Chantry Retirement Homes Limited

Euroclydon Nursing Home

Inspection report

Hawthorns
Drybrook
Gloucestershire
GL17 9BW

Tel: 01594543982

Date of inspection visit:
22 July 2016
23 July 2016
27 July 2016
28 July 2016

Date of publication:
23 November 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22, 23, 27 and 28 July 2016 and was unannounced.

Our last inspection was in August 2015 when we followed up a breach in regulation related to medicines. We found the provider had met this fully.

The care home's environment was being reconfigured and the provider's business restructured. In the care home, what used to be a separate dementia care unit called Bluebell had been opened up and incorporated into a new 28 bedded unit which was now housed in the extension end of the main building. The main building was to be entirely closed off from this unit once the last people had moved into newly allocated bedrooms. Relatives in particular had found this change difficult as had the staff. The people had needed to adapt to bedroom moves and, for those originally in the small dementia care unit, having more people around them. Modifications and refurbishment were also still taking place in the extension area. This was an unsettling time but the registered manager told us the changes were necessary and were sensible business decisions.These changes would enable the provider to carry on providing a nursing home service to the local community. Plans for the older main part of the building were not yet finalised.

The registered manage had been registered with the Care Quality Commission since July 2012. 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.

Despite the changes taking place in the environment the service was not as safe as it could be. Areas used by people were not kept clean or maintained well enough. You can see what action we told the provider to take at the back of the full version of the report. We also made three recommendations; that the service seek advice from a suitable source regarding the numbers of staff that need to be recruited and the numbers of staff required to be on duty to meet people's individual needs. Also, on what kind of window restrictor would be most appropriate to keep people safe and to review staffs' training in moving and handling to ensure it gave them the skills they required. There were other good arrangements in place in relation to people's safety.

People were cared for by kind and compassionate staff who understood them as individuals and their specific needs. Home cooked food was provided which looked appetising and smelt inviting. People who were at nutritional risk were monitored and action was taken to help the, for example, gain weight or swallow their food more easily. People who lacked mental capacity were protected under relevant legislation because the staff followed its principles. This meant staff were supported to make as many decisions as they could independently but when they were unable to decisions were made on their behalf and in their best interests. Staff actively involved other health care professionals and relatives in the planning of people's care and when best interests decisions needed to be made. People's health was

reviewed regularly by their GP and the care home had a good working relationship with the local GP practices. Staff were always able to get advice when needed from other health care professionals.

There were opportunities for social activity although these needed to become more personalised. Information had been gathered about people's life histories, their hobbies and interests before they had become ill so the staff had the information they needed. This now needed to be used in a more meaningful way. There were arrangements in place for people to raise a complaint and have this investigated and resolved where possible. The registered manager provided strong leadership. They communicated with relatives and staff through meetings and on a day to day, informal basis offering explanations and reassurance during a period of unsettling change. There were monitoring arrangements in place which helped the management staff and the provider identify areas of improvement. There was evidence to show that actions had been completed following completion of various audits which were on-going throughout a year's time frame. The provider's representative was a regular visitor to the care home and was fully involved in the changes taking place.

The views of people, their relatives, staff and professionals had been sought and listened to. Staff were asked for their ideas on how the service could be improved and some of their suggestions were implemented. It was planned that people's views would be sought again once the changes had been fully completed.

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 as safe as it could be.

People did not live in an environment which had been sufficiently cleaned, although there were other precautions in place which helped prevent the spread of infection.

People were protected from some health and safety risks because there were arrangements in place to monitor and manage these, although some potential hazards had not been addressed.

More staff needed to be recruited to ensure the needs of the care home could be met. When staff were recruited the processes in place ensured people were protected from those who may not be suitable.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

Arrangements were in place to make sure people received their medicines appropriately and safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People received care and treatment from staff who had been trained to provide this, although training in moving and handling was to be reviewed to improve staffs' skills.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Staff listened to what people had to say and showed them respect.

People's dignity and privacy was maintained.

Family and friends were made welcome and staff helped people maintain relationships with those they loved or who mattered to them.

Is the service responsive?

Requires Improvement

The service was not as responsive as it could be.

Care plans sometimes lacked detail but this did not prevent staff from being responsive to people's needs and there were plans to address this.

People had opportunities to socialise and partake in activities but these also needed to be more meaningful for some. Again this had been recognised and there were plans to address this.

There were arrangements in place for people to raise their complaints and to have these investigated and addressed.

Is the service well-led?

Good

The service was well-led.

Difficult changes for the service were being managed and although relatives and staff were finding these difficult they were being supported where possible by the management team.

There were arrangements in place which helped the management team stay aware of people's, relatives and staffs' views.

Quality monitoring processes were in place and these had identified areas of required improvement and actions had been taken to address these areas.

