Four Seasons Homes No.4 Limited

Swan House Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

Swan House Care Home is registered to provide accommodation and nursing care for up to 40 people. At the time of our inspection there were 38 people living at the home. The home is a two storey premises located in the town of Chatteris close to local shops, amenities and facilities.

This unannounced inspection took place on 25 July 2016.

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

Staff were knowledgeable about recognising, reporting and the recording procedures to help protect people from any, or potential, incident of harm. A sufficient number of qualified, competent and safely recruited staff were in post to meet people's assessed needs

People's medicines were safely administered, stored and disposed of. However, protocols for some people's 'as and when required' medicines were not in place, not correct or out of date. This meant that staff had a lack of up-to-date guidance to manage people's conditions, such as pain, by means of prescribed medicines.

Staff were regularly trained and assessed as being competent to safely administer people's prescribed medicines. An effective induction, supervision and mentoring process was in place to support staff in their role.

Risk assessments and risk management strategies were in place to help ensure that people were not exposed to unnecessary risks to their health. Risk assessment reviews were completed according to each person's needs. Systems were in place to support people in the event of an emergency such as a fire.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The registered manager, nursing, senior and care staff were knowledgeable about when an assessment of people's mental capacity was required. Appropriate applications had been made by the registered manager to lawfully deprive of their liberty as well as people being cared for in the least restrictive manner. Authorised and renewed DoLS were adhered to. This meant that, where appropriate, people were being lawfully deprived of their liberty.

People were supported to access a range of health care services and their individual health needs were met. People's nutritional support needs were met and people had access to refreshments and snacks. This included the provision and choice of appropriate or foods and drinks diets for those people at an increased risk of malnutrition, dehydration or weight loss.

People's care was provided by staff who undertook this role with respect, dignity and compassion. People, or their authorised representative, were involved in the planning and delivery of their care. Information was made available for people or their relatives who may have needed an advocate or requirement to access independent advocacy.

People were given various opportunities to help identify and make key changes or suggestions about any aspects of their care. A complaints procedure was in place and actions were taken to help prevent the potential for any further complaints.

A range of audit and quality assurance procedures were in place. This was to help identify what worked well and any area that required improvement. However, these audits were not always as effective as they could have been. People, staff and visitors were encouraged to provide their feedback and views on the quality of care people received.

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.

People were at risk of not always being safely or correctly administered their medicines as prescribed. This was because protocols to support people with their 'as and when medicines' were not always up to date or in place.

Recruitment records were in place to evidence that staff had been safely recruited. A sufficient number of safely recruited, qualified and competent staff were in post.

Accident and incidents were investigated and actions were taken to help ensure that any remaining risks to people were managed safely.

Is the service effective?

Good

The service was effective.

People were cared for with their consent or where this was in their best interests

People were supported by staff who had been trained and deemed competent for their role.

People's health and nutritional needs were met including those people who required a liquid or soft food diet.

Is the service caring?

Good

The service was caring.

People were encouraged to be as independent as they wanted to be.

Relatives, friends and visitors were able to visit people at the time that suited the person best.

People were looked after with respect and dignity by staff who showed compassion and upheld people's rights.

Is the service responsive?

Good

The service was responsive.

Reviews of people's care plans and needs were undertaken frequently and involved people and their authorised representative.

A range of hobbies and social stimulation was provided to people in the place they preferred.

People's complaints, suggestions or concerns were investigated and acted upon in line with the provider's policy.

Is the service well-led?

Good

The service was well-led.

People, staff and relatives were involved in identifying areas for improvements and developing the service. There were arrangements in place to listen to what people, relatives and staff had to say.

The registered manager and staff were aware of their role and responsibilities.

Quality assurance and audit processes and procedures were in place and most of these were used to help drive improvements.

Swan House Care 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.

This unannounced inspection took place on 25 July 2016 and was undertaken by two inspectors, a pharmacist and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in caring for older people and those living with dementia.

