Warmest Welcome Limited

Cymar House

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

This inspection took place on 14 July 2016 and was unannounced. This meant the registered provider did not know we would be visiting.

The service was registered with the Care Quality Commission on 20 May 2011. They were last inspected on 8 April 2014 and were found to be compliant.

Cymar House accommodates up to 25 older people, the majority having either dementia or mental health problems. The service does not accommodate people who have nursing needs. The service is owned by Warmest Welcome Ltd and is located in Glasshoughton in Castleford.

The service had a registered manager in place. 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.

Systems were in place to ensure that the medicines had been ordered, stored, administered, disposed of and audited appropriately. Staff we spoke with knew how to administer medicines safely and the records we saw showed that medicines were being administered correctly. However there were some discrepancies with the stock counts of medicines we looked at.

People and their relatives told us they felt that care was delivered safely. Individual risk assessments were being undertaken and key risks specific to the person such as choking and falls were being identified but no record subsequently highlighted what action should be taken to mitigate these risks.

The service had an up to date safeguarding policy in place and staff had a working knowledge of this. They were able to tell us about different types of abuse and were aware of the action they should take if they suspected abuse was taking place. Staff were also aware of whistle blowing procedures.

Accidents and incidents were appropriately recorded and analysed so that any trends could be identified.

We saw that safe recruitment and selection procedures were in place and appropriate checks had been undertaken prior to staff starting work. The checks included obtaining references from previous employers and a Disclosure and Barring Service check to ensure that staff were safe to work with vulnerable people.

We saw that at most times there were sufficient numbers of staff on duty in order to meet the needs of people who used the service. However staff did find it more difficult to manage during mealtimes and this led to people being taken to the dining room approximately half an hour before their lunch was served.

Appropriate maintenance checks had been regularly undertaken to ensure that the environment was safe

however water temperatures had not been within safe limits. This was immediately addressed after we pointed it out. We saw up to date certificates for safety standards such as gas safety, fire equipment and portable appliance testing.

Staff received appropriate training and had the skills and knowledge to provide support to the people they cared for and this included specialist training specific to the needs of the people using this service. New staff underwent comprehensive induction training and mandatory training was refreshed regularly in line with the training policy.

Staff had a working knowledge of the principles of consent and the Mental Capacity Act. We saw evidence of capacity assessments being undertaken and best interest decisions being made. Although there had been some initial confusion around the application for Deprivation of Liberty Safeguards (DoLS) authorisations we saw that the service was now following the appropriate procedure.

Staff received regular supervision and annual appraisals to monitor their performance and felt that these sessions provided a useful forum for discussion.

People were supported to access external health services such as dentists and opticians to ensure their general health and wellbeing. People were also referred to services such as the falls team or dietician where a need had been identified.

Kitchen and care staff were aware of people's dietary requirements and any extra support needed at mealtimes. Records were kept to ensure people enjoyed a suitable, healthy diet and maintained a good level of nutrition.

Staff were friendly and patient when delivering care and were mindful of respecting people's privacy and dignity. Staff were happy in their job and had a positive attitude about the care provided by the service. People using the service and their relatives felt that the staff delivered a good standard of care.

Care plans contained clear instructions regarding people's individual care needs but could be made more person centred by the inclusion of more detail to ensure people received support tailored to their personal needs and preferences. People and their relatives were involved in care planning and reviews.

People were offered a variety of activities and people were seen to enjoy participating. Relatives were free to visit at any time and were made to feel welcome.

The service had an up to date complaints policy that was made available in a communal area. Complaints were properly recorded and fully investigated within the timescale stated in the policy.

There were a number of systems in place to monitor and improve the quality of the service provided. The registered manager carried out several weekly and monthly audits and action plans were put in place to address any issues identified.

Staff felt very well supported by management and colleagues and felt that the registered manager was approachable. The registered manager had an open door policy and ensured they were also available to night staff on a regular basis. Staff meetings were held regularly and staff were also updated via a newsletter.

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.

Appropriate arrangements were in place for the safe storage and administration of medicines, however we found that there were discrepancies in some drug counts and recent audits had been missed.

