Tradstir Limited

Partridge House Nursing and Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 3 November 2015 and was unannounced.

Partridge House Nursing and Residential Care Home is purpose built, and was taken over in 2014 by Tradstir Limited. This is the second inspection since the new provider took over the service.The service provides nursing and residential care, across three units, for up to 38 older people with increasing physical frailty, many living with dementia or other mental health needs. Long term care and respite care was provided. There were 36 people resident at the time of the inspection.

Summary of findings

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.

This inspection was undertaken following the last inspection of the service in November 2014 which identified a number of breaches in regulations. The provider subsequently provided an action plan as to how these breaches in the regulations would be rectified. The focus of this inspection was to ensure improvements had been made. Although we could see significant improvements had been made, there were still areas in need of improvement, and further embedding into the service.

At this inspection we found there was evidence of some regular auditing by senior staff in the service. In addition an external group had been called in twice during 2015 to audit and give feedback to the senior staff. Quality assurance surveys had been sent out to staff and people's relatives and representatives. The information received had been collated. However, it could not be clearly identified how the provider addressed, monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. Quality assurance processes had not always identified areas in need of improvement. This is an area in need of improvement.

Safe recruitment policies and procedures were followed in the recruitment of new staff to work in the service. Senior staff monitored peoples dependency in relation to the level of staffing needed to ensure people's care and support needs were met. 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. They told us there had been good access to training to ensure they had the skills to meet people's care needs. However, training records were not fully up-to-date so it was not possible to fully evidence this. This is an area in need of improvement. The registered nurses could attend the essential training provided, but training updates for their clinical skills was being sought but not fully in place. This is an area in need of improvement.

Staff told us they felt well supported and had received regular supervision and support. One member of staff told us they received supervision, "Every couple of months, and we are listened to." However, supervision records showed us that not all the staff had received regular individual supervision. This is an area in need of improvement.

The experiences of people in the service and their relatives were positive overall. People and their relatives told us they felt safe living in the service, staff were kind and compassionate and the care they received was good. One relative told us, "Take it from me, it's lovely here, we don't have any issues or concerns about mum's care."

People lived in a safe and secure environment. Medicines were stored correctly and there were systems to manage medicine safely regular audits and stock checks were completed to ensure people received their medicines as prescribed. 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.

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 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. There were good examples of personalised care plans, and these included detailed information about people's personal histories and preferences, including details about their previous occupation, family, pets, hobbies, interests and food likes and dislikes. Staff spoke well of the new system as there were access point in the service which care staff could use to update the records and they told us this had led to the care plans being more up-to-date and accessible.Supporting risk assessments were in place to

Summary of findings

protect people.Where people had been assessed at risk for developing pressure sores, or from falling out of bed, the equipment identified to be used had been regularly checked to ensure it remained suitable for individual peoples use.

People were able to join in a range of meaningful activities. Staff told us there were now 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. Where possible care staff also joined in the activities with people, particularly during the afternoons. One member of staff told us, “The activity workers are really good. They find out what people like and try to find something for everyone. If they need help they ask us. Things are pretty good with them.” They saw activities as improving all the time. “The present two activities staff are a team. They try new things. Their weekly activity plan is good for showing what we should do.”

People’s nutritional needs were assessed and recorded. People told us they enjoyed the food provided. Where people were being supported to ensure they had adequate nutrition and fluids, records had been fully completed.

Procedures were in place for people and their relatives/ 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.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient staff numbers to meet people's personal care needs. There were recruitment procedures in place for staff to follow.

Staff knew how to recognise and respond to abuse appropriately and had a clear understanding of safeguarding procedures.

People had individual assessments for identifying and monitoring risk to their health and welfare, which had been regularly reviewed.

People received care in an environment that was clean and tidy and maintained.

Medicines were managed and administered safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

Care staff were able to attend training to ensure they could meet the needs of people receiving care and support. However, the training records were not fully up-to-date to evidence all staff had received all the required training. Staff told us they felt well supported, but although regular supervision was due to be provided in some instance this had fallen behind.

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.

People's nutritional needs were assessed and recorded.

People had been supported to attend healthcare appointments when needed.

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?

Good

The service was responsive.

Summary of findings

People were supported to take part in a range of recreational activities. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People had been assessed and their care and support needs identified. Care plans were in place and being developed to ensure people received care which was personalised to meet their needs, wishes and aspirations.