Before the inspection the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what it does well and improvements they plan to make. The registered provider returned the PIR and we took this into account when we made judgements in this report. We also looked at the number and type of notifications submitted to the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we spoke with eight people living at the home. We also spoke with, the registered manager; one nurse, one senior member of care staff and four members of care staff. We also spoke with two activities co-ordinators.

We observed people's care to assist us in understanding the quality of care people received.

We looked at four people's care records and the minutes of residents and staff meetings. We also looked at medicine administration and management records as well as records in relation to the management of the service. We also looked at staff recruitment, supervision and appraisal process records, training records, complaints and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People told us that they received their medicines on time and they were aware of the medicines that they were prescribed. One person told us, "I've got [health condition] and get a lot of pain at times but they [staff] give me my tablets regularly." Another person told us, "I take quite a few tablets but I get them promptly and regularly." Staff were regularly trained and assessed as being competent in medicines administration. We observed staff administering medicines. We saw that staff explained what the medicines were for and then made sure the person took all their medicines correctly. However, we found that the protocols for people's 'as and when required' medicines were in some cases not in place, incorrect and out of date. In addition, not all people's care records accurately recorded the reasons why they needed their medicines mixed in with their food. For example, one person's record stated that they needed to have their medicines with food but not why this was necessary. We also found there were discrepancies between the medicines administration record (MAR) and the 'as and when required' PRN protocols. One was to be given 'as per psych'. There was no reference on the MAR, label or care plan to what the psychiatrist said, how often it was to be given or what the maximum daily dose was. No doses had however been given. This meant that people were at risk of not always being safely supported with their medicines.

Staff had a good understanding of the procedures to help protect people from different types of harm and how these were put into practice. One staff said member explained to us the process for reporting any, or potential, harm. They said, "I would inform the senior [member of care staff], nurse or registered manager straight away. If I still had any concerns I could report them to the local authority, the police or you [Care Quality Commission]." They added, "We have had training on safeguarding and we are regularly checked to see if people's care is safe." Information about how to recognise and report incidents of harm was publicly available throughout the service for people, staff and visitors. One person said, "I feel safe here. Sometimes when I call the staff I may have to wait (a short time) but I'm quite independent. I really just need help in and out of bed." The person confirmed that they got this help when they needed it. Another person told us, "I've got my buzzer [call bell] on the chair and staff come quickly; I've never really had to wait." We saw that all people had their call bells within easy reach either on the bed beside them or fastened to their chair. Our observations confirmed that people's requests for assistance were responded to in a timely manner. Systems were in place to support people in the event of an emergency such as a fire.

However, one person told us that they had not been able to get out of bed because their wheelchair was awaiting repair and that the large hoist had been quarantined following an inspection on Friday 22 July 2016 by an engineer. We found that the registered manager was actively seeking a repair or replacement. The person commented to us that despite the fact that they had asked staff to go slow when moving them around in bed the person felt that not all the staff had listened and sometimes the person found the moving painful.

At lunchtime we saw that a person sitting at the table in their wheelchair had their left leg pressing on the footplate of their wheelchair. The footplate had been raised but not moved back out of the way and the person had quite an indentation on their leg from the pressure of the footplate. We alerted a member of staff to the situation and they acted promptly moved the footplate back out of the way of the person's leg. This

meant that staff weren't as attentive to people's risk of harm as they could have been.

One person said, "If I ever need help I am confident they [staff] would help. I have never been left for any time at all." We saw that staff gave people the time they needed with their care and support needs. This was by being patient, using the identified number of staff for any moving and handling practices and doing this in a safe way. This showed us that that there were systems in place to help ensure people were cared for in a safe way as much as practicable.

We found that staff had records in place to evidence that they had been safely recruited. Care staff confirmed to us the records that they had been required to provide, as well as their job interview before they were offered employment. We found that checks included recent photographic identity and proof of their previous employment history. In addition to these checks was also in place to ensure that nurse's registration with the Nursing and Midwifery Council was current. Other checks included a Disclosure and Barring Service check which had been carried out to ensure that the service had only employed those staff who were suitable. Where staff had been deemed unsuitable to continue working at the service, we found that the provider had followed their staff disciplinary procedures. This demonstrated that staff who were employed had undergone rigorous checks that deemed them suitable to work with the people who used the service.