Assessments were undertaken to identify risks to people using the service but there was no record of the steps to be taken to minimise the chances of them occurring.

Staff understood the safeguarding issues, knew how to recognise abuse and felt confident to raise any concerns they had.

There were sufficient skilled and experienced staff on duty to meet people's needs. Robust recruitment procedures were in place and appropriate pre-employment checks were carried out to minimise the risk of unsuitable staff being employed.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had the necessary skills and knowledge to care for them. Staff had received the appropriate training.

Staff had received training on the Mental Capacity Act (2005) and demonstrated some understanding of how to apply this in practice.

People were supported to access healthcare and their nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

Staff were seen to be friendly and patient and people using the service and relatives were happy with the standard of care being delivered.

Staff were mindful of respecting people's privacy and dignity.

End of life care plans were in place to inform staff of people's wishes and to ensure they were respected.

Is the service responsive?

Good

The service was responsive.

Care plans were comprehensive, were written with the involvement of people and were regularly reviewed.

People had access to a wide range of activities.

The service had a complaints policy in place and complaints were correctly investigated and documented.

Is the service well-led?

Good

The service was well led.

Staff said they felt supported in their role and regular staff meetings were held which helped to promote staff engagement.

Staff and people we spoke with told us the management team were very approachable.

There were systems in place to monitor and improve the quality of the service provided. Audits of areas such as medication, accidents and incidents and care records were undertaken regularly but were not always effective.

Cymar House

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 inspection took place on 14 July 2016 and was unannounced.

The inspection team consisted of two adult social care inspectors.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale.

The provider was asked 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 received this completed document on 2 February 2016.

During our inspection we spoke to 12 people who used the service, three relatives, six care staff, the cook, the registered manager and the director of care. Following our visit we also spoke on the telephone to a social worker who had worked with the service.

We undertook general observations and reviewed relevant records. These included three people's care records, four staff files, audits and other relevant information such as policies and procedures. We looked around the service and saw people's bedrooms, bathrooms, the kitchen, and communal lounge and dining areas.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe. One person told us, "I feel safe, staff help you all the time." Another person said, "I am absolutely safe."

People's relatives were also happy that their family members were kept safe. One relative told us, "[person's name] is safe here, [person's name] is content." Another relative said, "Oh yes [person's name] is safe."

We looked at the way medicines were managed. Systems were in place to ensure that the medicines had been ordered, stored, administered, disposed of and audited appropriately. Staff we spoke with knew how to administer medicines safely and the records we saw showed that medicines were being administered correctly. However there were some discrepancies with the stock counts of medicines we looked at.

Each person had a medicine cabinet in their room and medicines were kept in original packaging with a date started documented on each box/bottle. The staff member said, "I think having their own medicine cabinet provides a more personalised care." We observed a senior carer giving people their medicines at lunchtime. They followed safe practices and treated people respectfully. They always knocked on people's doors before entering the person's room, explained to the person what they were doing every step of the way and showed extreme patience. The staff member explained they could recognise if people were in pain or not and always asked if they wanted their 'when required' medicines.

Appropriate arrangements were in place for recording the administration of both oral and topical medicines. Staff had signed medicines administration records correctly after people had been given their medicines. Records of administration had been completed fully, indicating that people had received their medicines as prescribed. When people had not taken their medicines, for example if they refused or did not require them, then a clear reason was recorded.

Medication kept at the home was stored safely. Appropriate checks had taken place on the storage, disposal and receipt of medication. This included daily checks carried out on the temperature of each person's room, the treatment room and refrigerators which stored items of medication. Staff knew the required procedures for managing controlled drugs. Controlled drugs are drugs liable to misuse. We saw that controlled drugs were appropriately stored and signed for when they were administered. Eye drops which have a short shelf life once open were marked with the date of opening. This meant that the service could ensure they were safe to administer.

We asked to see the guidance information kept about PRN medicines to be administered 'when required'. These were not kept with the person's Medication Administration Record (MAR). The registered manager provided these saying for some reason they had been removed.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. We found that the registered manager completed a weekly stock audit. However the checks for the last two weeks had not taken place. When we checked stock levels

for two people's medicines we found one tablet was missing in a number of different boxes. We discussed this with the registered manager who provided a valid reason for the last weeks missing audits and had planned on doing it the day of inspection. The registered manager looked into the missing tablets and could provide no reason. The registered manager said they would start daily stock checks from now on.

