Tradstir Limited

Sycamore Court

Inspection report

Fitzherbert Drive
Bear Road
Brighton
East Sussex
BN2 4DU

Tel: 01273697331

Date of inspection visit:
07 March 2017

Date of publication:
02 May 2017

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 March 2017 and was unannounced.

Sycamore Court is purpose built, and was taken over in 2015 by Tradstir Limited. This is the first inspection since the service was taken over by the new provider. The service provides residential and nursing care, across three units, for up to 40 older people with increasing physical frailty, many living with dementia or other mental health needs. Long term care and respite care is provided. There were 20 people resident at the time of the inspection.

There was a registered manager for the service. 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.

Staff told us it had been a significant period of change with a new provider taking over the service, difficulties in recruiting staff and a number of staff changes. The registered manager told us for a long period they had been without a deputy manager and clinical lead for the service. This had meant process and systems had not been fully developed and embedded in the service as quickly as they had planned. However, one had recently been recruited and work had already commenced to start to address this. Staff also spoke of changes and improvements which were now starting to be implemented since the deputy manager had started to work in the service. There were also a lot of refurbishment works being carried out to the building, which had led to areas of the building not in use and people being moved out of their rooms for a period whilst the work was being completed. This was due to be completed shortly. Staff spoke of the passenger lift had been out of action for a significant period of time which had been difficult to manage and had restricted the movement of people around the service. One the day of the inspection one unit was closed for refurbishment and only half the beds were filled.

We found regular auditing by senior staff in the service to ensure the quality of the service had not been completed or regularly maintained and embedded in the running of the service. People had been able to feedback on the care and support they had received. An external company had also been used to audit in the service. However, action plans to address the issues had either not been drawn up or actions had not been taken to address the issues highlighted. We could not identify how the provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. This is an area which requires improvement.

People received care in an environment that was clean and tidy. However, regular health and safety checks of the building had not been maintained and not all risk assessments had been completed. Records were not fully accessible for senior staff to refer to and ensure essential checks of the building and services had been carried out. This is an area which requires improvement.

Senior staff monitored people's dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Feedback from people and staff was that there was usually enough staff to meet people's care and support needs. One member of staff told us, "This is generally a good place to work, we pick up lots of skills here. The place has potential and is designed for a certain type of care. We all sing from the same hymn sheet with similar aspirations and expectations." Another member of staff told us "It's really good I'm quite happy the staff are doing a very good job." Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. However, training records were not fully up-to-date so it was not possible to evidence this. This is an area in need of improvement. The registered manager told us all care staff were now being taken through the care certificate. Senior staff were monitoring this with staff to ensure its completion. Staff told us they felt well supported by the senior staff who were accessible, however, feedback and records showed us that not all the staff had received regular individual supervision or appraisal. Senior staff told us of the work which had commenced to address this. This is an area in need of improvement.

People told us they had felt involved in making decisions about their care and treatment and felt listened to. People's individual care and support needs were assessed before they moved into the service. A new electronic care planning system had been introduced into the service. Senior staff acknowledged that some reviews had fallen behind and it was not possible to fully evidence people current care and support needs and any risks that had been identified as people's care plans were in the process of being reviewed and transferred onto the new system. People's nutritional needs were assessed and recorded. People told us they enjoyed the food provided. However, where people were being supported with their fluid intake, records had not been fully completed for care staff to refer to. These are areas in need of improvement.

People were able to join in a range of meaningful activities. Staff told us there were two part-time activities co-ordinators who were trying out new ideas for activities and were receiving support and guidance on providing activities for people living with dementia. However, feedback we received was that activities for people who stayed in their own rooms had not been fully developed. This is an area in need of improvement.

Medicines were stored correctly and there were systems to manage medicine safely.