Accidents and incidents, such as people experiencing a fall or where they had behaviours which challenged others were investigated and action was taken to prevent recurrence. For example, by the appropriate use of pressure ulcer prevention equipment and strategies to calm people. One person said, "I've got my bell on the chair and I do feel very safe here I've not had any falls or anything untoward at all happen." One member of care staff said, "If someone does have a fall which was not expected we speak with the nurse in charge and they make a referral if the person's risk was too high or ask a GP to check their medications. If there are any changes the nurse makes sure that the care plan and risk assessments are correct."

Equipment and services were maintained to help ensure that the service and environment was a place to live and work in. This included checks for lifting equipment. Where repairs or replacements were required this was acted upon as quickly as practicable.

The provider used a dependency assessment tool to help determine the number of staff to safely meet people's needs. The level of people's care needs was reviewed regularly with an increase of staff when required. This included any change in the person's needs such as with moving and handling or following people's return to the service following a hospital stay or appointment. Staff told us that there was sufficient staff. One staff member said, "It would be nice to have a bit more time to sit chatting with people but we do get time to have a chat when providing drinks, meals and personal care." Another staff member said, "If ever anyone [staff] calls in sick or is on holiday we can generally cover this from our existing staff team." One person said, "They [staff] are quite busy but not so busy they can't have a chat or read me a story." Our observations confirmed that there were sufficient numbers of suitably qualified staff on duty to ensure that people remained safe. The registered manager told us that recruitment of staff was not a problem and several staff had worked at the service for over 10 years.

Good

Is the service effective?

Our findings

The registered manager had a programme in place to support staff with their training, nursing and care skills. The registered manager told us that they completed nursing staff's clinical supervision and made sure that the revalidation (Revalidation is the process that all nurses need to follow to maintain their registration with the Nursing and Midwifery Council (NMC)) of nurses was being undertaken.

We found that a staff training programme was in place as well as staff having access to the local authority's and a representative of the provider's trainers. We saw and staff confirmed to us the training and the refreshers for this that they had undertaken. This included subjects including, but not limited to, dementia care, infection prevention and control, moving and handling, safeguarding, first aid and health and safety. One nurse told us that they had time to undertake reflective practice and understanding of what they had learned. This was as well as adhering to the NMC code of practice. (This code sets out the standards of care people expect from health care professionals).

One staff member told us, "I can ask for more training, but I already get the training I need to do my job effectively." One senior staff member told us, "We do e-learning as well as learning at staff meetings about more complex subjects such as the Mental Capacity Act."

Staff told us that as well as their training, other support in the form of shadowing (shadowing is where more experienced staff work alongside newer staff. Shadowing is also for those staff who need additional support until they were confident in their role) was provided. We found and were told that a formal induction was in place for new staff. We asked if people felt that staff were well trained and able to meet their needs. One person told us, "The girls [staff] are very good, very kind and well trained." One staff member told us, "I had all the support I needed. I have previous experience of care so I found it [induction] quite straight forward." They added that if ever they needed more support that this was always available and provided. This could be from senior staff, nurses or the registered manager. The provider told is in their PIR, "Dignity and resident experience training was delivered in the last year. This was to help staff understand what it was like to be hoisted or be placed in a wheelchair." This showed us that there were support and development arrangements in place to help ensure that staff were confident and competent in their role.

Formal and regular supervision for all staff was in place and this was planned for the year. Staff told us that the supervision was a two way process and an opportunity to discuss what was going well and any area that may not have been going quite so well. We saw during our observations of the lunch time meal that people were offered their meals in a relaxed environment. This was by staff who supported people to eat and drink sufficient quantities. They sat and helped people with their eating, at a pace to suit them with a drink containing a prescribed thickener that was given in between. This was to assist the person maintain their weight.