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.

Systems were not yet fully in place to monitor the quality of the service and implement improvements.

The leadership and management promoted a caring and inclusive culture.

Systems were in place to ensure accidents and incidents were reported and acted upon.

Partridge House Nursing and Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 3 November 2015 and was unannounced. We undertook a comprehensive inspection. This inspection was done to check that improvements had been made as detailed in the providers action plan to meet legal requirements identified after our comprehensive inspection in November 2014.

The inspection team consisted of three inspectors, a specialist nurse advisor and an expert by experience who had experience of dementia care services. 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 did not request the provider to complete a Provider Information Return (PIR) on this occasion. 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 telephoned 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. We also received feedback from the Clinical Commissioning Team (CCG). Following our visit, we contacted two health care professionals to ask them about their experiences of the service provided.

We observed care provided and spoke with people, relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine people, and six visitors. We spoke with the provider, the registered manager, the deputy manager, two registered general nurses (RGN), three care workers, an activity co-ordinator, a chef and a maintenance person. 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, a sample of people's bedrooms, and the garden. We observed medicines being administered. 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 six staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

Good

Is the service safe?

Our findings

People and their relatives told us people were safe and were well treated in Partridge House Nursing and Residential Care Home. When asked if they felt safe one person told us," I think I do," Another person told us, "The staff help me to feel safe." One relative told us, "She's safe. The carers make it safe."

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 falls, nutrition, pressure area care and manual handling. There was a system in place to review these on a regular basis. 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.

The premises were well maintained. The environment was clean and spacious, which allowed people to move around freely without risk of harm. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. Staff were able to access external contractors or dedicated maintenance staff for the servicing and maintenance of the building and equipment. Discussions with the maintenance staff and records we looked at confirmed that any faults were repaired promptly. Staff told us the provider had instigated a number of changes and upgrading of the service. One member of staff told us, "Whatever we want he (the provider) orders." Another member of staff told us, "(Providers name) is very approachable. I told him of a shower not working properly and he got them all checked, problems were found and they were replaced within a week." Staff told us regular checks and audits which had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, for example flood or fire. Staff told us they had completed health and safety training. There was an emergency on call rota of senior staff available for staff to access for help and support.

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.

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. 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 both registered nurses 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 and the MAR sheets.

Good

Is the service safe?

People told us they did not usually have to wait long for help when they needed assistance form the care staff, and observations on the day confirmed this. Senior staff showed us the dependency tool they used which was part of the new electronic care plan system which had been introduced into the service 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 peoples care and support needs which helped them check there were adequate staff on duty. Staff told us although at times it could be busy there was adequate staff on duty to meet people's care needs. 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 was used to cover any care staff absences. 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, "The system enables enough staff to be allocated to both floors, but there are not always enough staff to cover the shift due to last minute sickness and people leaving the home. "Another member of staff told us, "We are allowed to have floaters on the rota, it doesn't mean we always do but that's not management's fault as it depends on recruiting and overall we are fully staffed now." Another member of staff told us, "Every day is busy, sometimes there is only time to do the basics of care, but usually there is time to talk or read with people; afternoons are generally more settled. We work as a team; in the past, we had a problem with that. (Providers name) spends a lot of time here, so does the manager, they have made it much better." 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 Partridge House Nursing and Residential Care Home 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, "The staff are alright. They look after me properly." A relative told us, "They look after her properly, very much so.

At the last inspection in November 2014, the provider was in breach of Regulation 10 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This translates in to Regulation 11 and 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because records to show consent had been gained for care or treatment (other than for the recent flu injections) were either inconsistent or not available. Inconsistent recording systems, including care plans and fluid charts, put people at risk of inappropriate care or treatment. Supervision and team meetings had fallen behind. During this inspection we found, improvements had been made and breaches had been addressed. However, further areas needed to be improved upon.

There had been a review of the consent to treatment forms to ensure these were all in place. There was a record on people's care plans that people had been asked to consent to their care and treatment. 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. We checked whether the service was working within the principles of the MCA.