Relevant staff had undertaken the safe handling of medication training. The registered manager told us they conducted annual observations to assess staff competency when dealing with medication and we saw that these competency checks had been conducted for all staff. This meant that staff had the necessary skills to ensure that people who used the service received their medicines as prescribed.

We saw maintenance records which confirmed that the necessary checks of the building and equipment were regularly carried out. Equipment such as hoists and wheelchairs had been regularly serviced and were audited monthly. Portable appliances testing (PAT) had been completed on all relevant electrical items and the home had an up to date gas safety certificate.

We saw records of monthly water temperature checks that showed the temperature of the water at the sentinel points was below the recommended 50 degrees Celsius, sometimes measuring as low as 44 degrees Celsius. The sentinel outlets are those furthest and closest to each tank or cylinder and should be operated at temperatures that prevent Legionella growth. Legionella bacteria is commonly found in water and is responsible for causing Legionnaires' disease. We also saw that two of the showers were running at temperatures of 43 degrees Celsius despite the safe maximum temperature of 41 degrees Celsius being noted on the paperwork where temperatures were being recorded. The registered manager contacted the maintenance team for the service who came out immediately and adjusted the thermostat to bring the water to the recommended safe temperature.

We saw that the emergency lighting within the service had been checked monthly but records showed that four units had been out of service for four months. The maintenance team checked this during our visit and found only two of the units were not working. We were told that these would be repaired by the next day. Wheelchair checks showed that faults had been identified but no record was made of any remedial work that had been carried out. An annual report on nurse call points showed that issues had been identified but there was no record of work being done to rectify this. This meant that risks to people arising from faults with premises and equipment were not always correctly monitored or addressed.

We saw individual risk assessments were being completed for people in areas such as choking, falls, manual handling and the provider used recognised risk assessment tools such Malnutrition Universal Screening Tool (MUST). These assessments were being used to establish the level of risk but they were not expanded to detail what action should be taken to mitigate these risks.

We saw on one person's records that they were a moderate choking risk. On the choking risk assessment it was noted that a member of the Speech and Language Therapy (SALT) team had found them to have a moderate choking risk but there was no mention of this in the person's eating and drinking care plan. Their food intake record showed that this person ate a normal diet with no adjustments currently being made to their food. The registered manager told us that this person had not experienced any problems eating a standard diet whilst living at the service and that the SALT assessment had been undertaken prior to their admission. We were told that a new referral would be made to SALT in order to ensure that records were up to date with current risk level.

The service offered movement and music exercise sessions and there were risk assessments in place to check that those people taking part were physically fit to do so. Medical advice was sought when making

this decision to ensure it was safe for people to participate.

The home had an up to date safeguarding policy that was reviewed regularly and all incidents of safeguarding had been appropriately reported to both the CQC and the local authority. Staff had all received safeguarding training and demonstrated a good knowledge of what constituted abuse, what signs to look for and the procedures for reporting any concerns.

One member of staff told us, "I know about what abuse is, it could even be not listening to them (people using the service), shutting curtains without asking." Another member of staff said, "Safeguarding is making sure people are protected in a safe environment and you stick to guidelines."

Staff told us they were confident to report any safeguarding concerns. One member of staff said, "Any concern I would report to my manager and I would have no problem going further."

The service had an up to date whistleblowing policy and staff were aware of the procedures. Whistleblowing is when a person tells someone they have concerns about the service they work for. Staff members we spoke with said they would report any concerns they had without fear of recrimination. One member of staff told us, "I'd go straight to the manager with any issues, you have to put people's care first, it could be you or me. I would whistle blow if I had to, you just have to do it don't you?"