We received mixed comments about the meals and people were generally satisfied with their breakfast and teas. For example, one person told us, "The food is not always good, there's enough, but too much swede and turnip which I don't like and I don't like pasties and sausage but staff don't always listen. I can always

have a sandwich if I'm hungry." Another person said, "I don't like the sauces on food but staff just put it on." A third person told us that the vegetables were always "overcooked". We also saw that lunch was served with gravy already on the plate. This limited people's ability to choose the amount of, and where they preferred, to have their sauces or gravy.

People with a need for a soft food or liquefied diet, were offered a choice of appropriate food. This was presented in a way that people could distinguish the different components of the meal with the meat and vegetables being separated on the plate. We saw that staff supported people to be as independent as possible with their eating and drinking. For example, they were provided with adapted cutlery and plates.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and DoLS.

Staff had received training on the MCA and DoLS and they had a good understanding of applying the respective codes of practice. We found that staff were knowledgeable about these subjects and how to put them into practice. For example, one staff member said, "People have a right to choose. We may not agree with them but as longs as they are safe, that's fine." Another staff member told us, "We used to have some restrictions in place such as a sensor mat. This was to alert us if the person got out of bed." Staff explained how this was in the least restrictive manner and in the person's best interests. In addition, where required, the use of controlled access to areas of the home's premises was controlled by staff accompanying people who needed close supervision.

We found that people recently admitted had a mental capacity assessment in place. However, for people who had lived at the home for some time this was not the case. This meant that there was a risk that staff would not provide care in consideration of the person's decisions that they could or couldn't make for themselves. We did, however, find that staff were able to tell us what decisions people could a make and the level of understating they had of these. Appropriate applications had been correctly made to, and authorised by, the local authority to lawfully deprive people of their liberty. The conditions of people's in date DoLS were being adhered to. This showed us that the registered manager and staff considered people's rights.

We found that appropriate health care referrals had been made. One person told us, "I need to have blood tests weekly, the staff take me, I'm on [name of] tablets and they're [staff] very good."

These referrals had been made to those such as a dietician, tissue viability nurse, and a speech and language therapists. This was to ensure that any risks associated with people's health were minimised. We also saw that people's wound management was promptly taken in line with provider's guidelines. However, we found that people's care plans had not always been updated to reflect the guidance that had been provided and it was not clear which was the most up to date. Where required, we saw that people were supported with medicines in a liquid format to help them achieve or maintain their health and wellbeing. This showed us that people's health and nutritional needs were responded to.

Good

Is the service caring?

Our findings

People were generally complimentary about the care that they were provided with. One person told us, "The girls [staff] are always so nice, kind and polite. I couldn't manage without them." Another person told us, "I've been here for a few months, it's [the care] lovely. I like to stay in my room, the carers [staff] are ever so caring, there's help there when you need it."

Our observations confirmed that staff were considerate of people's needs and listened to what people had to say. Staff spent time answering questions with one person and took the MAR chart and medicines in to their room to go through them with the person. We saw how nursing staff spent time encouraging a person to take their medicines. We saw that they were respectful manner and understanding that when the person refused their medicines that this is what the person wanted. We also observed that the registered manager engaged in conversation with people and asked about their wellbeing. People responded positively that they felt well.

We saw examples of people being assisted gently with their mobility around the home as well as staff helping people in a caring way to play dominoes, apply sun cream, watch TV or do some art. The TV in the lounge downstairs had text on the screen for those people who were hard of hearing. We also heard staff asking people if they had slept well, had they enjoyed their weekend and if people needed any pain relief. Staff gave people time to move in an unhurried manner and staff maintained communication with each person. One person told us, "I get more than enough care; sometimes they're [staff] a bit busy to come and talk about things but the [registered] manager is very nice she comes in and sits and has a chat." Another person said, "They [staff] ask me when I want to get up and go to bed." This showed us that staff were considerate about the people they cared for.

We saw and found that staff knew the people they cared for well including their likes, dislikes and personal preferences such as their daily newspaper, religious beliefs and values. This was as well as people's life history where this had been provided. Staff told us that the new format care plans contained more information about each person. One member of care staff said, "The care plans inform me about the person including those parts of their care that are really special." They gave us examples of what was special to people including seeing families, taking part in the various social stimulation and hobbies that were provided and having a poem or book read. These hobbies and social stimulation could be in the person's room and at a time they preferred.