Euroclydon 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 took place on 22, 23, 27 and 28 July 2016 and was unannounced. The inspection was carried out by one inspector. Before visiting the care home we reviewed the information we held about it. This included a review of all statutory notifications received since our previous inspection in August 2015. Statutory notifications are information the provider is legally required to send to us about significant events. The provider had completed a Provider Information Return (PIR) in April 2016. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sought the views of commissioners of the service, on the care and services provided as well as the views of one health care professional.

There were 32 people living at Euroclydon Nursing Home. We met with several people who were unable to talk to us about their experiences. This was because they lived with dementia or had other health issues which prevented this. We therefore 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 also spoke with four relatives who gave us their views on the care and service provided. We spoke with seven members of staff including the registered manager. We attended one hand-over meeting between the nurse going off duty and the nurse coming on duty.

We inspected various documents and records relating to the people who lived at Euroclydon Nursing Home and the staff who worked there. These included three people's care files and records relating to how people's nutritional intake and weight was monitored. We reviewed records related to the management of medicines including four people's medicine administration records. We reviewed three staff recruitment files. We reviewed the service's main staff training record. We discussed with the registered manager the complaints the service had received and their responses.

We also inspected various records and documents relating to the running of the service. These included a

selection of quality monitoring audits, maintenance records and records relating to accident and incident monitoring. We completed a tour of the inside and outside of the care home.

Requires Improvement

Is the service safe?

Our findings

People were not living in a sufficiently cleaned or maintained environment. In making this judgement the Inspector was aware of the extensive changes being made to the environment. Work had consisted of closing off one part of the care home building and modifying an existing extension. Some alterations had already been made but work was on-going. The extension area had been in use by people throughout the modification work so it had been unsettling. One relative said "the changes are difficult". Despite the planned modification work the areas people lived in had not been sufficiently cleaned or maintained. One relative said "the environment is not great."

On entering the building at the front door there was an odour when walking past an area that people no longer used on a regular basis. One person's bedroom had an overwhelming odour. It was explained this person was frequently incontinent. We were told the room had been cleaned but required new flooring. The same explanation was given for the heavily stained carpet seen in what was now the main lounge. We were told it had been cleaned regularly but needed changing. It was confirmed that both of these floor coverings were due to be replaced soon. We were shown relevant documents relating to the quote and order for this work. Several other bedrooms were being refurbished and having new flooring. People were moving from areas of the building that were being closed into these bedrooms.

We observed toilets, bathrooms, skirting boards and other carpeted areas which would have benefitted from better cleaning. One member of staff told us there were not enough cleaning staff and, there were not always cleaning staff on duty. Another referred to the lack of cleanliness. The registered manager confirmed they had not been able to cover each day with a cleaner as only one was currently employed. They did confirm they were due to interview a person for housekeeper role in the next week and that one new cleaner was due to start soon.

We could see there were maintenance jobs that needed to be addressed in order to keep people safe and reduce potential risks. We were told the maintenance person had stopped working at the care home in the last week. It was highly unlikely that the lack of maintenance we observed had all occurred in the last week. Areas still used by people had rucked carpet which was a potential trip hazard. The window restrictors on the first floor of the extension were not fit for purpose and one was unsecured. The design meant there was access to the screws used to fix a chain to the window and then the window frame. The registered manager explained, this area was being refurbished and was not in daily use. The registered manager assured us people did not currently access this part of the building. The garden directly off what was now the main lounge could not be used safely by people. It was overgrown with weeds which also grew between uneven path stones. The gate which had secured this area so people who lived with dementia could use the area independently could not be secured. On examination the gate and fence were no longer in alignment so the bolt was no longer able to be closed. We were told people did not go out in the garden alone. We were told some people accessed the other part of the garden through one of the areas that had been moved out of. This part of the garden also needed to be maintained. The hairdresser still used part of the care home that had rucked carpet and which was not being cleaned. We observed a metal carpet door bar trim which had split and one member of staff catch their foot in it as they entered the room. No-one made comment about

this took action to get rid of the hazard.

The environment had not been sufficiently kept clean or maintained. This was a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The modifications to the building had included the removal of some doors. The registered manager confirmed they had taken advice from a fire safety specialist beforehand. They had also reviewed the service's fire risk assessment in January 2016 and told us no changes had been needed to this. We saw the next review was due in February 2017. Following this inspection we discussed these changes with the County's Fire Safety Team. They had not visited the care home since 2014. In light of the changes to the environment they told us they would carry out a review of the care home's fire safety arrangements.