The service had a fire emergency file in place that included information such as emergency contact numbers, a plan of the building and personal emergency evacuation plan (PEEP) for each person. 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. We saw that PEEPs were reviewed monthly and contained sufficient level of detail to enable emergency services to evacuate people safely. There was also equipment such as a high visibility vest, a torch and batteries and stickers to identify people following an evacuation. These items were kept with the fire file but they were not kept together in a way that made them easy to grab in an emergency situation. When we pointed this out the registered manager told us they would store these things together in a bag in future.

The service did regular checks on fire alarms and equipment and held regular fire drills that involved all staff. As well as drills the service undertook emergency evacuation tests with staff practising the use of escape equipment on one another.

There was an up to date emergency contingency plan in place that contained information on how to deal with emergency situations such as the lift breaking down, fire, flood, gas leak and electrical failure. These plans had all been reviewed and updated in June 2016. This meant that people would receive appropriate support in emergency situations.

We looked at four staff files and saw that safe recruitment processes and pre-employment checks were in place. We saw application forms and interview records along with evidence that identification had been checked and references had been received. Disclosure and Barring Service (DBS) checks had also been undertaken for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

At the time of the inspection there were 25 people who used the service. We saw duty rotas and signing in sheets which confirmed the service was staffed in the way the registered manager described, with two care staff and one senior on both the morning and afternoon shift and an extra care worker between 8:00am and

11:00am. There were always two waking night staff on duty and two part time activity coordinators worked Monday to Friday. Through our observations and discussions with people using the service and staff, we found there were sufficient staff to meet people's needs at most times of the day. We did observe that at lunchtime staff were overstretched and this meant that people were being taken to the dining room up to half an hour before food was served. We observed one person try to get up from the table and walk away but they were in a wheelchair and struggled because of the footplates. They were settled by staff and encouraged to wait for their meal. We discussed the lunchtime staffing levels during our feedback and the manager said that they would look into ways of addressing this.

One member of staff told us, "There are enough staff, we have someone 8:00am to 11:00am but it would be better if they could do 8:00am to 2:00pm to cover lunch, there are just two carers and a senior at lunch time so if we get an emergency or even if someone needs the toilet we are stretched." Another member of staff said, "Other than lunchtime we are pretty well staffed." Another said, "There is enough staff, there are four of us in a morning and four of us from three till seven which gives us chance to get baths done."

The visiting hairdresser told us, "It seems like everywhere you go could do with more staff but from what I see the staff here cope just fine."

Accidents and incidents were being appropriately recorded and we saw that 24 hour observation charts were put in place after a fall and body maps completed to document any injuries sustained. Information regarding accidents and incidents, including falls, was audited each month and analysed to look for trends and patterns. One person had fallen a number of times and we could see what action had been taken. For example they had been referred to the GP and the falls team, they now had a sensor mat in place and were due an assessment to see if they now required nursing care. If anyone had more than one accident or incident in a month, staff completed a form to state what they had done in response to this. For example whether the person had been referred to their GP, when the last risk assessment had been updated and who they had informed.

We looked at the arrangements that were in place for ensuring cleanliness and infection control. The service had one domestic staff member on duty six days a week with two people every Monday to complete a deep clean of the service. We found that the main communal areas of the home were clean and free from unpleasant smells. The bathrooms and toilets we looked in had a supply of hand wash and paper towels, dispensed from wall mounted containers. This meant that appropriate hand washing facilities were readily available. We saw that personal protective equipment (PPE) such as gloves and aprons were available throughout the service. We saw a recent infection control audit that had been conducted by Wakefield Council and the service had scored 91%. This showed steps were being taken to help prevent and control the spread of infection.

Good

Is the service effective?

Our findings

A person using the service told us, "It is lovely living here, there's nice food and you have everyone to talk to."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

We looked at whether the service was applying the DoLS appropriately. Capacity assessments were being undertaken on every resident, even when there was no reason to believe they lacked capacity. We saw that DoLS applications had been sent for some people who were assessed as having capacity. We discussed this with the registered manager and the assistant director of care and were told that the advice they were given in respect of the DoLS procedure had changed since its introduction. As the service had a keypad in place to secure the main entrance to the building there had been some confusion as to whether everyone living at the service required a DoLS in place. The registered provider is now aware that this is not the appropriate response and we discussed the options regarding the locked door with the registered manager, for example those people who wished to have the code to the door could be given it and those who did not wish to come and go independently could sign consent to say they did not require the code. DoLS applications were now only being submitted to the supervisory body for authorisation when people were identified as having possible cognitive impairment after undertaking a simple six step test.