Consent was sought from people with regard to the care that was delivered. Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation, which they put into practice. Where people were unable to make decisions for themselves staff were aware of the appropriate action to arrange meetings to make a decision within their best interests. People told us they felt safe. One person told us, "I am safe and happy and will give them 'thumbs up'." Another person told us, "I feel safe here. They take me to the balcony to smoke and watch me and bring me in." We observed staff speaking with people in a kind and respectful manner and saw many examples of good natured but professional interaction. Staff were aware of the values of the service and understood the importance of respecting people's privacy and dignity. A compliment received by the service detailed, 'It was clear to us that mum felt safe and well cared for during her short stay at Sycamore Court. This was important and reassuring.'
Procedures were in place for people and their relatives and their representatives to raise any concerns. No one we spoke with had raised any concerns, but they felt it was an environment where they could raise issues and they would be listened to.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People received care in an environment that was clean and tidy. However, regular health and safety checks of the building had not been maintained and not all risk assessments completed. Records were not fully accessible for senior staff to refer to and ensure essential checks of the building and services had been carried out.

People had individual assessments for identifying and monitoring risk to their health and welfare. Some reviews had fallen behind. However, these were in the process of being updated and transferred onto the services new electronic records system.

There were sufficient staff numbers to meet people's personal care needs. There were safe recruitment procedures in place for staff to follow. Staff knew how to recognise and respond to abuse appropriately.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Training records were not up-to-date so it was not possible to evidence all staff had received all the required training. However, all care staff were being taken through the care certificate to address this. Staff told us they felt well supported. However, regular supervision and appraisal had not been provided to help ensure the quality of the care and support provided.

People's nutritional needs were assessed and recorded. However, where people were on a fluid chart used to inform care staff of people's fluid intake these had not been fully completed to inform care staff. People had their healthcare needs met.

Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people in the decision making process where lacked capacity to make a decision.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

Care staff provided care that ensured people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had been assessed and their care and support needs identified. Some of the reviews to ensure people's current care and support needs had been identified had fallen behind. However, reviews were in the process of being completed as part of the transfer of information onto the new electronic care plans.

People were supported to take part in a range of recreational activities both in the service and in the community. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them. However, there were limited social opportunities for people who stayed in their rooms.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems used to monitor and help improve standards of service delivery had not been maintained and fully embedded in the running of the service. People were able to comment on the care and support provided. However, we could not clearly identify how the provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. Records were not fully in place for senior staff to reference.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of

the service was approachable and very supportive.

Sycamore Court

Detailed findings

Background to this inspection

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

This inspection took place on 7 March 2017 and was unannounced. We undertook a comprehensive inspection.

The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection, we reviewed information we held about the service. This included any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. This helped us to plan our inspection. We requested the provider to complete a Provider Information Return (PIR). 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 contacted the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people for feedback on the service provided, and the Clinical Commissioning Team (CCG) for feedback on their experience of the service provided. Following our visit, we received feedback from a health care professional about their experience of the service provided.

We observed care and spoke with people, visitors and staff. We spoke with nine people, and three visitors. We spoke with the provider, the registered manager, the deputy manager, a registered general nurse (RGN), three care workers, a housekeeper and a chef. We observed the care and support provided in the communal areas, and the mealtime experience for people over lunchtime.

We looked around the service in general including the communal areas, and a selection of people's bedrooms. We observed medicines being administered and sat in on a staff handover meeting. As part of our inspection we looked in detail at the care provided to five people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medicines administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing

of the building and equipment, policies and procedures, meeting minutes, staff training records and five staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

This was the first inspection since a new provider took over the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us people were safe and were well treated in Sycamore Court. One person told us, "I am safe because no one ever is angry with me. I only have pills when I need them." Another person told us, "I feel safe because I only have to ring my bell and they come at once. I don't use the bell as much as others, so they come quickly and they know it must be urgent." A third person said, "They won't let me out on my own. I expect that is to keep me safe." Staff told us there were usually enough staff to meet people's care and support needs. However, despite these positive comments we found areas in need of improvement in relation to health and safety checks of the building and services, and the accessibility of records kept of essential checks of the services and equipment. Reviews of risk assessments had fallen behind.

Risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. Individual risk assessments where completed including for falls, nutrition, pressure area care and manual handling. People were supported to take positive risks. For example, one person was supported through the risk management process to assist with preparing vegetables in the kitchen. The registered manager acknowledged that some reviews of people's care and support needs were late in being completed. This meant it could not be assured that people's current care and support needs had been identified. This is an area in need of improvement. However, reviews and updates had started to be completed as part of the transfer of information onto a new electronic care planning system. Staff told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. Where people had been assessed to be at a risk of skin breakdown (pressure sore) we found that current guidance was being followed. People had prescribed creams which had been applied to help support the skin integrity of the person. Records we looked at detailed the areas for application and recorded the applications undertaken. An air mattress (inflatable mattress which could protect people from the risk of pressure damage) had been provided where required. We were informed by staff that air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. Records we looked at confirmed this. One person told us, "I feel safe and secure here I can wash my top but they wheel me into the shower. I have to be hoisted every time. Some time ago one carer did not seem to know how to do it, but I noticed that she was retrained after I told them. They have to be careful as it can be painful. They are all right now." One member of care staff told us how care staff were alerted to people at risk of falling by, "A magic eye where an alarm goes off. There are no crash mats because they have bed rails up."

The environment was clean and spacious, which allowed people to move around freely. Staff were able to access external contractors or dedicated maintenance staff for the servicing and maintenance of the building and equipment. However, records to demonstrate that regular tests and checks were completed on essential safety equipment were not all fully accessible for senior staff to access and to view during the inspection. Senior staff could not in all instances reference or confirm the schedule in place to ensure essential checks had been carried out for emergency lighting, the fire alarm system and fire extinguishers, gas safety and lifting equipment. The provider subsequently provided evidence of checks completed following the inspection. This is an area of practice in need of improvement.

Staff told us systems were in place for the regular checks and audits to be completed in relation to fire, health and safety and infection control. However, these not been completed and so senior staff could not be assured that they had been informed of any issues in need of rectifying. The fire risk assessment had not been fully completed. This meant that potential fire risks had not been identified and there was not a plan in place to reduce such risks. PEEP's (Personal Emergency Evacuation Plan) were in place for people in the event of a fire. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. There was an emergency on call rota of senior staff available for staff to access for help and support. However, contingency plans were not fully documented and in place to respond to any emergencies, for example in the event of flood or fire. These are areas which require improvement.

There was a lack of effective risk management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were clear systems for protecting people from abuse. These had been reviewed to ensure current guidance and advice had been considered. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the Commission when safeguarding issues had arisen, and therefore it could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. One member of staff told us if they had any concerns, "We would report and record it. The numbers for social services are in the office." There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Medicines were administered safely to people. There was a clear system for the ordering of people's medicines and for disposal of medicines no longer in use. One person told us, "I have pills at 9.0 am and 7.0 pm and two paracetamol at night. They don't let me self-medicate, they watch me take them and I expect they record it on a chart." Another person told us, "I have Warfarin at 5.0 pm. If they forget I remind them by ringing my bell. "We observed medicines being administered and where appropriate, people were assisted to take their medicines sensitively, they were not rushed and simple explanations, appropriate to people's level of understanding were provided. Medicines were well managed. The medicines were double checked and signed for by the registered nurse on duty. Medicine was stored safely and correctly in cabinets in a locked room. There were no gaps in signing on Medicine Administration Record (MAR) sheets used to record the administration of medicines.

People told us they did not usually have to wait long for help when they needed assistance from the care staff, and observations on the day confirmed this. Staff told us that there were enough staff generally to get through the work. One member of staff told us, "The bells make it busy but in general there is enough of us." Another member of staff told us, "There's the emergency bell and everyone runs to the room, it shows which room on the bell pad we would inform the nurse and record it. We would tell the manager." A third member of staff said, "Mornings are heavy if there is not enough staff we ask agency, it can be very heavy for us but we help each other." Staff told us they were allocated to a floor at handover and that there was a registered nurse on the top floor and one covering the middle and bottom floors. Senior staff showed us the dependency tool they used to help ensure that there were adequate staff planned to be on duty. Senior staff

also regularly worked in the service to keep up-to-date with people's care and support needs which helped them check there were adequate staff on duty. They told us minimum staffing levels were maintained. There had been a number of staff changes and there had been a recruitment programme to address staff vacancies. Agency staff were used to cover any care staff absences. Agency staff were requested who had previously worked in the service and had an understanding of how the service was run. One member of staff told us, "It's hard if the nurses are bank and don't know the issues, there are only two regular nurses." They also spoke of good team spirit. On the day of our inspection there were sufficient staff on duty to meet people's needs. Staff had time to spend talking with people and supported them in an unrushed manner.