There were other prevention and control precautions being followed however. These helped prevent the spread of infection and reduced cross contamination. For example, we observed staff using a specific sanitiser to clean furniture after one person had been sick. Staff wore plastic aprons and gloves and changed these between each person's care to prevent cross contamination. They also wore plastic aprons when helping people with their food. We observed hand washing taking place. Bathrooms and toilets contained paper towels and liquid soap to also reduce the spread of germs. People who required equipment to move them had their own hoist slings and slide sheets. Cleaning equipment was colour coded so specific equipment was used for specific areas. This for example prevented the cleaning equipment for the toilets being used to clean the lounges or bedrooms. In June 2016 the Food Standards Agency had awarded the kitchen with a rating of "5". A rating of "5" means the business (food related areas) was found to have "very good" hygiene standards. Soiled laundry was segregated from the general laundry. There was a process in place which meant the soiled laundry was handled once, by the care staff who wore plastic gloves, and not again until it came out of the washing machine clean. There were appropriate arrangements in place for the storage and collection of waste. All staff had received infection control training in November 2015. The service's infection control policy had been reviewed in January 2016. The last reported infectious outbreak in the care home (diarrhoea and vomiting) was in 2014 and this had been correctly reported.

People's needs were met although staff had to help out with staff shortages to ensure this were the case. When we asked care staff, relatives and management staff if there were enough staff to care for people; there were mixed comments. Nearly all the care staff told us they ensured people's needs were met but there were not enough of them. Reasons for this included the levels of care and supervision and the unhelpful lay out of the building. It also included the fact that some staff had left and problems with staff sickness did not help. One relative said. "There are not enough staff". This comment was based on observations they had made during their frequent visits. They did however qualify this by telling us they were satisfied with the standard of care provided. We received concerns about staffing numbers being insufficient in October and November 2015. Both the registered manager and representative of the provider confirmed that, although at times the service worked below full staffing capacity, people's needs were met and people were never placed at risk. A report written by the Physical Inclusion Network Gloucestershire (PING) team in December 2015 said the provider must make every effort to ensure there were enough staff to meet people's needs and this should be from immediate effect.

The registered manager told us they discussed with their senior staff regarding how many staff needed to be on duty. They told us they ideally aimed to have six care staff and one registered nurse on duty in the morning, but due to sickness and holiday leave this had not always been possible. From our observations, on a morning when there were five care staff and one registered nurse on duty, we found people received the personal care they required, but they also had to wait sometimes until care staff were available. We were unable to ask people how they felt about this because they lived with dementia and none complained

about this. We did not witness any distress caused by this. On this particular shift staff had either not taken a rest break or had postponed their rest break until later so all people received the care they required before lunch time. The staff were constantly very busy and worked in a task led way.

Lunch time on this shift was extremely busy with care staff attending to personal care needs and people being poorly throughout the meal. Several people needed full support to eat their food and many others required direction and supervision. The two cooks served people their food but at one point were unable to proceed with five meals as there were no care staff available to help the people eat their meals. These people were not distressed by this because they slept or were unaware of their surroundings. We watched one person independently feeding themselves and they spilt a large amount of their first course. One member of staff explained that ideally they would have remained with this person and guided them but they said, "there are others who need to be fed". The member of staff did return to this person to help them with their pudding.

During the afternoon there were five care staff rostered to be on duty and one registered nurse. However, this went down to four care staff as a shortage of staff on the night shift needed to be addressed. This was due to staff sickness. One member of staff therefore went off duty in order to return later to help the night staff. Another member of staff stayed on duty for the afternoon as they told us there was also no late afternoon kitchen assistant to prepare teatime food. They said "the staff would never manage so I've decided to stay on." The staff gap in the kitchen, on this occasion, was due to holiday leave although tea-time kitchen shifts were not covered every day. We were told when this was the case the management staff would try to ensure there were extra care staff on duty. The registered manager told us they had recruited kitchen assistants but they had left. When on duty the activities co-ordinator helped to serve breakfast and supervise the dining room up until 10am in the morning. Staff told us that every other weekend this help was not included which had a knock on effect.

The night shift started with the usual two care staff and one registered nurse because staff had changes how they worked to help out. The member of staff who had returned however, could only stay on duty until midnight. We asked the night staff how they would manage with two of them on duty from midnight onwards. They said, "It will be hard but we will do our best. We will not take our usual breaks". Two members of staff agreed to start earlier the following morning, one at 6am and the other at 7am to help with the early morning care. Senior staff told us the care staff always tried to help where they could with gaps in staffing.

Staff sickness was clearly difficult for the registered manager to cover if other staff were unable to help. Even if requested, as was the case in the sickness situation above, care agencies were not always able to assist. The registered manager explained they had lost some staff as they had become unsettled by the changes. They were aware they need additional staff and were advertising and trying to recruit to the posts that needed to be filled. One of the reasons for reducing the care home in number and environmental size was to address the balance in what size accommodation was needed for the numbers of people being admitted. Less people were being funded for nursing care but the care home still operated in a large space. This space had to be covered by the staff when providing care and supervision to people.