Staff understood the principles of the MCA. They were aware of any decisions made for people who lacked capacity had to be in their best interests. They gave us examples of how they had followed these procedures in practice supporting people through best interest meetings. For example, for one person where the use of bedrails had been considered. Care staff had a good understanding of the need for people to consent to any care or treatment to be provided. One member of staff told us how they saw all care was provided on the basis of establishing understanding and consent. If they were unsure, they referred to registered nurse in charge. Another member of staff told us, they saw the most important aspect of caring was explaining to people the care offered to them and making sure they are comfortable to receive care, "We are here for the whole person, what makes them happy." However, where people had medicines administered covertly, not all of these agreements had been reviewed, and within the timescales identified to ensure that the practice followed was safe and still met people's care needs. This is an area in need of improvement.

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 receivethe care and treatment they need. The registered manager and senior staff told us they were aware how to make an application to deprive someone of their liberty. They talked with us about the current applications which were in place. For one person an Independent Mental Capacity Advocate (IMCA) had been appointed as they had no family or friends to speak on their behalf and their involvement was recorded within the care plan and within a DoLS Assessment. 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.

The registered manager told us all care staff completed an induction before they supported people. This had recently been reviewed to incorporate the requirements of the new 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. Two care staff had received 'train the trainer' training to do this. 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. This had provided them with all the information and support they needed when moving into a new job role. One member of staff told us they had begun by shadowing shifts for two weeks, and in the first three

Is the service effective?

months they had started to complete their essential training Their experience was that the whole staff team was very supportive. Another member of staff told us the first three weeks of working in the service were shadowing experienced staff. They told us of the staff mutual support and team work which underpinned how the service worked.

Staff told us they had received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Staff had also received 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 services own 'champions' who had been trained to provided staff with training in the service. One member of staff told us, "Training has helped in making situations safe in event of difficult behaviours" However, staff were still in the process of completing all their training, and it was not possible to fully evidence if all the staff had received the training they needed to meet peoples care needs as the training records had not been fully updated. Training for the registered nurses to help them with their revalidation of their qualification and update their clinical training had not been fully formulated. The registered manager told us they were in the process of arranging this with staff from another of the provider's services. This is an area in need of improvement. One member of staff told us, "We join in the generic training in the home, but have had to push for more support to our developmental training. They are now looking at what free training is available. Syringe driver update training is being arranged and we have done catheter care recently."

Staff told us that the team worked well together and that communication was good. Staff told us they had received supervision from their manager, they felt well supported and could always go to a senior member of staff for support. They told us they 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. One member of staff told us, supervision was regular with a registered nurse, and supervision enabled the supervisor to, "Look at how I perform and whether I need any improvement." It also considered relationships with other staff and with people, including people they were the key worker for. Another member of staff told us, they had supervision from the same registered nurse every three months. At the last supervision they said they wanted to learn more about behavioural aspects of dementia care and had guidance on where to look for further information. However, the records we looked at and some staff feedback did not confirm that all the staff had received regular supervision and this had fallen behind. We spoke with the registered manager about this who acknowledged there had been some slippage in providing all the staff with regular supervision, but that senior staff were working hard to address this. This is an area in need of improvement. Additionally there were regular staff meetings to keep staff up-to-date and discuss issues within the service. One member of staff told us their experience of staff meetings was, "Staff meetings are two-way with management listening to staff."

At the last inspection people were consulted about their food preferences each day and were given options. However this choice was given verbally with no visual prompts, to help assist people to make their choice. Food and fluid charts were not being kept up to date. This did not reflect good practice and was discussed with the registered manager in relation to the standard of record keeping. At this inspection food and fluid charts had been fully completed. We observed people were consulted and supported to make decisions about their meal choice. For example, at lunchtime we saw staff supporting people in a caring way to make choices about where they wanted to eat their meal. One staff member asked someone, "Would you like to come and join everyone at the table or I can bring a table over if you'd like to stay here?" They gave the person time to make a decision and then brought two complete meals over and asked them to indicate which one they would like. For another person there was a detailed discussion of the options available. They were not sure what one of the options were, and a complete dinner was brought over to them to help them make their choice. Care staff demonstrated an understanding of people's likes and dislikes and offered encouragement to support people in their menu choices.

Requires improvement

Is the service effective?