People were cared for by staff who had been recruited through safe recruitment procedures. Where staff had applied to work at Sycamore Court they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written reference requested. Where registered nurses were being recruited we saw that checks had been made on their pin number. This is an information system which can be accessed to ensure nursing staff were still registered to work as a nurse provided nursing care. This meant that all the information required had been available for a decision to be made as to the suitability of a person to work with adults.

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively of the service, the support staff and of the healthcare provided. They felt that the staff had the skills to meet their needs. One person told us, "They never make me do anything against my will." Another person told us, "We are fortunate to have so many well trained staff. (Staff member's name) my carer showers me every two days and changes the dressing on my hip. (Staff members name) the nurse was responsible for reducing the length of my scar, he is brilliant." However, despite these positive comments we found areas in need of improvement in relation to the training, supervision and appraisal of staff.

The registered manager told us all care staff completed an induction before they supported people. This incorporated the requirements of the care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. New members of the care staff told us they had recently been on an induction. They had been given an induction leaflet and been shadowing care staff. One experienced member of care staff had two days shadowing, another had two weeks shadowing. This had provided them with all the information and support they needed when moving into a new job role. However, it was not possible to fully evidence all the staff had received the training they needed to meet people's care and support needs as the training records were not up-to-date. This is an area in need of improvement. The registered manager told us, to address this, they had been updating the records and training certificates. All care staff were in the process of working through the new care certificate, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. This would include training and guidance on providing care and support to people living with dementia. Training was provided by a mixture of E Learning, training provided by the local council and through the providers own trainers. Senior staff were monitoring to ensure the completion of this training. One member of staff told us the training was, "Fairly good and additional training is listed." Another member of staff told us," We can do advanced decision making which is sensitive and very valuable." A third member of staff told us, "There is plenty of training and refreshing of NVQ monthly. The registered nurse checks training and ask if you want to do extra training."

Staff told us that the team worked well together and that communication was good. Staff told us they felt well supported and could always go to a senior member of staff for support. The registered manager told us senior staff provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. There was a supervision and appraisal plan in place which the senior staff were following to ensure staff had regular supervision and appraisal. However, senior staff acknowledged regular supervision and appraisal had not been regularly completed or embedded in the practice of the service to meet the requirements of the provider's policy and procedures. Records we looked at and some staff feedback did not confirm that all the staff had received regular supervision. This is an area

of practice in need of improvement. One member of staff told us, "I can't remember the last time it's done by the allocated nurse but it's not happened yet." Another staff member told us, "I had supervision with the manager and we talked about concerns, problems, training and development." The registered manager acknowledged not all the staff had had regular supervision, a plan to address this had been drawn up and senior staff were working hard to address this. Additionally there were regular staff meetings to keep staff up-to-date and discuss issues within the service.

One person told us, "The food is very good, the chef works very hard but they bring in agency chefs which are not as good. "Another person told us, "If you don't like everything they will make you egg & chips." A third person said, "The food is very good, they are very good here" 'People were consulted about their food preferences each day and were given options. During lunch time, we observed there were sufficient staff to ensure that time was taken to support each person who needed assistance. Staff did not rush people, they explained to people what the food was and chatted during the meal. The chef told us that there were three weekly menu changes and that people could have snacks and sandwiches whenever they wanted. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the chef. On the day of the inspection there was an agency chef on duty, who did not demonstrate they had been made aware of people on special diets. Senior staff told us the chef should have been given a 'location dietary summary' with the name, room, guidance, special diet and additional information on it. We saw that these forms had been used previously and contained information such as, 'Give thickened milk shakes twice daily.' However, care staff who were serving the meals to people had a good understanding of people's likes and dislikes and dietary needs and offered encouragement to support people in their menu choices. We did not judge this to put people at risk of harm, but ensuring all staff had the necessary information on people's dietary needs is an area in need of improvement. People told us they had a choice of either eating their meals in their room or in one of the dining rooms. We observed the lunchtime experience for people. It was relaxed and people were considerately supported to move to the dining areas, or could choose to eat in their bedroom or in the lounge. People were encouraged to be independent throughout the meal and staff were available if people wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. Where people were supported to eat their meal they had a dedicated member of staff to support them, they were not rushed and there was evidence of friendly conversations occurring.