There were arrangements in place to help prevent abuse. Any concerns relating to the safeguarding of people had been reported to the appropriate agencies by the service. These agencies included the police, the local county council and the Care Quality Commission. The service had not thought it necessary to raise a safeguarding since January 2015. In November 2015 the Care Quality Commission received information of concern about the care of one person which we shared with the local safeguarding team. This was investigated on behalf of Gloucestershire County Council and the care of this person was found not to be of

a safeguarding nature. Staff were aware of what constituted abuse. They had received training in what to do if they witnessed or suspected abuse taking place. They also knew that any allegation of abuse had to be reported immediately. When asking one relative if they considered their relative to be safe in this respect they said, "We feel she is protected here".

People received their medicines safely and when required. All medicines were stored securely and the required records were maintained well. Appropriate guidance was in place for medicines prescribed to be used "as required". This additional guidance told staff what the medicine had been prescribed for. It gave specific guidance on how many doses could be used in a 24 hour time frame for example which helped to prevent overdosing. Medicines were delivered in a timely manner and those not used either disposed of correctly or returned to the pharmacy. People's medicines were regularly reviewed by their GP.

People were protected from those who may be unsuitable because there were good recruitment processes in place. Recruitment files showed appropriate checks had been carried out before staff started work. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and in particular, from previous care providers. Reasons for any gaps in employment were explored.

Contracts were in place with various specialist companies for the maintenance and servicing of some equipment and safety systems. A specialist company serviced and maintained all lifting equipment, which included the passenger lift, care hoists and slings. Similar arrangements were in place for the nurse call system, emergency lighting, fire alarm and fire safety equipment. At the time of our inspection we queried with staff what appeared to be a problem with the call bell system. Staff confirmed this had happened before. A member of staff said, "The call bell system needs sorting out to be fair". Another member of staff told us they had reported the fault the week before when the maintenance person was still in post and they had told them it had been rectified. When we visited the care home on the third day of our inspection a specialist engineer was testing and rectifying the system. They had suggested an upgrade to prevent the problems that were experienced.

Accidents, such as falls were recorded. The management staff monitored these to check if people received the correct treatment following an accident and to check if appropriate action had been taken. Where a person experienced a further fall they looked for trends and patterns in the circumstances leading up to the falls. We reviewed one person's accident form. They had been found outside the conservatory door during the late evening. We asked if the doors were alarmed and we were told they were and this was how the person had been found. Another person's accident form recorded they had been found on the floor. This had happened twice in the space of two days and on each occasion not witnessed. On one occasion they had refused help to get up and had fallen to sleep. Staff explained this person sometimes put themselves on the floor. One relative told us staff had always informed them if their relative had fallen. They said, "When [name] had falls it was looked into so we could understand why [name] had fallen". This person was now not mobile and the risk of falls had reduced.

Requires Improvement

Is the service effective?

Our findings

Relatives who had made comments about the environment also said "we're very happy with the care; the care staff are really very good". Another said, "They [staff] did a superb job of supporting [name] when [name] moved in". One relative described their relative as being under a "chemical cosh" (sedated) before and when they were first admitted to the care home. They told us the staff had asked the person's GP to review the person and their medicines. They told us their relative was no longer "chemically coshed". They said, "The staff like to see the brightness in [name's] eyes and see [name] be able to interact". A visiting health care professional commented, "I think the staff are well trained".

People were cared for by staff who had received relevant training. We reviewed the care home's main training record as well as some training certificates. We spoke to two members of staff about the training and support they provided to staff. We observed two poorly managed moving and handling manoeuvres. One followed a person falling from their arm chair. We spoke with the senior member of staff present, who had checked the person for injury before staff attempted to move them. They agreed the manoeuvre had been poorly managed. We also observed care staff not positioning themselves appropriately before supporting a person to stand. Both staff carried out this manoeuvre in a twisted position. This potentially could cause injury to them and be unsafe for the person being moved. The training record confirmed staff were up to date with relevant training. The senior member of staff confirmed from their observation that staff required additional training in helping a person up off the floor. They told us they would get the in-house trainer to re-visit this.

All new staff completed the provider's set induction training. This comprised of an initial introduction to the care home's routines, policies and procedures and receipt of the staff handbook. Staff then completed training in subjects which the provider considered necessary in order to carry out their tasks safely. Subjects for all staff included, health and safety, safe moving and handling, safeguarding people from abuse, fire safety and infection control. Further training varied according to the staff member's role and responsibilities.

Staff new to care were supported to complete the care certificate. This lays down a framework of training and support which new care staff can receive. Its aim is for new care staff to be able to deliver safe and effective care to a recognised standard once completed. One member of staff had completed the care certificate's mentor course so they were able to support staff through the certificate's modules.

