Care Quality Commission

Gracewell Healthcare Limited

Randell 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

Overall summary

The inspection took place on 4 and 5 August 2015 and was unannounced. Randell House provides residential accommodation and respite care for up to 39 older people, including people living with dementia. At the time of our inspection 36 people were living in the home.

The home is an old two storey building, with stairs and lift access between floors. Corridors were narrow, with hand rails fitted to aid people's mobility. Passing areas ensured wheelchair users and equipment trolleys could navigate corridors safely.

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

At the last inspection on 20 and 21 October 2014 we asked the provider to take action to make improvements

Summary of findings

to ensure staff had the skills to meet people's dementia care needs, and to ensure falls risks were managed safely. At this inspection we found these improvements had been made.

Although people's dependency needs had been assessed and reviewed monthly to ensure staffing levels were sufficient to meet their identified needs, staff had not always been deployed appropriately to ensure people were supported safely at all times. People's dignity and preferences had been affected by insufficient staff to attend to their needs promptly.

Recruitment processes were not sufficiently robust to ensure people were protected from the risks of unsuitable staff. Some checks, such as identity and criminal records checks, had been completed satisfactorily. However, the provider had not ensured that gaps in applicants' employment history had always been identified or investigated, or explanations recorded. Evidence of suitable conduct in previous relevant employment positions had not always been requested. There was a risk that staff employed may not be of suitable character to safely support people.

People were protected from risks to their health, because risks had been identified and actions put into place to remove or control them. For example, staff training and implementation of the provider's falls protocol ensured people at risk of falling were supported to safely mobilise. Other risks, such as fire and water safety, were managed appropriately though checks and servicing.

People were protected from the risk of abuse, because staff understood the actions required to identify and report safeguarding concerns. Management acted robustly to safeguarding incidents to ensure people were protected from potential harm.

People's medicines were administered safely by trained and competent staff. Medicines were stored and disposed of safely, and people were given time-specific medicines at the correct times to promote their health and wellbeing.

People were supported by staff with the skills and knowledge to meet their needs effectively. Training ensured staff developed and retained the skills required to support people. Staff had opportunities to raise concerns, and were supported to develop skills and progress their careers.

People were supported to make informed decisions about their care. When they had been assessed as lacking capacity to make specific decisions about their care, or people's liberty had been restricted to protect them from identified risks, the process of mental capacity assessment and best interest decision-making was documented. Applications for Deprivation of Liberty Safeguards had been appropriately submitted.

People's meal preferences and nutritional needs were known, and nutitonal risks such as choking were effectively managed. People were supported to eat and drink sufficient amounts to ensure their nutritional needs were met.

People were supported to attend appointments to maintain their health and wellbeing. Staff worked effectively with health professionals to ensure health issues and conditions were safely managed.

People were supported by staff who understood how to provide them with reassurance and comfort. Staff treated people with kindness and respect. They supported people to maintain their independence, and respected their privacy. People's social relationships were supported to ensure they were able to maintain friendships that were important to them.

People's changing care needs were identified and met. Care reviews with people and their representatives ensured their care was planned in accordance with their wishes. Activities were planned to encourage people's diverse interests, and opportunities provided to ensure people's views influenced the support they experienced.

Staff spoke positively about the support they received from the managers. The provider's values of empathy, individual care and respect for people were demonstrated by staff, and rewarded by the provider. Individual skills and interests were encouraged and developed in people and staff.

The registered manager and deputy manager worked as a team to provide support for people, relatives and staff and meet managerial demands to run the home. Systems were in place to monitor and drive improvements to the quality of care people experienced.

Summary of findings

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

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?

Requires Improvement

The service was not always safe.

People were not always attended to promptly, because staff were not always deployed appropriately. Staffing levels were not always sufficient to meet people's needs safely.

Recruitment checks were not sufficiently robust to protect people from the risk of unsuitable staff.

People were protected against risks associated with their health needs, because staff understood how to support them safely. Environmental risks were managed safely through a process of checks and servicing.

People were protected from the risk of abuse, because staff understood and followed the correct procedures to identify, report and address concerns.

People were protected against the risks associated with medicines, because appropriate checks and records ensured they received their prescribed medicines safely.

Is the service effective?

Good

The service was effective.

People were supported effectively by staff who were trained and skilled to meet their health and support needs.

