot of time going over the best things they can do for [their loved one]." Staff told us, and records confirmed, that care plans were reviewed on a regular basis, to ensure they remained up to date and reflective of people's current needs. They were also aware to report any changes in people's conditions to the management team so that their care plans could be reviewed and updated if needed.

Staff received equality and diversity training as part of their professional development, and told us that the service was committed to providing support which met people's needs with regards to their race, religion, sexual orientation, disability and gender. Records showed spiritual support was available to people in the home, which included regular services which people could attend if they wished. One person told us, "I go to the communion service here, but also go to my church every week." Another person said, "I am a believer and that is important to me; the staff here respect my beliefs."

People were supported to maintain the relationships that were important to them. One person told us, "My family come and see me here regularly. They can drop in when they want." Another person told us that the provider was arranging for them to have a phone line installed in their bedroom so they could keep in touch with their loved ones. A relative said, "We're able to visit whenever we want; we're always welcome and the staff have shown us where we can go to help ourselves to drinks while we're here." We observed relatives and people's friends visiting at different times throughout our inspection and noted that staff were friendly and engaging when welcoming them on arrival.

The service offered people a range of activities to take part in, in support of their need for social stimulation. Planned activities included arts and crafts, armchair exercises, quizzes, and reminiscence sessions. We also saw entertainment from musicians and singers was booked for people to enjoy, as well as events celebrating people's birthdays or festive occasions. Staff encouraged people to take part in a range of activities during our inspection, including cake decoration and a quiz. We also saw staff spending time

chatting with people on a one to one basis in their bedrooms, where they chose not to spend time in communal areas.

We received positive feedback from most people regarding the activities on offer. One person told us, "I can go to the theatre or for a pub lunch [with staff]. I also like the bands they get in, as they play all sorts of different music." Another person said, "I enjoy the activities, particularly the quizzes." However, one person told us, "I can't do anything and get fed up and bored. I don't like going to the lounge." We talked to the manager about this issue and they told us they were looking at ways to increase activities options for people who preferred to stay in their rooms. A member of the activities staff also told us of their plans to increase the number of one to one activities they arranged with people. An additional activities co-ordinator had been employed in support of these plans, and was in the process of completing their induction at the time of our inspection.

The provider had a complaints policy and procedure in place which was included in the information about the service that people received when they moved into the home. The procedure included information on what people or relatives could expect if they raised any concerns, including details of the timescale in which they could expect a response, and the action they could take, if they remained unhappy with the outcome.

People and relatives told us they knew how to make a complaint and expressed confidence that any issues they raised would be taken seriously and investigated. One person said, "I'd speak with the manager if I was unhappy about anything." A relative told us, "I've not complained formally, but talked to the manager once about the way a member of staff spoke to me. The manager took the issue on board and dealt with it; it's not happened again." The manager maintained a record of received complaints which included details of any conducted investigations as well as a copy of the provider's response. We noted that responses were open and apologetic where any issues in the service provision had been identified by the manager as a result of complaints investigations.

People received effective and timely support at the end of their lives. Records showed that staff had discussed people's end of life wishes with them and their relatives, where appropriate, as part of the planning of their care. Assessments included consideration of the potential need for pain management and we found that end of life medicines had been prescribed and on hand for use where required to help ensure people were comfortable and pain-free.

The service had achieved the highest level 'beacon status' accreditation from the Gold Standards Framework, which is nationally recognised in the provision of end of life care. We spoke with a healthcare professional from the local hospice who told us they considered staff to have made appropriate referrals to their service in a timely manner. A relative also spoke positively about the palliative care their family member had been receiving at the service, telling us, "The staff have been excellent and shown great humanity in the care they've provided [their loved one]. Nothing has been too much for them; they've given us the privacy we've needed as a family, but have always been on hand when needed."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found a breach of regulations because the provider had no system in place to monitor the use of pressure relieving mattresses to ensure they were set at the correct pressure levels. We also found that records relating to people's care had not always been completed by staff. Following the inspection, we took enforcement action, serving a warning notice on the provider and previous registered manager. At this inspection we found improvements had been made to our address this.

The provider had systems in place to monitor the quality and safety of the service people received. Records showed that regular checks and audits had been conducted in a range of areas, including health and safety, people's care plans, infection control, medicines, checks on equipment and the environment and checks made on night staff, conducted by the management team. Where people required the use of pressure relieving equipment, we saw the correct pressure settings for the individual needs had been identified and recorded, and were checked daily by staff to ensure they were maintained correctly. We also saw action had been taken to address any issues identified as a result of the provider's audits. For example, a recent medicines audit identified the need for a staff member to have their competency to administer medicines assessed, and records showed the assessment had been carried out with the staff member shortly thereafter.