Staff were supported to improve their knowledge and develop their skills. Out of the 22 care staff, 17 held a nationally recognised qualification in care. Nine of these staff had gone on to achieve a higher level of qualification giving them skills to supervise less experienced staff. Many staff were experienced in meeting the needs of people who lived with dementia and had received relevant training. Dementia care was supported by the registered manager and another member of staff. Both held an additional qualification in how to improve outcomes for people who lived with dementia. They attended county wide workshops to ensure their own knowledge and ideas were up to date. Four staff members were signed up Alzheimer's Society 'dementia friends'. They were committed to improving the lives of those with dementia inside and outside of work.

Staff were also supported by visiting mental health professionals to meet the needs of people whose behaviour could be perceived as being challenging. Staff managed this behaviour by weighing up the risks to the person and others and at the same time considering the person's individual choices, preferences and refusals. One member of staff told us they were always looking to identify training which would be meaningful to staff. They had recently found that staffs' recording of challenging behaviour incidents was not giving the required information. This included what the possible trigger had been, the action taken and the outcome. We had also identified this when reviewing relevant records. We were told "bite size" training sessions were planned to address this.

The registered manager told us she wanted to support staff to be able to develop both professionally and personally. One member of staff discussed with us how the registered manager had supported them to do this. The registered manager also wanted to up-skill some members of staff so they could support the nurse on duty with people's health needs. They were looking for an appropriate course for this. The registered manager told us staff had received one to one support known as supervision. We did not look at staffs' supervision records to confirm how frequently this had been provided. They also told us all staff had received an annual appraisal of their performance and training.

People were asked for their permission first before staff delivered care and support. We observed staff explaining to people what it was they wanted to do and then waiting for the person's agreement. When the person refused staff went back later and asked again. Many people required a lot of support and staff exercised great patience to help them make simple day to day decisions. For example, what they wanted to wear, where they wanted to sit, if they wanted to join in an activity and if they wanted to eat and drink at a particular time. Many people were unable to make these simple decisions independently. This was because they lived with dementia or lacked the ability for other health reasons.

People who were unable to give their consent or make decisions for themselves were protected under the Mental Capacity Act (MCA) 2005. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We observed staff supporting people to make simple daily decisions such as, where they wanted to sit, if they wanted to use the toilet, if they wanted to join in an activity and if they wanted to eat and drink. This was because many people lived with dementia or lacked the ability for other health reasons to do this without support.

Where staff made decisions for people it was done in their best interests. Such a decision was made for the person who had fallen from their armchair. Senior staff had assessed the person as requiring a recliner chair, both for increased comfort and safety. They were aware the person could not consent to its use or the change in their care. Staff therefore completed a mental capacity assessment in relation to this specific decision which recorded the person unable to do this. They recorded what care the person needed and the decisions they had taken in the person's best interests. We observed the person using the recliner chair on another day. They looked very comfortable and safe. We also observed staff helping this person out of the chair when they wanted to move; it was not being used as a form of restraint but as a falls prevention strategy.

Also under the MCA legislation staff had considered if people living in the care home were deprived of their liberty and under continued supervision and control. 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).

Where this had been the case DoLS applications had been completed. For one person staff were expecting a mental capacity assessor to complete their assessment within the week.

People's nutritional risks were identified and action taken to support a better food and drink intake. One member of staff took the lead for managing people's nutritional risks. A list of people's recent weights recorded 14 people having lost weight. We reviewed 10 of these with the nutritional lead. They told us all had specific circumstances leading up to their loss of weight. These included, expected deterioration in health following an infection or admission to hospital and being assessed as being at the end stage of life but improving following admission. One person had sustained an injury and staff had needed to help them eat their food but the person had not always allowed this. Some of the people had gained weight, several we were told were actually eating well but their weight had not improved hugely and others had stabilised within acceptable levels. Where one person continued to lose weight they were monitored closely. All had been reviewed with their GP Some people were prescribed supplement drinks and others referred to a dietician or speech and language therapist if they had a swallowing problem. The cooks were fully aware of who required their food to be fortified. Fortification included adding additional butter, cream and whole powdered milk to foods to provide additional calories. At lunch time we observed one person refuse their food. The cook explained this person often had their cooked breakfast later in the morning because they preferred this. Therefore, just after lunch a plate of "snack like foods" were provided which the person enjoyed.

People were provided with homemade food which looked attractive and smelt inviting. A choice of two main meals were verbally explained to people. Most people were able to tell the cooks what they wanted but some could not. We asked one member of staff if they ever provided a visual choice for people. They said, "I have done that but it's not normally done here". The day's meal choices were written on a wipe board on the wall but smaller individual written and pictorial menus were not provided to help people decide on what to choose. Snacks and fruit was not left out for people to help themselves because people tended to handle them but not necessarily eat them. To avoid the spread of germs and to ensure people actually ate their snacks and fruit staff regularly provided these and then provided people with the support they needed to eat them. Apart from fruit, snacks included biscuits, cake and on occasions chocolates. We observed people being supported to eat their food in a dignified and kind way, but as previously reported, sometimes they had to wait for this support.