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. There was a rotating menu based on people's likes and dislikes. 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, who demonstrated they were aware of people on special diets. 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. The tool included guidelines which could be used to develop people's care plans. People's weights were regularly monitored to check that they were maintaining their weight or losing or gaining weight as needed. Where people's nutritional intake was being monitored there was recording in place to inform staff of people's food and fluid intake. We saw that these were fully completed and that food and fluid charts were completed where needed. However, during the lunchtime experience we observed staff demonstrated knowledge of peoples likes and dislikes. The chef also spoke with about one person who was having trouble using their cutlery and they were looking at finger foods to help them eat independently and maintain their independence and dignity. 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. Care plans were in place for people with diabetes and risk assessments for where people suffered with dysphagia. There was clear guidance for care staff to follow where people had thickened fluids and 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.

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 when asked if the staff were kind, "Mostly they are kind." Another person told us, "Yes, they're kind," Another person told us, "They're 100%". People were seen to be comfortable with staff and frequently engaged in friendly conversation.

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.

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 peoples 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. One member of staff told us of an example of using a person's life history information,"The person's family said they liked Manchester Utd so we got material together from them to facilitate interactions. We are expected to make a point of seeing key clients every shift wherever we are working, I talk about all kinds of things that interest him."

Care staff demonstrated they were knowledgeable about people's likes, dislikes. One relative told us that they was confident that the staff understand their mother's needs, "They know her really well, she's got a really sweet tooth and they will often bring her an extra pudding to encourage her to eat." Staff spoke positively about the standard of care provided and the approach of the staff. We observed staff responding quickly when someone in the lounge became distressed following a slight alteration with another person. One member of staff went to talk to the person and offered reassurance in a quiet, calming tone of voice whilst another member of staff encouraged the other person to move with her to another area of the lounge where they interested them in an activity. The care plan of the person who was distressed clearly detailed that, "When (name) is distressed she does not like others near her." The staff actions indicated that they were aware of how best to support the person when in such a situation

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, "Everybody treats me with 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, "I ask for their consent and give them options." Another member of staff told us they, "Knocked and waited for people to invite us in." We observed staff knocking on people's doors and waiting before entering. People were supported to maintain their personal appearance. On the day of the inspection people were seen to be dressed appropriately in clean clothes. At lunchtime one member of staff was heard to say, "You've got a lovely top on today, would you like me to get an apron before I bring your lunch over?" A number of women had their nails painted during the course of the afternoon and staff were seen to be interacting with people, chatting and massaging their hands during this process. One relative told us they felt that their mother's dignity was respected, "She has her hair done regularly here and she always looks nice. Whoever is in charge of the laundry here does a really good job, her clothes are always put away clean and tidy now."

Observations through the day were of many kind and careful care interactions by care staff, good skills in

Good

Is the service caring?

assistance to eat, allowances for communication difficulties, explanations given. For example, one person in a craft activity group said they did not wish to continue, their choice was respected and an activity co-ordinator sought a member of the care staff to see where person would like to go. Another member of staff was observed singing and dancing in one of the lounges and involving people in there. There was a good light-hearted atmosphere. Routine service of drinks was accompanied by acknowledgement and conversation.

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. Relatives told us they were always welcomed and this was evident during the inspection 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.

Care records were stored securely. The new electronic care plans were 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.

Good

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.

At the last inspection in December 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This translates into Regulation 9 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people, did not have access to meaningful personalised activities, reflecting people's needs, interests and preferences. We found there had been improvements to the activities people could be involved in.

At the last inspection there was a programme of activities and an activities co-ordinator was employed for 18 hours a week to work across all three units. However, observation during the day showed that any minimal activities provided seemed to be focussed on people who were more able to take part. The vast majority of people were left unsupervised for long periods of time during the busy morning.

At this inspection we found there were now two activities co-ordinators, one who worked 30 hours and another who worked 24 hours a week over six days per week. An external organisation had been sourced for ideas and support in providing activities to people living with dementia. One co-ordinator belonged to a related forum and had been able to visit other services to see what they did and get ideas for activities. Once a week the co-ordinators set aside time for administration, review and planning, and produced the following week's activity programme. One member of staff told us, "The present two activities staff are a team. They try new things. Their weekly activity plan is good for showing what we should do." The activity plans included weekly arts and crafts which were partly geared towards producing art suitable to decorate corridors in the service. Topics included fashion fun, autumn collage, and flower arranging. One member of staff told us the aim was to introduce one new activity each week, which could then be developed further if successful. The new activity for the previous week was the use of a 'photo booth', which had proved popular and involved people dressing up and several care staff joined in too. For the week of the inspection the new activity was finding people who might respond to use of dolls and soft toys.