The registered manager kept a record of those people who were subject to DoLS authorisations and when they were due for review. Where people lacked capacity to make decisions about aspects of their care, staff were guided by the principles of MCA to make decisions in the person's best interest. We saw that best interest decisions had been completed, were decision specific and showed involvement from people's family and staff.

Staff had a limited understanding of MCA and DoLS. One member of staff told us, "DoLS is when you deprive them of their liberty." Another member of staff said, "DoLS is where you have to apply for people who can no longer make decisions for themselves, there is a list in the office of people with a DoLS." One member of staff was not able to tell us what DoLS meant. We saw that all staff had recently received training in this area and

when we discussed this with the registered manager and assistant director of care it was agreed that alternative training resources would also be looked at to improve staff knowledge in this area.

Staff told us they obtained consent prior to delivering care. One staff member told us, "I always ask people before I do anything, you can't force people." Another staff member said, "I ask people for their consent. I can also check the care plan and they let you know if they are happy or not."
On one of the care files we looked at we saw that a person who was deemed to have capacity to make their own decisions had all of their consent forms and care plan agreements signed by their next of kin. We questioned this and we were told that this person had requested that their relative sign on their behalf. Whilst the relative had lasting power of attorney this was only for property and financial affairs. The registered manager told us that they would get confirmation in writing from this person that they wished their relative to sign all paperwork and we also discussed the possibility of a lasting power of attorney being put in place for health and wellbeing.

Mandatory training for staff was all up to date. Mandatory training is training that the provider thinks is necessary to support people safely. The assistant director of care was also responsible for the registered provider's training programme. They told us that they put together a quarterly training programme which included mandatory training and refresher training along with external specialist training that was sourced and delivered each three month period. Two of the people who were living at the service at the time of our inspection had a schizophrenia diagnosis but staff had not received any training in this area. We saw that the registered manager had sourced some training information for staff during our visit and a training course was to be arranged as soon as possible.

Staff were happy with the training they received. One staff member told us, "I have done loads of training, dementia, health and safety, fire, moving and handling, safeguarding and infection control." Another staff member said, "My induction was good. I had a day in the office and I shadowed a couple of shifts. I had enough support during my induction." New staff were also undertaking the Care Certificate. The Care Certificate was introduced within the care sector to ensure that workers had the opportunity to learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received regular supervision and annual appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. Supervisions took place approximately every eight weeks. During each supervision a different topic was discussed such as head injury, DoLS or Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR). As part of their annual appraisal staff had to rate themselves as well as their line manager. During appraisal meetings staff discussed workload, attitude, being a team player, skills, training, using initiative and overall contribution. Staff also discussed their key achievements what they liked most and least about their present job, areas they would like to improve and any further training needs.

If the registered manager or the staff member had any concerns arising from a supervision meeting they completed a staff counselling form. These were completed every time there was an issue for example not passing on information correctly during handover.

Staff told us that they felt these meeting were useful. One staff member told us, "I find supervisions helpful, we have to think about our weaknesses and what we can improve." Another staff member said, "Supervisions are very regular and you are always asked how things are and if you've got any problems." This meant that there were procedures in place to monitor and support staff performance.

We observed the lunchtime dining experience. The tables were set attractively and condiments were

available. Although it was apparent, as mentioned in the Safe section of the report, that staff were stretched during the lunch service they were still good humoured and interacted well with people. The atmosphere in the dining room was relaxed.

People told us they were happy with the food provided. One person said, "The food is very good." Other people said, "The food is good, put it this way I don't refuse anything", "The food is beautiful" and "That pudding we had today was so lovely."

A relative we spoke with told us, "As soon as [person's name] came in here they put on weight. They look so much better."