However, despite the provider having made improvements to their monitoring systems, further improvement was required because call bell response times were not being effectively monitored at the time of our inspection in order to help identify potential issues. We spoke with the manager about these issues and she told us she would implement procedures for monitoring a sample of response times, although we were unable to check on this at the time of our inspection. We will check on this at our next inspection of the service.

The service did not have a registered manager in post. The previous registered manager had left the service during the summer. The current manager had started work at the service in August 2017 and was in the process of applying to become registered. They demonstrated an understanding of the requirements of being a registered manager. However, improvement was required because we found that, whilst they had submitted a number of notifications to CQC as required under the current regulations, they had failed to submit a notification in regard to an allegation of abuse that had been investigated by the local authority safeguarding team during the month prior to our inspection.

People and relatives told us that the service had been well managed in the time since the manager had taken their post. One person said, "The manager's been doing a good job; things are going well here." Another person told us, "I've no problems with the way the home is run; I'm happy living here." A relative commented, "The manager has made such a difference; it was chaotic, when [their loved one] first moved here, but the quality of the service has improved so much." Another relative said, "The manager makes this place feel like home."

Staff spoke positively about the way in which they worked together as a team, and told us they were focused

on providing high quality care. One staff member said, "We're here for the residents, and want them to be happy, healthy and well looked after." Another staff member said, "I think we're all committed to giving the residents the best quality of life we can." We observed staff working well together in establishing their joint and individual responsibilities in order to meet people's needs. For example, we noted staff that staff were prompt in identifying people's support requirements during a lunchtime meal, and quickly allocated themselves to the task of ensuring everyone who needed support received it. We also received positive feedback from people and relatives about the way in which staff worked. For example, one relative commented. "The staff here act openly; there are no secrets. I would recommend the home." Another relative said, "The team all seem to work well together."

People and relatives told us that the manager was a visible presence at the service, and led by example. One person said, "The manager's not afraid to get her hands dirty. She's very hands on and I've seen her talking to all of the staff about their ways of working, from the cleaners to the nurses." A relative told us, "The manager really mucks in; I've seen her helping people to eat, and with the cleaning, which I'm sure doesn't happen everywhere."

Records showed that the manager held regular meetings with staff to discuss the running of the service. Areas discussed at a recent meeting included changes in people's conditions and how best to manage them, cleaning and maintenance, activity planning and staff recruitment. Staff also told us that the manager had introduced changes which they felt improved the way in which they worked. One staff member said, "We're better organised; our team meetings are more frequent, which I think helps remind us of our responsibilities. The manager's also increased the staffing level, which has enabled us to spend more time with the residents."

The provider sought people's views on the service they received through regular meetings, an annual survey and by inviting people to submit any feedback they had in writing through the use of a comments box located in one of the communal areas in the service. One person told us, "They [staff] ask us all the time about the things we would like." A relative said, "They [staff} do ask what we think, and I know I can fill out the survey or use the comments box."

Minutes from a recent residents meeting showed that areas discussed had included the meals on offer at the service, cleanliness of the home, quality of the care, activities and complaints. The minutes included details of people's feedback which indicated they were experiencing positive outcomes and considered many areas of the service to have been improving. The manager also told us that they were waiting for the outcome of the most recent survey conducted by the provider so that they could analyse the results an act on the feedback received.

The manager had a continuous improvement plan in place which identified on-going areas for improvement where issues had been identified. We noted that actions had been followed up where required. For example, we saw the plan had identified the need for a legionnaire's disease risk assessment to be conducted at the service and this had been carried out by an external service, shortly prior to our inspection. The provider was in the process of carrying out a programme of service improvements. For example, we saw redecoration was underway in areas of the service where needed, and improvements to the service facilities had recently been made, including air conditioning units having been put in place in some areas, and a room in the home having been developed into a hair salon for people to use.

The manager told us the service was committed to working in partnership with other agencies, to ensure people received good quality, joined up care and this was reflected in the feedback we received from external health and social care professionals. For example, a social worker who had been involved in a

recent safeguarding investigation at the service told us they had found the manager to be open, helpful and able to provide all of the information they had requested, when needed.