We saw staff helping people; they were kind, caring and respectful in their approach to them. We heard staff addressing people by their names and also knocking on their doors asking permission to enter showing respect for the person's privacy and dignity. This also included a member of the housekeeping team knocking on the door of an occupied room, and the housekeeper asked if it was convenient for them to go in. This showed us that staff provided care in consideration of the person's privacy.

Staff told us how people's dignity was respected. One staff member said, "I always make sure the curtains are closed, talk to the person as a person and explain everything that I am doing. Imagining what it is like to

have personal care from a stranger and putting myself in their [the person's] position helps me to focus on their dignity and privacy." The staff member added that the training they had undertaken on 'resident experience' had helped them to implement the way they gave compassionate care much better.

During the lunch time we saw when people were eating their meal, staff helped and spoke to them in a kind and respectful way. People were also able to choose where they wanted to eat their meals. We also saw how care staff spoke discreetly with people when asking if they needed any assistance with their personal care needs. Staff dealt with the situation quickly and sensitively putting the person at ease.

People we spoke with who were ostensibly cared for in bed told us, "I like it that [my door] is always open and everyone pops in to say hello. I can't have a bath or shower just now [due to health condition] so I have a bed bath I was a bit embarrassed [initially] they [staff] were very good and the female staff give my personal care." Another person told us, "They [staff] are wonderful. We could do with more [staff] but I never feel that I am uncared for."

People, the registered manager and staff confirmed to us, and we saw, that relatives, friends and other visitors were free to visit at any time and at people's discretion. One person said, "My family member] visits every other day at any time. Care records were held securely and staff ensured that these were only reviewed or read in private.

We found that people had relatives, friends and representatives who acted as an advocate for them if required. Formal advocacy was also available if required for any person who lacked mental capacity, such as an Independent Mental Capacity Advocate. Advocacy is for people who cannot always speak up for themselves and provides a voice for them. The registered manager and staff were aware of organisations which offered this service if required. This showed us that people's wishes, needs and preferences would be respected if people were not able to speak up for themselves.

Good

Is the service responsive?

Our findings

The provider told us in their PIR that new format care plans had recently been introduced and that they were easier to follow. However, we found that these did not always contain accurate, up to date and person centred information. For example, we found that one person's care plan had three different accounts of the person's impairment. Each of the three staff we asked about this person also gave us three different accounts. One member of care staff said, "When you talk to the person they have to turn their head." The care plan gave staff no guidance on which side of the person was best to speak to them from. In another person's plan we saw that they required a certain type of shower gel due to their skin condition and that their "family member" knew what this was to be used for. Although the registered manager told us that the person's relative brought in the shower gel there was no guidance for staff what this was. We also saw that where reviews of people's wound management or risk assessments had been completed that errors and omissions in these had not been identified. For example, wound dressing replacement records did not accurately record that the specified time period had been adhered to. Staff had recorded these on a piece of paper but had not always transferred these records onto the required form which could then be reviewed.

Some people had individual needs to aspects of their care such as a particular way to support the person due to their health conditions or anxieties. We found that there was no information or guidance on how best to support these people. Although guidance was provided on how best to mitigate this such as calming strategies, we found that this information had not been cross referenced to the moving and handling of the person. This was because it was the number of staff which could be a trigger for the person's anxieties or the equipment the person needed such as a slide sheet. This and the preceding paragraph information meant people's care was not as individualised as it could have been and put people at risk of receiving care that was not based on their needs.

People's needs were assessed before the registered manager deemed that they were able to meet the person's needs. Other information including that from any hospital admissions was also used as a way of identifying what was important to each person. During the afternoon the activity co-ordinator was visiting people in their rooms. This was for them to go through with people their individual activity plans and asking them what activities they enjoyed and what they would like to be involved with. They showed us one of the plans they were updating whilst sitting and talking with the person in their room. This and other information about people such as life histories formed the foundations of people's care delivery. This information was then used by staff to help them understand what really made a difference to people. One person told us, "I can go out into the garden, watch TV or have a nap. Another person told us, "We have pets visit and I like to give them a good fuss. It is nice to see them as well as the other animals which have been."