Life profiles were compiled. Staff told us good information was received from the initial assessments, and had then also tried to get more information from people's relatives, which had been particularly useful for identifying one to one interests. For example, the potting shed (upstairs indoor garden room) had been set up and was a great success. A group was run in there every week, attended mainly by men, and had seen people now choosing to spend time there spontaneously, where previously it was little used. A post box had been moved there and there was now an activity of writing cards and letters, sticking on stamps and posting them. Staff had noted people not watching the televisions that were on in lounges, so experimented with choosing a film, darkening the room and serving ice creams, which had been successful. Senior staff had picked up on this and were creating a cinema room with large screen television. All the televisions were interactive smart televisions, and care staff told us they made use of this. For example on the day of the inspection a channel was on playing just Frank Sinatra music to meet the wishes of one person in particular. External musical entertainment was bought in, there was some volunteer input, for example a musician visited on alternate weeks, pet therapy, and the Brighton Toy Museum was due to visit with a presentation. Later in the week a birthday celebration was planned, to include a singer, a buffet and fireworks. One member of staff told us there was, "Something for everybody."

Feedback from staff was that all staff were trying to work together to see activities as integral to care provided to people. There was still some work in developing activities with people who spent all their time in their room, which staff were in the process of addressing. The weekly activity plan showed in blue the activity co-ordinators suggestions for activities to be provided by care staff in their absence . One member of staff told us what staff did when the activities co-ordinators were not there, "Some of them do things of their own volition; we always leave resources available and see that they have been used." One senior member of staff told us, "We encourage staff to consider if people are bored and what they can do to avoid that. Things have improved between care and activities staff. I don't think people are bored, staff do interact but people

Good

Is the service responsive?

are also left alone enough to have time to themselves. We always consider with families whether people want to spend time in their rooms, there's nothing to say they have to come into the lounges or join activities but we do find people respond to some amount of daily routine." Another member of staff told us, "You grab those minutes when you can, we fit it in when we can but it can all change quickly. Most days we have a floating member of staff between units, which is a great help. We make sure all care tasks are complete in all units before doing anything else.

At the last inspection concerns were noted about care records and the difficulty in retrieving essential information about people's needs and risks and actual outcomes. At this inspection people received a comprehensive assessment undertaken before someone moved into the service. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. If they felt they did not have enough information to make a decision they requested further information. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. Records we looked at confirmed this. Care staff told us that care and support was personalised and confirmed that where possible, people were directly involved in their care planning. New electronic care plan documentation had been introduced since the last inspection, with easy to access touch screens, which staff told us had made recording much quicker and better. Staff had received training in how to use the new system and there was ongoing monitoring to ensure the quality of the detail recorded. The detail included on the care plans was varied, and senior staff were already working with the staff team to address this. Good examples of personalised care plans were seen and these included detailed information about people's personal histories and preferences, including details about their previous occupation, family, pets, hobbies, interests and foods. In others the information, for example around likes and dislikes, was more limited. Care staff told us they were working with people's relatives to try to address this. One relative confirmed this and told us staff were trying to get more information about the life stories of individuals.

One care staff explained how it was easier now to keep the care plans and risk assessments up-to-date. Another member of staff told us," The new care planning system has been a big improvement, quicker and more accurate. People's personal background is there to be seen. Staff were given a lot of training time on this and able to ask all the questions needed. "Another member of staff told us, the electronic care plans had been "brilliant", so much better, and things were inputted quickly as they happened. They saw care staff observations influenced care plans, for example they had recorded that one person ate better with plastic cutlery and the care plan was amended.

There was a review process in place, however as the system was still quite new it was not possible to fully evidence the effectiveness of this yet. One relative told us they were a regular visitor and were happy with the care and treatment at Partridge House Nursing and Residential Care Home. They were aware of their relative's care plan and stated that they had been involved in the review process. Evidence of this was seen within the details of the care plan. The relative told us, "The staff all seem caring here, and I am really impressed with the way that they communicate with me, they always let me know if anything has changed, they phone or text me. If I ever have any little concerns I am happy to talk to the care staff directly, they usually put things right. If I was worried I would go to the manager, he's really approachable too." Another relative told us they were aware that his sister had been involved in the decision making process for their mother since she was no longer able to be actively involved herself. Electronic care plans include a social needs section. Each person's individual profile showed what activities they have been involved in and activities workers added the nature of response seen.