People had choice of what they wanted to eat. On the day of the inspection people were offered Hungarian chicken stew or meat and potato pie and for pudding a choice of apple strudel and cream or cake and custard. The cook visited each person just before lunch time to ask them what they wanted. For tea time people preferred sandwiches. The cook said they had tried other foods such as beans on toast but people preferred sandwiches with pork pies and sausage rolls. The cook said, "[person's name] always has tuna and cucumber with brown bread, I offer other fillings but that is all they want." We saw hot drinks being served throughout the day and containers of fruit squash were available in communal areas.

We spoke to the cook and found they were aware of people's special dietary requirements. Information on people's needs and preferences was recorded and kept in the kitchen for easy reference. The cook explained that they had a meeting with the diabetic nurse regarding the food for diabetics. They told us, "We keep an eye on sugar intake and if they want something we provide smaller portions." For people who needed a pureed diet each item was blended separately and those people who required extra nutrition had their diet fortified with added butter, cream and milk powder. The cook also said, "I always use fresh vegetables and push food that is high in vitamins. I love cooking and I love the residents."

Food and fluid charts were in place for people when a need to monitor nutrition and hydration had been identified. We saw that these records were fully completed. Fluid charts had a target daily intake recorded and the volume drunk was totalled to check against this target. If anything gave cause for concern this was noted in the handover book. This meant staff were alerted when people may need more encouragement to eat or drink. This meant that the service were ensuring people's healthy nutrition and hydration.

People's records showed details of appointments with and visits by healthcare and social professionals, for example GPs, district nurse teams, opticians and chiropodists. This demonstrated that staff worked with various agencies and sought professional advice, to ensure that the individual needs of people were being met and maintain their health and wellbeing. One staff member told us, "We have to take care of people, if they're not well we call the doctor."

Handover books were completed at the end of each shift and the handover included a brief overview of how each person using the service had been during the shift. There was also a diary that was to be read by all staff at the start of each shift. This contained details of any actions to be taken that day. This meant that staff were kept up to date with any changes in the day to day needs of the people using the service.

The service felt homely and there were comfortable communal areas for people to spend time in outside of their bedrooms. The service had dementia friendly signage and we saw that in one toilet they had fitted a red seat to make it easier for people living with dementia to use independently. Colour and contrasting colour in particular, can help people with sight loss and dementia to identify key features and rooms.

Good

Is the service caring?

Our findings

A person using the service told us, "I am sure it is lovely, they look after me." Another person said, "We are being well looked after, staff are lovely." Another said, "Staff are good with you, you can't grumble about the staff."

Relatives we spoke with were also happy with the care their family members were receiving. One relative told us, "It is absolutely brilliant." Another relative said, "I could not wish for anything better."

There was a relaxed and homely feel about the service. Staff spoke to people in a friendly manner and were observed crouching down when they spoke, or sitting next to people making sure their faces could be seen clearly by the people they were talking to. We observed lots of laughter and conversation between people using the service and staff.

When people needed assistance staff attended promptly and we observed staff employing safe moving and handling techniques. Staff demonstrated a good knowledge of the people they cared for. For example one member of staff told us, "[Person's name] can get anxious and agitated at night so we put in a night light, this has really helped them settle."

A visiting hairdresser told us, "I love it here, I love the atmosphere. It's like a family when I come in. The staff all talk to you, they seem jolly and happy in their job and that's what makes it such a good atmosphere. I'd put my parents in here, they are all lovely. People confide in their hairdresser and I've never had anyone say anything bad about it to me."

We saw within care records that people were involved in writing and reviewing their care plans. One relative told us, "I have seen the care plan and I was asked about their life history." This meant that people and their relatives were consulted about their care, and thus the quality and continuity of care was maintained.

Staff spoke passionately about the care that was provided within the service. One staff member told us, "We are all caring and we look out for everyone, we have their best interests at heart." Another said, "This is a nice place, people like living here, they laugh, they feel secure and cared for." Another told us, "This is a lovely little home, fantastic, I won't be leaving put it that way."

We saw a number of compliments and thank you cards from relatives. The service had also received two recent compliments from visiting health professionals. A community nurse had complimented the staff on being trustworthy and always there and a dietician said that it was always a pleasure to visit the service.