People had access to health care professionals and staff ensured people's health needs were met. One of the care home's nurse's was trained to take people's blood for testing. A local GP visited the care home weekly and reviewed all of their patients which were the majority of people. They were contactable for advice when needed. Other GPs also visited as needed. One health care professional told us, "The staff seem to have a good understanding of residents' needs and health problems". To help get people's health needs met one member of staff had been trained to take people's blood for testing.

People's records recorded visits by mental health practitioners and other health care professionals. Staff told us they liaised with physiotherapists and occupational therapists, continence advisors, speech and language therapists and community nurses to ensure people's health needs were met. People had access to foot care from a chiropodist and an optical (eye) service. Access to a NHS dentist was arranged when needed but was not a routine service. Staff took advice from other specialists when they needed to, such as tissue viability and wound care advisors.

Good

Is the service caring?

Our findings

All the relatives we spoke with made positive comments about how the staff were towards their relative and them when they visited. One relative said, "They [staff] are very caring, extremely caring I would say". They said, "They [staff] take time to know [name] little idiosyncrasies (habits)", They explained that in achieving this it had helped to make their family visits and trips easier as staff knew how to re-settle their relative and prevent any distress following their visit. Another relative told us their relative lived with Alzheimer's Disease. They said, "The staff just know [name] so well, they can calm [name] down". Another relative described the staff as being "very connected" to the people they looked after. They said, "The staff watch how relatives are with their relatives and learn what works and what does not work when it comes to approaching them". Another relative described the staff as "very kind". One health care professional commented, "The staff I have dealt with appear very caring and compassionate. In general the carers seem very dedicated and the residents respond well to them. I would say they get to know their residents well".

We observed kind and caring interactions from the staff towards people. People who were distressed were not left in this state for long. We observed people's distress being managed in different ways. It was obvious the staff knew how to approach individuals and the actions to take as people usually returned to a place of well-being fairly quickly. We observed staff putting their arms around some people, talking quietly with others and trying to understand what a person had become upset about. Sometimes the use of distraction worked and other times the introduction of an activity worked. Staff supported people's preferences and were aware of their likes and dislikes. Much of this information had been found out by talking with people's relatives. One relative told us they had brought various items in for their relative including a television. They had told staff what their relative liked and what helped to settle them. The relative confirmed that each time they visited staff had ensured these items were around their relative. They told us staff always made sure the person could see their television which they enjoyed watching.

We observed relatives and friends receive a warm welcome when they visited. This involved a friendly greeting and then an inquiry about how the person and their family were. Relationships looked relaxed between people, relatives and staff. One relative said, "They [staff] always welcome us. They make me feel part of a family and this has helped me to be able to support [name] more". Another relative said staff were "always very welcoming". If visitors stayed for a period of time they were offered a drink.

Many people were reliant on the staff to maintain their dignity and privacy, either during care such as being helped to the toilet, when being fed or when they compromised this themselves. We observed on two occasions people starting to undress in front of others. Staff intervened quickly and quietly reminding the person where they were and helping to re-adjusted their clothing for them. One person was suddenly very sick in front of others and became very distressed by this. Several staff responded immediately to the person's upset with reassuring and comforting words. Two staff then quietly helped the person to leave the room and supported them to have a wash and change their clothing in private. On their return one member of staff sat with them to make sure they were settled again. We observed staff asking people very discreetly if they wanted to use the toilet when they suspected they had been incontinent. When people were moved by the use of a hoist staff covered their legs so they were not inappropriately exposed.

We observed very busy staff taking the time to always reply to someone who called out or asked a question. Often what people said sounded confused in content and appeared to have no relevance to what was happening around them. Staff however demonstrated that they understood that whatever a person was saying had relevance to them in some way. They showed people respect by making sure they were responded to and that what they had to say mattered. The care home's main training record recorded that further training in dignity and respect had been booked for all care staff.

Requires Improvement

Is the service responsive?