Staff understood and implemented the principles of the Mental Capacity Act 2005 to ensure people were supported to make informed decisions about their care. Deprivation of Liberty Safeguards were only implemented where it was appropriate to lawfully restrict people's access to promote their safety.

People were supported to maintain a nutritious diet. Staff worked effectively with health professionals to maintain and support people's health and welfare.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness by staff supporting them.

Staff understood how to provide people with reassurance when they were distressed.

Staff respected people's privacy when they wished to be alone, but encouraged socialisation.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's needs had been assessed. Changes were identified, and appropriate measures put into place to ensure people's needs were met.

People and their representatives were able to raise concerns, and the provider listened to their comments.

A range of activities was planned to meet people's diverse interests.

Is the service well-led?

Good

The service was well-led.

People and staff were empowered to develop their skills.

Staff demonstrated the provider's values of individualised care, empathy and respect.

People were supported by effective managers who were focused on providing them with high quality care.

Quality audit systems were in place to review and drive improvements to the quality of care people experienced.

Randell 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 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.

The inspection took place on 4 and 5 August 2015 and was unannounced. The inspection team consisted of two inspectors. Before the inspection we looked at previous inspection reports and notifications that we had received. A notification is information about important events which the provider is required to tell us about by law. We reviewed information shared with the Care Quality Commission (CQC) by commissioners of care. A Provider Information Review (PIR) had been submitted for the inspection in October 2014. We did not ask for an update on this prior to the inspection, but did discuss the PIR during this inspection. A PIR 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.

During our inspection some people were unable to tell us about their experience of the care they received. We observed the care and support people received throughout our inspection to inform us about people's experiences of the home. We spoke with six people living at Randell House, and three relatives and friends of people living in the home to gain their views of people's care. We spoke with the registered manager and deputy manager, the regional operations director, and five care workers, including team leaders and agency staff. We also spoke with a district nurse during our inspection, and a specialist nurse who supports the home following our inspection.

We reviewed five people's care plans, including daily care records, and ten people's medicines administration records (MAR). We looked at six staff recruitment files, and records of staff support and training. We looked at the working staff roster for three weeks from 6 to 26 July 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how relatives' and staff's comments and quality assurance audits were used to drive improvements in the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe in the home. One person stated "I would say I'm safe", and another said "I wouldn't leave if they paid me, I do feel safe". However, people and their visitors raised concerns about staffing levels, and several staff told us they did not feel there were always sufficient staff on duty to support people beyond meeting their basic care needs.

Although one care worker was required to remain in the lounge to oversee people's safety at all times, we observed they were sometimes called away to support people with their personal needs. This meant that the people remaining in the lounge were not always supported by a care worker. During our inspection there was an incident that resulted in one person's dignity being compromised, because a member of staff was not available to support them in the lounge when needed.

People's lunchtime experience varied over the two days of our inspection. On 4 August two staff struggled to serve meals and provide people with support and prompting to ensure they were encouraged to eat their meals. On 5 August four care staff were in the dining room, and had sufficient time to support people to eat their meals. Although the same number of staff were on duty, the deployment of staff had impacted on people's dining experience. Because catering staff who were inexperienced at Randell House prepared lunch on 4 August, the service of this was delayed. A requirement to support the district nurse on rounds on 4 August meant that less staff were available to support people's needs at lunchtime. The deployment of staff affected people's dining experience on 4 August. On 5 August 2015, a regular chef and no competing staff demands, such as visits by health care professionals, meant that people were supported by sufficient staff to enjoy their meal in a timely manner.

Although a wide range of activities were planned, relatives and staff told us that these were not always provided. The registered manager stated that staff were responsible for leading activities when the activities coordinator was not on duty, but staff told us they did not have time to deliver this. The activities coordinator was on leave during our inspection, and we saw people were often under-stimulated, as some planned activities were not provided.

People told us there were certain times of the day when staff were less able to meet people's needs. One person said "I keep buzzing for a carer but nobody comes" at afternoon shift change times, and another person told us "They don't come quickly during the night but I just ring again". One person described how delays to their morning care affected their wellbeing, as they required specific care before they were able to get dressed.

Staff told us that staffing levels were usually sufficient to meet people's care needs, but were occasionally affected by short notice unplanned absence. One care worker said "Most days we don't struggle unless one goes off sick and if we all pull together we can manage", and another told us "Basic care needs are met but we can't spend time with people".