A social worker we spoke to told us that people at the service were smartly dressed and well cared for. They told us that one person had been admitted for emergency respite and had been in bed for a number of weeks prior to their admission. They told us, "They took [person] in, got them walking and within four months they were able to move on to sheltered housing. They were able to give them a new lease of life because of the care they received."

People were involved to maintain close links with family and visitors were welcome into the home at any time. A relative told us, "You are always welcome, it's like another home, like my second home, it is so friendly." Another relative said, "I'm always asked if I want to stop for some food."

Staff told us how they supported people with privacy and dignity. One staff member said, "I close doors, curtains…I'm discreet. I treat people how I would want to be treated or a family member would want to be treated." Another staff member told us, "I make sure everything is in place so you're not coming and going, I just make sure that things are done how they should be done."

Staff also told us the ways in which they encouraged people to retain their independence. One staff member said, "I encourage them to do as much as they can for themselves such as washing their hands for example." Another staff member said, "I promote independence by trying to let people do things for themselves, for example one person can stand up on their own but they sometimes expect you to help, we also encourage them to keep walking."

People using the service told us that they did what they could for themselves but staff were there to assist. One person said, "I do what I can but the staff look after me when I need them to."

A church minister came in to the service to provide Holy Communion once a month. This showed that people's religious needs were being considered and catered for appropriately.

People were involved in the service through resident and relative meetings. We saw the minutes from these meetings which took place every three months. They discussed topics such as upcoming events and introduced new staff.

Although there was nobody using the service who was on an end of life pathway at the time of our inspection the majority of staff had all received training in end of life and palliative care. End of life care plans were in place which meant healthcare information was available to inform staff of the person's wishes at this important time and to ensure their final wishes were respected.

We saw that information on advocacy services was available. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

Good

Is the service responsive?

Our findings

People and their relatives told us they felt involved in decisions about their care. One relative told us, "I have seen the care plan and I was asked about their life history."
One of the people using the service told us, "We do exercise, I enjoy doing that." Another person said, "I've just had my hair done." Another said, "It is marvellous here, I have good mates."

The care plans we looked at covered all aspects of care needs. For example, communication, eating and drinking, mobilisation, sociability and sleeping. The care plans were evaluated monthly and relevant information about tasks to be undertaken by staff to provide care to a person was present. However, more detail about the individual and their preferences was needed to make the plans truly person centred. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. We saw that the service was taking part in a study on enhancing person centred care in care homes (EPIC) and the registered manager explained that work was to be undertaken on the care plans to make them more person centred. As part of the person centred planning 'Life Story' booklets were completed for each person and those we looked at contained a good level of detailed information about people including their favourite things and their past. Detailed daily records were also kept for each person and entries to these were made twice daily. We saw information that had been given to staff about writing effective daily notes and these guidance sheets were also kept on people's care files to remind staff of best practice.

A full review of care plans was undertaken every six months and we saw evidence that people and their relatives were involved in these reviews. When relatives had not been able to attend they were contacted by telephone to discuss any changes.

We looked at the care records of one person who was now permanently cared for in bed. This change was not reflected in either their sociability care plan or their activities care plan. There was some record of staff interaction, for example, 'played noughts and crosses' and 'chatted about family,' but the last of these entries was dated 14 April 2016. We discussed this with the registered manager who acknowledged that the risk of social isolation was greater for someone who spends all of their time in bed.

A range of activities took place within the service. An activities board was on display showing the activities taking place on each day of the week. These included things such as bingo, needlecraft, knitting, seated exercise and pamper time. We observed activities taking place on the morning of our visit. People were making items for the raft stall at the upcoming summer fayre. They had made hanging ornaments and decorated picture frames. Afterwards we saw people painting pictures. The service subscribed to a weekly newsletter called the 'Daily Chat' that was used to stimulate reminiscence discussions. This included articles about historical events, 'trip down memory lane' items and activities such as crossword puzzles.

We saw detailed records of activities that had taken place, who had participated and whether the activity had been successful. In the week prior to our visit we saw records of a Wimbledon themed day to tie in with the tennis tournament. People had played armchair tennis with balloons, had cream teas and played a

memory game matching pictures with a Wimbledon theme. Records showed that people had enjoyed this and it was evident that similar events were taking place regularly. This meant that people were provided with a variety of meaningful activities that prevented social isolation.