A screening tool was used to identify people who were malnourished or at risk of malnutrition. People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. One member of staff told us, "The nurses are good on weighing and put them on food and fluid charts, this is very important, we weigh new residents." Another member of staff told us, "If they have a urine infection we encourage them to drink more water." 'Where people's nutritional intake was being monitored there was recording in place to inform staff of people's food and fluid intake. However, we saw that these were not fully completed where needed. This is an area in need of improvement. Referrals had been made for guidance and support from the speech and language team (SALT) team or dieticians as required and any guidance for staff to follow had been implemented. Staff told us they monitored eating and drinking, and one member of staff told us, "The SALT team come in and we tell the nurse if anyone is coughing when feeding." Care plans were in place for people with diabetes and risk assessments for where people suffered with dysphasia. There was clear guidance for care staff to follow where people had thickened fluids including the consistency these should be.

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare

professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. This was confirmed by healthcare professionals we contacted, as part of the inspection process, who spoke of good communication and working relationships. One person told us, "I only go out to have my hearing attended to. I had wax removed from my ears recently." Another person told us, "They are quite quick in responding." A third person said, "The Carer took me to hospital and because there was a long wait a different carer picked me up, it went very smoothly."

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. Staff had knowledge and an understanding of the (MCA) because they had received full training in this area. People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. Staff told us how people had choices on how they would like to be cared for and they always asked permission before starting a task. One person told us, "We make our own decisions." One member of staff told us, "It's about the capacity to make choices that are in their best interests such as whether to keep the bed rails up or use the strap in the wheelchairs." Another member of staff told us, "There are restrictions on how you can implement this, we had a lady who was able to make a clinical decision about haematuria and wanted treatment and we made an urgent referral. MCA is about making decisions with the family or carers and make sure that everyone is involved, it's a balance between self-care and the need to balance this." Senior staff were able to tell us for one person who had just been admitted to the service who had their medicines administered covertly, how this was being considered through a 'Best interest' meeting.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are the process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. The registered manager and senior staff told us they were aware of how to make an application to deprive someone of their liberty. They talked with us about the current applications which were in place. Care staff told us they had completed or were due to complete this training and all had a good understanding of what it meant for people to have a DoLS application agreed.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the kindness and caring approach of the staff. They told us they were happy with the care and support provided in the service. One person told us, "The carers are very kind. I had a sore throat and they made me some special lemon tea." Another person told us, "They really care. They found I was anaemic and wrote down how to deal with my constipation. " A visitor told us, "Cheerful, Staff were helpful and it was peaceful." A compliment received in the service detailed, 'Everyone always makes me feel welcome, but today was special. Great atmosphere, music we were all singing, staff resident and visitors alike.' Another compliment received, 'You were all so kind and caring towards her.' A third compliment detailed, 'You were all so lovely towards us, we thought of you as part of our family as mum was with you a long time.'

We saw that positive caring relationships had developed between people and staff. Observations showed that staff were very kind and caring in their relationships with the people they supported. Everyone in the service had their own key worker, which is a member of the care staff who took a special interest in their care needs, for example made sure their room was tidy and any shopping needs were identified and fulfilled. When staff were around people there was a calm and supportive atmosphere. People were treated in a kind and compassionate way. Interactions between staff and people were observed to be positive and respectful. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listened to people, and there was a close and supportive relationship between them. We observed care staff reassuring and distracting one person who was wandering, by making tea with them and looking at family photos. One member of staff told us, "Carers give instinctive care and know how to support and give up time. They are close to the next of kin and can provide what's needed."

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met people's individual needs. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it influenced them today. Care staff demonstrated they were knowledgeable about people's likes and dislikes. Staff spoke positively about the standard of care provided and the approach of the staff.

People and their relatives told us care staff ensured their privacy and dignity was considered when personal care was provided. They told us that staff always knocked before going into their room. One person told us, "They always treat me with dignity and respect." Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people. They were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they how protected people's dignity and treated them with respect. One member of staff told us when they assisted people with their personal care it was about, "Keeping their doors shut and covering them when washing them so that they are not naked. We knock doors and put signs up that

care is in progress."