Relatives told us they sometimes had difficulty finding staff, and there was a reliance on agency staff to cover weekend shifts. Staff rosters demonstrated that agency and bank staff were regularly used as part of the weekend work force. The registered manager stated that staff recruitment meant this reliance was reducing. There had been a virus in the home in early July 2015 that had affected staffing levels, and had resulted in a temporary increase in the number of agency staff used to ensure people were supported safely.

The registered manager and Regional Operations Director explained that staffing levels were managed to meet people's assessed dependency needs. Care records demonstrated that these needs had been reviewed on a monthly basis to inform staffing levels.

Sufficient numbers of staff had not always been deployed to meet people's needs safely. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not ensured that their recruitment procedures met the requirements of the Regulations or the provider's recruitment policy. Although recruitment checks, such as proof of applicants' identity, investigation of any criminal record, and declaration of fitness to work, had been satisfactorily investigated and documented, three of the six recruitment files we reviewed did not show evidence of full employment history. There were gaps in employment history, or dates of previous employment only stated the year of employment, which meant months may be unaccounted for. Evidence of character references had not always been sought from all relevant previous

Is the service safe?

employment positions in health and social care. There was a risk that staff of an unsuitable character could be employed, as the provider had not completed robust recruitment checks.

The provider's recruitment procedure did not ensure that staff employed were of good character. This was in breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had taken actions to address the concerns identified at our previous inspection in October 2014 regarding the identification and management of falls risks. The registered manager had worked with a specialist nurse to improve falls management. The specialist nurse told us staff were "Doing well" with this area of people's care, and had put effective systems into place.

Training ensured staff understood and implemented appropriate actions to support people at risk of falling without affecting their independence. Assessments identified people at risk of falling, and care plans demonstrated that risks were managed in accordance with the provider's falls protocol. Equipment such as walking aids supported people to maintain their mobility, and pressure mats alerted staff when people at risk of falling got up from their beds or chairs. This ensured staff offered support promptly to reduce the risk of falling.

All falls were investigated to identify the cause, and actions implemented to address or control identified factors, such as clutter in people's rooms or inappropriate footwear. Staff understood when it was appropriate to refer people to the falls clinic, and monitored people's health following a fall to ensure they did not experience ill health or injury. People were protected from falls risks because staff implemented appropriate actions to manage and reduce the risk of harm.

Equipment was checked and serviced in accordance with manufacturers' guidance and health and safety guidelines. For example, water taps were flushed weekly, water temperatures were checked monthly, and the water was last tested for Legionella bacteria in March 2015. Legionella is a waterborne disease that can harm people. Fire equipment was serviced by professional contractors, and a fire risk assessment completed in September 2014 found fire risks were satisfactorily managed. Following a viral infection, the home had been deep cleaned to protect people, staff and others from the risk of re-infection. Appropriate actions were taken to protect people and others from identified risks to their health and safety.

Staff were able to describe indicators of abuse, and understood the process of reporting concerns. One care worker explained "I look for changes in personality, change in appetite, reacting in a scared manner around certain people. If I had a concern I would go straight to the manager, they would definitely do something about it". Staff were confident that safeguarding reports would be dealt with appropriately. Training records demonstrated that staff had been trained to identify and address safeguarding concerns.

Safeguarding concerns brought to the manager's attention had been notified to the appropriate agencies promptly in 2015, and the provider had acted robustly to protect people from potential harm. Posters displayed around the home provided contact details for people and their visitors to report concerns, and safeguarding and whistle blowing contacts for staff were displayed in the staff office. This meant people and staff were aware of the process to report safeguarding concerns.

People were administered their prescribed medicines safely. One person who required their medicines at a precise time to manage their health condition confirmed "I get my medicine at the right time". Senior care workers had been trained to administer people's medicines by an external professional. Their competency was checked before they were permitted to administer medicines, and reviewed by the managers to ensure they maintained the skills required.

Medicines were appropriately secured during and after use. Temperature checks ensured medicines were stored at a safe temperature. Controlled drugs (CDs) were stored in the CD safe. CDs are prescribed medicines controlled under the Misuse of Drugs Act 2001. A record book logged when CDs were used, and checks ensured the correct balance of medicines remained. This ensured CDs were stored and used safely. Medicines that were spoiled or no longer required were disposed of safely by the pharmacy.