Our findings

People had their needs recorded in care plans which were used to outline what these were and how staff should meet them. Additional records, such as food and fluid intake records and repositioning charts were also used to record what care had been delivered. The care plans we reviewed varied in the detail they gave staff about how to meet people's needs. Some care plans were really personalised, telling staff about the person's preferences and what worked well in meeting their needs. We identified some missing information in one person's care plan and a member of staff told us they had also identified missing information in others. We were told staff had identified that a person who had lost weight ate better when presented with finger foods. This valuable piece of information was not included in the person's relevant care plan. A member of staff told us another person coped better with personal care when a particular song was sung to them. They had identified this information as missing from the care plan. They had already planned to review care plans to ensure all pertinent and personalised information was contained in them. We observed some food and fluid intake records were completed well and others had gaps. The gaps did not explain whether food and drinks had been offered but possibly refused. There is a potential risk of people not receiving consistent care and the care they require if care records designed to provide staff with guidance and an audit trail of care are not accurate and kept relevant.

One person had returned from hospital and their needs had altered. The community nursing staff were meeting the person's health needs. They had therefore provided additional equipment such as a pressure reducing mattress and cushion. The care home's nurses were making alterations to this person's care plans and other documents so staff had up to date information. In the nurses hand-over meeting improvement or deterioration in a person's health was discussed including any changes in care or abilities. Care staff received a similar hand-over so the verbal information given to them kept them updated.

The majority of people, not all, lived with dementia and were unable to engage in the process of giving information and planning their care. People's representatives and family members were able to be involved on their behalf. One relative confirmed they had been fully involved in this process and had opportunities to speak on their relative's behalf. Relatives confirmed they were fully informed of changes in their relative's health.

People were admitted to the care home following an assessment of their needs. This assessment took place so senior staff could be sure the care team would be able to meet people's needs. It also gave relatives and people, if possible, a chance to discuss their concerns and expectations. Information from the pre-admission assessment was used to inform the care plans. Relatives we spoke with confirmed the pre-admission process had been detailed and they had been asked lots of questions.

People had opportunities to join in social activities within the care home. One relative commented they felt activities needed to be more personalised to people's individual strengths and interests. They told us they felt the information given about people's work, interests and hobbies could be used more to help personalise the activities. The member of staff due to review the care plans told us they wanted to also see information from people's life histories incorporated more in their care plans. This was to aid

personalisation of people's care.

We observed one group social activity which included staff and people singing songs. People had chosen the songs to be sung and some were sung because staff knew people liked them. Bubbles were blown during this session as visual stimuli and the majority of people were awake and fully engaged with this. We saw that the artistic achievements of individual people and groups from some of the activity sessions had been given value and were hung on the walls.

Two relatives commented they were unsure if the activity co-ordinator was always able to carry out activities. They told us the activity co-ordinator's time seemed to be re-directed to providing people's care. The registered manager explained the activity co-ordinator did help with the delivery of breakfasts and feeding people up until 10am. However, from then onwards, until lunch time, it was designated activity time and again after lunch. Apart from group activities, activities also took place on a one to one basis and also included small engagements which may not always be obvious. Activities also included reading to people or just talking and reminiscing with them. Some people preferred their own company and were able to carry on their own choice of activity. One person told us they had watched their favourite film whilst resting in bed.

One relative told us they felt the garden could have been used more for activities if it had been maintained. We were told people had sat outside but with supervision and only at the seating area immediately outside the conservatory doors. We observed and made comment that there was not one summer flower in sight, no colour for visual interest or stimuli; no use of summer flowers to help orientate people to the season. The only colour was provided by a bright pink parasol at the outside table. Instead there were dead plants and weeds in plant pots and hanging baskets. The registered manager told us they were aware the garden needed maintaining and when a newly appointed maintenance person was in post this would be done. They also told us the 'resident committee' had decided that monies raised would be spent on a gazebo which could be enjoyed by people in the main garden.

People's wish to be independent was supported by the staff where it was safe to do so. Levels of independence varied from wanting to be independent at mealtimes to being able to carry out a degree of personal care but needing help with other areas of care. The majority of people required the full support of the staff however. One person was able to and was free to use the local community shop and they took part in the activities they preferred to do on their own. People were free to go out with their relatives and friends.

People, their relatives including other visitors to the care home were able to raise a complaint. The provider's complaint procedure was on display. Complaints were investigated and responded to by the registered manager or the provider's representative. The registered manager told us two complaints had been raised since January 2016. One had been about a lack of care provided to a person and we were told this had been investigated and resolved. The other had been a disagreement between the registered manager and one person's relative. This had been over action the registered manager had decided needed to happen to protect the health of other people. We were told the relative had not agreed however the registered manager told us they would not act differently if the situation arose again.

Good

Is the service well-led?

Our findings

Two members of staff told us they found the registered manager to be very supportive. One relative told us the registered manager "had been wonderful". The registered manager was currently steering the care home through change. The Provider Information Return (PIR) had told us the care home planned to reduce its registered bed capacity. When the PIR was completed by the registered manager in April 2016 there were 39 people living at Euroclydon Nursing Home. Some relatives and staff had found these changes difficult. The registered manager told us questionnaires had been sent to people or their relatives on their behalf and staff. They told us the main comments received back so far were around "insecurity with the changes". They told us they had spoken with staff and relatives about these changes. Staff and relatives told us they were aware the care home was reducing in size, that people needed to move from one part of the building to another and refurbishment was also taking place. The last meeting for relatives however had been in April 2016. The registered manager explained that she saw many relatives on a regular basis and often spoke to them individually about the changes.