There was a wide variety of planned and also ad hoc hobbies and interests which were available. These included people singing; doing puzzles; reading or being read a book, and one to one time with staff for day to day conversations and also reminiscing. One staff member said, "We have a 1940's day every year and one of the staff's relatives is a collector of memorabilia. People's faces light up and they love chatting and telling us about their experiences during the Second World War."

We saw recent photographic records of events and occasions which had been held at the service this included visiting Pets As Therapy (PAT) cats and dogs as well as visits of birds of prey from a local raptor centre. We observed that staff, including the activities coordinators interacted with people and supported people to maintain their interests. This was by providing various social stimulation such as going into the local town, to a pub as well as attending, or being supported by, various religious organisations. Some people told us that they preferred the peace and quiet of their own room and were happy with relatives visiting and staff who provided personal care. One person said, "I just like to be in my room, and watch TV; I like to watch the news and keep up with things."

In the morning we saw that the activity co-ordinator had, with a group of people, been wrapping small prizes and preparing for the summer fair which was being held in the home. In the afternoon we observed in the craft room a group of people were painting 'sun catchers' (these are items which are designed to catch the sun light and make various patterns as they spin). The people were engaged, having tea and biscuits and seemed to be looking forward to the home's summer fair.

Improvements had been made to the gardens which had been tidied and included various flowers, plants and raised beds as well as a barbecue facility. One person said, "When I go downstairs I like to go into the garden when it's nice; I do go downstairs to play dominoes and do some painting I really like to do that it's good."

People were supported with their faiths and religious beliefs if they preferred this. A regular religious service was offered for those people who had a preference for this. People could also request someone for their particular faith if this was required.

Each person had a key nurse (this is a member of staff with a specific role for people's care such as keeping care plans up to date and informing relatives about any changes in people's health). Some people told us that they were not aware that they had a care plan. However, other people told us the same and said, "Oh yes, I've got a care plan the care assistant [staff] has it, and she comes in and chats about things I need, quite often." Another person told us, "I have a care plan the staff do talk to me about what I need." The person had a folder with their care plan on their bed. Other ways people were involved included day to day conversations with staff and if any changes to their care needs were required these were then implemented.

People and their relatives knew how to make a complaint and management and staff knew how to respond. People were actively encouraged to give their views and raise concerns or make suggestions before they had the potential to become a complaint. We saw that a suggestions box was provided and accessible for people and visitors. The registered manager explained that the electronic recording device used to gather people's, relatives' and visitors' comments. They said it was now part of the day to day information gathering. This was planned to gain an understanding of those aspects of the service that worked well and if any improvements were needed. The registered manager said, "If there are any complaints these are automatically recorded and have to be responded to within our timescales." Records viewed showed us that this was the case.

As part of people's admission to the service they, or their relatives, were given information on how to raise a concern or compliment. One compliment stated, "Each and every one of the staff had shown such care and kindness". Most people were satisfied or happy with their care. One person said, "If I had any problems I would talk to the [registered] manager, I think that she would sort it out, but I don't see a lot of her." One staff told us, "If anyone ever complains, makes a suggestion, or had any concerns I always report this to the nurse in charge or the [registered] manager." Another person said, "I've no complaints at all but I would talk to the [registered] manager if I had."

Good

Is the service well-led?

Our findings

The home had a registered manager. They were supported by a deputy [lead nurse] as well as the regional manager and staff team. People told us that they knew who the registered manager was. One person told us, "The [registered] manager does come round once a week; she talks and listens to me." Another person told us, "The [registered] manager is alright she does come round to see us."

From information we hold and our findings at this inspection we found that the registered manager had notified us about those important events that, by law, they are required to do so. For example, where people were lawfully deprived of their liberty where this had been authorised. We saw that the provider was displaying their previous CQC inspection rating conspicuously in the service and on their web site. In conjunction with the support they provided to staff, this showed us that the registered manager was aware of their responsibilities.