We observed people being given choice throughout the day regarding what food and drink they would like and whether or not they wished to participate in activities. One member of staff told us, "I always ask what they would like to do."

The service had an up to date complaints policy and the procedure was clearly displayed on a notice board and also provided to people within their residents' guide making it easily available to people using the service, relatives and visitors. One complaint had been received since the beginning of the year. We saw that this had been fully investigated by the registered manager and an outcome was correctly recorded. One relative told us, "I have never complained but I would if I had to."

Annual residents' surveys were conducted and action plans drawn up to address any issues raised by people using the service. The most recent survey took place in June 2015 and 100% of those responding said they would recommend the home to family or friends. Meetings for people using the service and their relatives were also held every quarter. We saw minutes of these meetings, the most recent having been on 21 June 2016 when the summer fayre was discussed along with the introduction of new staff.

Good

Is the service well-led?

Our findings

People told us the service was well-led and that the manager was approachable. A person who used the service told us, "It is fantastic living here." A relative said, "The manager is brilliant, if there are any problems they always ring me."

The registered manager told us that they had an open door policy for staff, relatives and people using the service. Staff we spoke with told us the registered manager was approachable and they felt supported in their role. One staff member told us, "I feel supported by the manager, you can go with concerns and ask anything." Another staff member told us, "The home has an open and honest culture, anyone can say anything." Another said, "The manager is lovely."

Staff members we spoke with said they were kept informed about matters that affected the service by the registered manager. They told us that staff meetings took place on a regular basis and that they were encouraged by the registered manager to share their views. One staff member said, "Staff meetings are useful, people always say what they think and the manager encourages this. It is good for everyone to get together." We saw records to confirm that meetings took place on a regular basis. Minutes of the most recent meeting, held on 21 June 2016 showed a range of topics were discussed including staff changes, training, upcoming events and best practice around the delivery of care. Meeting minutes were displayed in the office for those staff who were unable to attend. We saw that the service also produced a monthly newsletter for staff that included information on upcoming events, training issues, details of new starters and reminders on topics such as uniform policy and confidentiality. This meant that staff were well informed and had opportunity to be involved in the service.

We spoke to a social worker who had working links with the service. They told us, "Since they got a new manager the service has improved immensely. I visit quite a lot and it is now my first choice if I have an emergency admission."

The registered manager carried out a comprehensive range of audits to ensure quality assurance of the service. These included audits of medicines, accidents and incidents, the kitchen, pressure sores, bed rails, pressure cushions and mattresses. Two care files were fully audited every month. Any issues identified had an action plan drawn up with a target date for remedial work to be completed and this was signed by staff once necessary amendments were made. The registered manager also undertook a dining environment and nutrition audit monthly. As part of this they participated in a mealtime and went through a satisfaction survey with a different person who used the service each month. We saw the results of these questionnaires which showed 100% satisfaction. This meant that regular quality checks were being done however they had not picked up the issues we had found during the inspection. For example medicines not reconciling, unsafe water temperatures, emergency lights being out of service for four months and no record of remedial work on faulty wheelchairs. We discussed this with the registered manager who acknowledged the need for more effective auditing of the service and assured us that this would be the case going forward.

The registered manager told us that they would regularly work a night shift in order to observe the working

practice of night staff. They also told us that they often began work at 7:15am in order to ensure contact with night staff and give the same open door access to them that day staff were offered.

The registered manager understood their role and responsibilities in relation to compliance with regulations and the notifications they were required to make to CQC. The paperwork was well organised and the registered manager was able to provide all of the records we requested quickly and efficiently. They demonstrated a good knowledge of the service, this included both the people using the service and staff. We saw that staff were comfortable approaching the registered manager throughout the day and the atmosphere within the service was relaxed.

The registered manager told us that their visions for the service included individualised care, providing a nice environment to live in and making sure people were engaged and not bored. They told us, "The service is just the right size to feel homely. It's very important to me that it feels like a home." We found that the service was being led in a way that encouraged the achievement of these visions.