The registered manager held meetings with the staff. These were sometimes full staff meetings and sometimes smaller, more specific staff meetings. For example, meetings for senior care staff or for kitchen staff. One member of staff told us these meetings were a two way process. They confirmed they were able to raise concerns and the registered manager responded to these. They told us staff had been able for example, to raise concerns about the numbers of staff and recruitment progress. They said "it may not always be what we want to hear but she does give an explanation". They told us the registered manager also asked for ideas and feedback from the staff. One area of feedback had resulted in the purchase of a small hot tray/cabinet to keep people's breakfasts warm once they had left the kitchen.

The registered manager told us a full staff meeting had been last held in July 2016 and staff had been given an update on the changes happening to the service. The registered manager had also used this meeting to remind staff of some of her expectations and the actions required following audits. For example, a discussion had been held about getting away from a task led routine, the need for improved record keeping and better evaluations of people's care plans. They discussed wanting to see more staff interaction with people. They also used this meeting to update staff on specific tasks they had completed, for example, applications completed for deprivation of liberty safeguards. The registered manager told us she was in at least one meeting a month with different staff groups. We were shown a plan for the year where dates had already been booked for these meetings.

Prior to the inspection we read the report written following a visit by the Physical Inclusion Network Gloucestershire (PING) team in December 2015. This had recorded that they wanted to see 'resident' meetings reinstated. A meeting in April 2016 had been led by the activity co-ordinator. The registered manager explained it had not been successful as many had not been able to engage in it because they lived with dementia. It was planned that people's individual views and feedback would be sought, where possible, on a one to one basis. PING had also wished to see the introduction of a Professional Boundaries Policy. This would state the provider's position on what was expected from staff in maintaining a professional boundary - relationship between themselves, service users and their relatives. We did not look

at policies and procedures during this inspection but the registered manager told us staff had been asked to complete a questionnaire on dignity in care and what staff perceived to be their professional boundaries. The results had shown that staff understood what these were and that they promoted dignity in care. The results of this survey had been shared with relatives and staff.

The registered manager told us they had regular face to face meetings with the provider's representative and spoke to them on the telephone most days. In these meetings the results of the completed in-house audits were discussed. Any actions required were planned with the provider's representative who followed up on the completion of the actions during their next visit/s. The registered manager explained that at the present their time was predominantly spent managing and co-coordinating the changes and ensuring the business plan was kept to. They were also the registered manager of a small domiciliary care agency; the office being based in the same building. One member of staff told us if the registered manager was not present, which was most days during the week, they were always contactable by telephone for advice. One of the inspection days fell on a weekend day and the registered manager attended. On another day they had already left the care home but they returned and stayed into the evening.

People did benefit from the provider and registered manager having a quality monitoring system in place. Audits were on-going with a year's plan of audits in place. Some audits were planned to be completed more frequently, for example, the medicine audit. One senior member of staff completed an "overview audit" each month and submitted this to the registered manager. This helped provider monitor bed occupancy, what activities had taken place, quality and standard of the meals and staffing numbers. Odours in some areas of the building had been identified at the end of June 2016. The registered manager told us this had led to looking at which carpets needed replacing outside of those included in the refurbishment plans. A domestic/cleaning audit in July 2016 repeated the findings of odours despite cleaning taking place and quotes for new flooring were gathered.

A catering audit completed by the registered manager in April 2016 identified some staff required an update in food safety training. The service's training record recorded this as completed in May and June 2016. A laundry audit completed in July 2016 recorded the need for replacement linen and the registered manager confirmed 40 new sheets had just been purchased. The waste audit had identified a need for new outside storage bins and for them to be locked. This had been addressed. A selection of care plans were audited on a monthly basis and these looked for missed monthly reviews, lack of cross referencing with specific care and health assessments. As previously reported staff had planned to review some care plans. Staff practices were also monitored through observation. It was through observing staff practices that senior staff had identified a need for more interaction with people. There were therefore quality monitoring processes in place which helped the management team meet various areas of legislation and identify areas for improvement.

The Provider Information Return (PIR) told us the service was part of a local initiative - a dementia friendly community. This had involved the registered manager and one other member of staff. They had attended community events/meetings to provide support and education to those caring for people who live with dementia.

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 15 HSCA RA Regulations 2014 Premises and equipment People who use the service and others were not protected against the risks associated with an unclean and insufficiently maintained environment. Regulation 15 (1) (a) (c).