All staff said that the registered manager and lead nurses were approachable and that they felt listened to and supported. One staff member told us, "Their [registered manager's] door is always open and they are always walking around the home checking on us. But also just to have a chat on how things are going."

The provider's representative and registered manager carried out regular audits of various subjects such as quality of care, people's dining experience and medicines management. The provider told us in their PIR, "Random audits are carried out monthly and additional audits of high risk areas such as pressure areas and weight loss are also carried out." Where any issues were identified these were recorded on the provider's electronic records system. This automatically sent an alert to the registered manager who then investigated and reviewed these and took any necessary actions. These audits had not however identified issues such as the lack of protocols to govern administration or discrepancies in stock levels which staff had recorded on the medicine charts. This meant that the provider's representative and registered manager was not aware of the potential learning from these incidents with staff, or identified training needs.

We found discrepancies between the medicines administration record (MAR) and the 'as and when required' PRN protocols. We also found that people's care plans were not as accurate or person centred as they could have been. The quality assurance audits and spot checks had not identified these issues.

We saw that the provider's representative and registered manager had an action plan with dates and actions. These were planned to be completed by and the staff who were responsible for implementing their actions. This was following concerns identified at the local authority's most recent contract monitoring visit as well as the provider's representative's and registered manager's audits. We found that improvements had been made to the storage of medicines, staff's knowledge of the MCA and DoLS and improved supervision recording for staff. All of which we found had been rectified.

People's, staff's and health care professionals' views about developing and improving the service were sought in the most appropriate way. This included views which were captured on an electronic device which was available to provide feedback. In addition, a suggestions box was in an easily and identifiable location

in the entrance area of the service. People and staff confirmed that the registered manager was always available to talk about anything and was always willing to listen and, where practicable, act on and suggestions or comments. One person told us, "I see the [registered] manager she comes round and talks about my care. She is very nice; she comes in and has a chat. I've no complaints I can't speak highly enough of everyone [staff team]."

The regional, and registered, manager kept themselves aware of the day to day staff culture. This was by regular contact with the clinical and senior care staff leads. Staff confirmed that the support they received enabled them to do their job effectively. One staff member told us, "We get support in various forms. We have observed practice, [staff] meetings and supervisions." The registered manager told us that they worked some shifts to keep their skills current as well as making sure that staff adhered to the standards of care expected of them.

The regional manager visited the service at least fortnightly and maintained electronic communications in between their visits with the registered manager. This was to help ensure that the support arrangements that were in place were sufficient and effective. The registered manager and provider's representative had an understanding about the key risks and challenges in running the service. For example, embracing changes in the way social and health care support was provided and also maintaining a stable staff team.

Planned staff meetings as well as a daily handover meeting helped staff to share and be aware of people's changing or new care needs such as hospital visits or changes to prescribed medicines. We saw that during staff meetings the registered manager reminded staff of their responsibilities and the values of the provider. For example, in the review of people's care plans, completion of training and when annual appraisals were due. Staff were also praised or rewarded for their efforts. Other examples of information shared at staff meetings included any accidents or incidents and; any health care referrals. Staff were then able to implement the necessary changes to people's care such as different diets or replacement wheelchairs and hoists. We saw that these were being used to the benefit of people's wellbeing.

Links were maintained with the local community and included visiting singers, a visiting mobile library, musicians, as well as people going out into town or doing some shopping. We also saw how some staff had undertaken various charity fund raising as part of their commitment to people. Other links included a monthly newsletter. This provided people and staff with information of events that had occurred and those that were planned such as the summer fair. This was as well as access to a community car scheme which was a local authority funded scheme to support people to access health care appointments.

The service had been awarded and maintained a rating of five out of five for food hygiene [this is the highest award]. Part of this assessment includes the management of food hygiene. We saw that the current systems in place had helped ensure a good standard of food and kitchen hygiene. In addition, two people had written a poem which had come second in a national poetry awards contest.