The visiting healthcare professionals told us staff have worked well with them, and ensured the correct information was available when they visited, or undertook a review. Staff were helpful, approachable and available to discuss people's care needs, whilst also ensuring people in their care were safe. Their experience of requesting information from the new computer system was that it was provided promptly and accurately. The staff appeared to know the people, and their care needs. They were keen to talk about the people and seemed open when discussing what they felt they were doing well and what could be better.

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.

Good

Is the service responsive?

Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. 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.

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. There were also periodic residents and relatives meetings.

People and their relatives 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'd go to one of the carers." Another person told us, "I'd go straight to the top man." We looked at how people's concerns, comments and complaints were encouraged and responded to. 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. 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.

Requires improvement

Is the service well-led?

Our findings

People and their relatives were asked for their views about the service. They said 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. Everybody felt that there was a good atmosphere in the service. Comments received included, "It's a good atmosphere," "I think it's very good," and "It's a very friendly atmosphere. We asked people if they felt the service was well managed, one person told us, "I think it's very good." Another person told us, "Yes, it's well managed. "I'm more than happy with the way it's managed." One relative told us "It's friendly, very caring and personal to the residents. Nothing needs to change."

At the last inspection in December 2014, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This translates in to Regulation 17 the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was inconsistent auditing and monitoring systems which resulted in shortfalls in care planning and a lack of robust analysis of incidents and accidents meant lessons were not learned. At this inspection we found improvements had been made. However, we found some areas in need of improvement.

At the last inspection there was a lack of regular and effective auditing and monitoring of the quality of the service. Staff were not fully aware of the process of assessing and recording people's capacity to make specific decisions and their consent to care and treatment. At this inspection we found there was continued evidence of some regular auditing by staff in the service. In addition an external group had been called in twice during 2015 to audit and give feedback to the senior staff and quality assurance surveys had been sent out to staff and relative and representatives. The information received had been collated. However, it 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. For example, an external group who had been commissioned to carry out audits in health and safety housekeeping, infection control, maintenance, recruitment and medicines identified areas in need of improvement. However, there was no record of an action plan to show how and when outstanding items had been addressed. For example, the medicines audit had identified where medicines were given 'as and when' required there was no written guidance for staff to follow as to what would alert them to administer this medicine, or for how long before the guidance of the person's GP was sought. This was an area highlighted in need of improvement, but was still not in place. We discussed this with the registered manager who acknowledged that the quality assurance process in the service was still in the process of being fully developed. This is an area in need of improvement.

Records showed that audits included health and safety, medication and infection control reviews. However, medicines audits had not identified shortfalls in recording to support medicines administration had not been fully completed in all instances. For example, where medicine was being given covertly, plans to support this activity for care staff to follow had not in all instances been fully completed and reviewed. People who were prescribed nutritional supplements this had not always been clearly recorded in people's care plans this had been prescribed. This was to fully inform the care staff and to ensure safe and consistent of approach to administration. There had been an audit of new staff recruitment documents. Staff told us that two written references were requested as part of the recruitment checks to ensure the suitability of staff. However, we found one new member of staff only had a record of one written reference having been received. We discussed this with the registered manager who told us two written references had been received and he would ensure a copy of this was on file to reference. There was detailed feedback following the completion of quality assurance questionnaires. However, there was no evidence as to how this information had been used to improve the service. This is an area in need of improvement.

Not all the policies and procedures had been updated since the new provider had taken over the service. The registered manager told us that the provider was in the process of commissioning a quality assurance package for the service which would include the provision and updating of all the existing policies and procedures in line with the new providers requirements.

There was a system in place for recording accidents and incidents. We reviewed a sample of these and found recordings included the nature of the incident or accident,

Requires improvement

Is the service well-led?

details of what happened and any injuries sustained. The deputy manager now reviewed these and monitored or analysed incidents and accidents to look for any emerging trends.

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 every Monday, 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. 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, "The owners are listening and trying to correct the issues we have."

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.

Staff meetings were held throughout the year. These were used as an opportunity to both discuss problems arising within the service, as well as to reflect on any incident that had

occurred. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service. Staff had also had the opportunity to comment on the service provided through two staff quality assurance questionnaires. This looked at how communication systems worked in the service, training and development opportunities, job satisfaction and recognition and reward. The results from the second questionnaire were that staff indicated an improvement in the feedback in all the areas they were asked to comment on.

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.