People's medicine administration records (MARs) documented people's prescribed medicines, including PRN medicines. These are medicines prescribed to be given as required, for example to manage pain. Guidance ensured

Requires Improvement

Is the service safe?

staff understood when PRN medicines may be required and the maximum safe daily dose. Homely remedies people used had been checked by the person's GP to ensure they did not adversely react to people's prescribed medicines. Homely remedies are medicines that do not require prescription. Staff checked each person's MAR before administering their medicines, to ensure people were administered the correct dose at the correct time. Where people had been prescribed a topical cream, the MAR included a body map to inform staff of the required point of application.

NHS guidelines for safe medicines administration were available for staff reference. The care workers told us they checked MAR charts at the end of each medicines round to identify any errors, such as missed doses or records that had not been signed. Medicines were checked to ensure identified errors were due to missed signatures rather than missed administration. The registered manager explained that if staff were responsible for notifiable medicines administration errors, their competency to administer medicines was reviewed, to ensure people received their medicines safely.

Good

Is the service effective?

Our findings

Staff spoke knowledgeably and confidently of their skills to support people effectively. They attended practical training in topics including mobilising people safely, administering people's medicines, and actions to take in the event of fire. Electronic training provided theoretical knowledge in topics including safeguarding people from harm, controlling infection and Equality and Diversity. Staff were required to reach a pass rate of 100% on tests following electronic training to demonstrate learning. Staff were informed when training required refreshment, to ensure their learning remained up to date.

The provider's training programme showed that some staff had not updated all their required training. For example, training records documented a staff completion rate of 71% for safe moving and handling, and 85% in the Mental Capacity Act (MCA) 2005. The registered manager was aware of training shortfalls, and had arranged additional training opportunities for staff to update their learning. Records demonstrated that MCA 2005 training had risen from 76% in June 2015, showing that staff completion rates were rising. The registered manager told us that computer problems meant some training had not been uplifted onto records, although staff could demonstrate that they had completed this. They were currently investigating the computer system to ensure it remained fit for purpose. Staff had been trained to lead practical training in fire safety and safe mobilisation to provide further opportunities for 'in house' training, and minutes from a recent staff meeting warned staff that they would not be rostered for duty if training was not up to date. We did not identify any evidence that people's care was impacted upon because some staff had not received updated training in the skills required to support them effectively.

The deputy manager worked shifts with staff. This provided an opportunity to review staff skills, to ensure they were able to support people's needs effectively. Staff attended regular supervisory meetings. This provided an opportunity to discuss training completion and any additional support required, development aspirations and any concerns. Staff told us this was a two way discussion, and provided the support they required. The registered manager's open door policy and availability of the deputy manager working in the home meant staff could raise issues and concerns as they arose.

Staff had been supported to complete Qualifications and Credit Framework (QCF) qualifications to progress their careers. QCF is the national credit transfer system for education qualification in England, Northern Ireland and Wales. Staff spoke with pride of their progression within the home as they developed skills and confidence.

An induction programme supported new staff to gain the skills and knowledge to support people effectively. In addition to training, they shadowed experienced staff to ensure they understood and demonstrated safe methods of support, for example in the use of hoists to transfer people from chairs to wheelchairs or bed. An agency care worker said they had "A proper orientation" prior to starting work in the home. This ensured they understood how to deliver their care role effectively.

Staff understood the principles of the MCA 2005. One care worker told us "We try to figure out what the person needs, and how they can communicate it, for example they may be able to read if they can't speak. People may be forgetful, but they can still understand".

We observed staff asked people for permission before they provided support or entered their rooms, and explained the actions they were taking, such as administering people's medicines. When people refused support, staff followed their wishes. People were given choices, such as clothing or meal options. Staff understood their responses, and ensured they met people's preferences.

Team leaders understood the process of mental capacity assessment and best interest decision-making if people lacked the mental capacity to make a specific decision, for example about their health needs. One care worker told us "When I train people in mobilising people I need to make them aware of the Mental Capacity Act [(2005)]."