Observations through the day were of many kind and careful care interactions by care staff, good skills in assistance to eat, allowances for communication difficulties, explanations given. The atmosphere in the service was calm and relaxed, but there was also a general hum of activity. People had their own bedroom and ensuite facility for comfort and privacy. They had been able to bring in small items from home to make their stay more comfortable such as small pictures. People had been supported to keep in contact with their family and friends, and told us there was flexible visiting. Visitors said they were always welcomed and this was evident during the inspection visit when staff were observed chatting to visitors and offering them cups of tea. People were able to use the public phones sited in the service and there was internet access provided. Where people had support when making decisions about their care and did not have family support, a representative from an advocacy service had been requested. Senior staff were able to confirm they knew how to support people and had information on how to access an advocacy service should people require this service. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

Care records were stored securely. The new electronic care plans were being implemented which would be password protected. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Requires Improvement

Is the service responsive?

Our findings

People were asked for their views about the service. Relatives told us they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. People were supported to be as independent as possible. One person told us, "I am independent, I get up make my own bed and wash and dress. I just don't lift anything heavy so I am perfectly safe." Another person told us, "I have a shower in my room which they supervise but I can wash myself." People spoke of the activities they had been able to join in. One person told us, "The carers do their best to include everyone in the activities. We all go to the lounge to join in singing and dancing and playing skittles." However, despite these positive comments we found areas in need of improvement in relation to care planning and review and activities provided.

New electronic care plan documentation was in the process of being introduced into the service. Staff had received training in how to use the new system and there was ongoing monitoring to ensure the quality of the detail recorded. One member of staff told us, "There's lots of paperwork and computerised will be better." Care and support plans were between both the systems. The detail included on the care plans was varied. Some reviews of people's care needs had fallen behind, and so it was not possible to evidence that people's current care and support needs had been identified and recorded and that the review process was embedded in the service. This is an area in need for improvement. The registered manager acknowledged reviews had fallen behind, but this was in the process of being addressed as people's care plans were being reviewed as part of the transfer of information onto the new system. Senior staff were able to confirm this and show us work being completed to address this. Care staff told us that care and support was personalised and confirmed that where possible, people were directly involved in their care planning. Staff told us that they provided personalised care, and one member of staff told us, "We ask them what they want to wear for example, we read the care plan and get to know the resident and give them emotional support." Care plans detailed people's individual preferences, for example, 'Prefers bed bath needs one person to shower and two for a bed bath, assess skin changes and assist in the application of creams,' and 'Make time to sit one to one and encourage eye contact, staff to initiate conversations.'

Staff told us that communication throughout the service was usually good and included comprehensive handovers at the beginning of each shift between health and social care staff and regular staff meetings which they used to update themselves on the care and support to be provided. One member of staff told us, "The handover is generally enough for us.' Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs." Another member of staff told us," I would check with the nurse if I wanted to know something." There was a shift plan in place which described tasks that needed to be undertaken either 'am' or' pm' and also recorded the staff member allocated to complete each task

There were no activities taking place during our inspection as the activity coordinators were away. However, there was a coffee morning in the main lounge and the shop where people could buy small items was open for people to make purchases run by one of the people living in the service. Most people spoke highly of the activities provided. These were published in a monthly newsletter which was circulated. One person told us, "We had Elvis and Buddy Holly last week. They bring in animals and we have the school choir, they are all

very good." Another person told us, "The activities are OK but not for me." A visitor told us, I have been in many care homes but this is the best. They have wonderful activities for the residents. Last week there was an Elvis Tribute. They always have live entertainment, quizzes, music, animals and skittles." Records we looked at detailed a range of activities had been provided including, armchair exercises, quizzes and board games bingo, cinema afternoons, and reminiscence sessions. Themed activities had taken place, including a Halloween party, and remembrance activities. However, there were limited opportunities for people who stayed in their own rooms. Staff told us people had the choice to come into the main areas of the service but, one member of staff told us, "Some don't like to socialise." We noted that the majority of people stayed within their rooms on the day of the inspection. This is an area in need of improvement. One member of staff told us, "There are not enough activities going on and it's always on the middle floor because some of the dementia patients are loud. There could be activity all day long, we could do more, they love music and singing but we don't have time to do this with them." Another member of staff told us, "We need more outings there's not many, that's the downside of this place they're bored and not stimulated enough." A third member of staff said people were able to do gardening and, "There are no activities today but we have it four days a week. Residents in the other areas can miss out as the lounge is the communal area and they miss out. Staff can't do the activities and there shouldn't be a gap in activities." We discussed this with the registered manager who acknowledged this was an area in need of development. They already had sought support and guidance from an external group for activities and support for people living with dementia. A sensory room was also being constructed for people's use. Meeting people's religious and cultural needs was part of everyday practice at the service. Staff were able to describe how people's religious customs were respected, and pastoral visitors and church leaders visited.

People and their representatives were able to comment on the care provided through reviews of people's care and support plans, and by completing quality assurance questionnaires. One person told us, "I have filled in a tick box questionnaire it is anonymous." There were also residents and relatives meetings. One relative told us, "They have residents meetings to discuss things but I don't go, perhaps I should."

There were systems in place to record any compliments, concerns or complaints. People were encouraged to raise any concerns and knew who to speck to if they had any concerns. People told us they felt it was an environment where they could raise any concerns. People generally felt that if they had any complaints they would tell a member of staff. One person told us, "I have never had a reason to complain but if I did I would ask to see the Manager immediately." Another person told us, "I have not complained but made comments like 'I would like to see a duty manager in the office at weekends." People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which was available in people's bedrooms. No one we spoke with had raised any concerns. People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. Where any concerns had been raised these had been recorded and responded to appropriately. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns. One person told us, "If I want anything I only have to ask. If I had any worries I would tell my son."

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff all told us that they were happy with the care and support provided at the service and the way it was managed and found the management team approachable and professional. People looked happy and relaxed throughout our time in the service. One member of staff told us, "If concerned we can go to (Registered manager's name) she is happy to chat and help if there are problems." Another member of staff told us, "The manager is very good I like her you can go and talk to her and the deputy any time, it's all about the residents." The visiting healthcare professional told us staff had worked well with them, and ensured the correct information was available when they visited, or undertook a review. Staff was helpful, approachable and available to discuss people's care needs, whilst also ensuring people in their care were safe. However, despite these positive comments we found areas in need of improvement in relation to the auditing of the care provided.

We found there was a lack of regular and effective auditing and monitoring of the quality of the service. This is an area in need of improvement. Senior staff had carried out some internal audits, including care planning, checks that people were receiving the care they needed, medication, and infection control. However, these had not been carried out regularly. Fire and health and safety checks of the building had not been completed and embedded into the practice of the service in line with the provider's policy and procedure. There was a system in place for recording accidents and incidents, but these had not been collated. However, it was not clear how the provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. For example, an external group who had been commissioned three times in 2016 to carry out audits in health and safety, housekeeping, infection control, maintenance, recruitment and medicines identified areas in need of improvement. It was not clear how and when outstanding items had been addressed. For example, it was identified health and safety checks had not been completed in the service, but senior staff were not able to tell us of plans to address this. Records were not fully in place to evidence checks made.

The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided, including the experiences of people who used the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Policies and procedures had been updated since the new provider had taken over the service.

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager, and a team of registered nurses. Head of department meetings where held regularly to discuss the working of the service. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided. One member of staff told us," The management are approachable and we are all feeling our way with the proprietor." Another member of staff told us, "There are meetings with heads of department and the deputy manager represents the nurses, there are empty beds and we need to work on the staffing and get the systems in place." Staff members told us they felt the service was well led and

that they were well supported at work. They told us the managers were approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "This is generally a good place to work, we pick up lots of skills here. The place has potential and is designed for a certain type of care. We all sing from the same hymn sheet with similar aspirations and expectations." Another member of staff told us "It's really good I'm quite happy the staff are doing a very good job." A third member of staff said," The deputy has done so much since he has been here."

The organisation's mission statement was incorporated in to the recruitment and induction of any new staff. The mission statement was detailed in the service user's guide for people, visitors and staff to read. The aim of staff working in the service was, "To deliver high quality nursing and residential care that enables service users to maximise their independence and feel supported in the decisions they want to make." Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, and diversity and understood the importance of respecting people's privacy and dignity.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. Policies and procedures were in place for staff to follow, and current guidance had been used to regularly update policies and procedures.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a lack of effective risk management.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective governance to enable them to assess, monitor and drive improvement in the quality and safety of services provided, including the experiences of people who used the service.