People's care plans documented people's consent to specific areas of their care, such as the use of their photograph or involvement of family in decision-making. For people who's orientation varied, specific times were noted to promote their involvement in decision-making. People's wishes and preferences were documented to guide staff to care for them in accordance with these. Where relatives or others held a Lasting Power of Attorney to make decisions about a person's health or welfare, this was recorded. This ensured that the appropriate lawful person was consulted to make decisions on a person's behalf if they were unable to do so for themselves. Where

Good

Is the service effective?

specific decisions had been made for people, documentation demonstrated that the required process of mental capacity assessment and best interest decision-making had been followed. This ensured that people were involved in making decisions about their care, or that lawful procedures were followed if they lacked the mental capacity to do so.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this is a necessity to promote their safety. The DoLS are part of the MCA 2005 and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. The registered manager understood the process to identify potential restrictions to people's liberty, and when it was appropriate to make a DoLS application. One person had been granted a DoLS, and an application to the safeguarding authority had been made for another person. This ensured that restrictions on people's liberty were lawful, and promoted their safety in the least restrictive way.

People told us they could choose whether they ate in the dining room or in their rooms, and we observed people's preferences were met, as some people enjoyed eating in their rooms watching tv. One person told us "I don't eat meat, and they have always accommodated me. They don't make a fuss". People were offered a choice of meals, either verbally or on plates, to ensure they were able to make an informed choice. Staff listened patiently to people's wishes to ensure they had the meal they preferred. If people did not indicate a wish for any of the options offered, staff suggested alternatives. The chef was willing to prepare these as necessary. We observed one person was provided with a freshly prepared pureed dessert when they declined other options, and they appeared to enjoy this, eating it all.

The menu had been reviewed with input from people to ensure it met people's preferences. The provider's menu had initially not suited the palate of people at Randell House. The chef explained how they had discussed people's preferences with them to ensure the menu provided them with meals that they would enjoy.

Staff understood people's dietary needs. For example, they knew people at risk of choking who required thickened drinks and soft or pureed meals, and those who required prompting to ensure they ate sufficiently to maintain their health. They were able to describe how they prompted people to eat, for example by sitting with them or providing favourite meals. People's care plans documented their meal preferences, dislikes and known allergies, and staff were aware of these. One care worker said "There is a white board in the kitchen which tells us what each person eats". This ensured that temporary kitchen staff unfamiliar with people's needs or preferences were informed and able to meet people's nutritional needs.

The chef was informed of people's nutritional needs when they arrived at the home, and reviewed people's preferences with them regularly to ensure changing dietary wishes were met. We observed the chef chatted with people at lunchtime to gather feedback on the meal.

Risks such as choking had been identified and assessed, and people had been referred to the speech and language therapist (SALT) or dietician when necessary. Staff were aware of those at risk. One person was coughing during their meal, and a care worker kept a careful watch on them to ensure they were not choking. People identified at risk of malnutrition or dehydration had been identified through regular weight checks and reviews of skin integrity. People's monthly care plan reviews identified any changes to people's nutritional needs. A review of people's weights over a six month period indicated that these were well managed, and people were not at risk of malnutrition.

People and their relatives told us they were supported by health professionals to manage and address their health needs. One person said "I get to see the doctor, and they take me to the dentist". A district nurse told us "I think care is very good here. They [staff] pick up on things quickly, and let us know". They said communication from care staff was effective, and they had trained staff to support people's health needs, such as taking blood samples and providing catheter care. Staff understood when it was appropriate for health professionals to be called. "They don't do anything they shouldn't, they always come to us for advice". The registered manager had improved communication with the GP and district nurse team to ensure staff documented guidance and instructions. Team leaders accompanied the GP and district nurses on their rounds, and GPs were able to access people's health records via the home's computer system. This ensured that staff were aware of changes and updates to people's health needs promptly.

Good

Is the service effective?

People's health appointments were planned and recorded in the diary to ensure transport and an escort was arranged as needed. They had worked with a specialist nurse to address identified risks, and were part of a voluntary group set up to review and improve communication between care homes, the local hospital and paramedics. This was put in place to improve people's experience when their health meant they required temporary hospitalisation. We noted one person's discharge letter following a hospital appointment recommended that the person's blood pressure was monitored, and a follow up visit with the GP should be planned. The person's care plan documented that these required actions had been implemented to ensure the person's health was promoted.

Good

Is the service caring?

Our findings

People spoke positively about the staff who cared for them. One person told us "Staff are good for everything, it's perfect", and another said staff were "Top notch, they do anything you ask really, they try their best". Relatives agreed that staff were caring. Comments included "Staff are very good, the girls are very kind and caring", and "Staff are very nice".

Relatives told us staff discussed people's interests and social history with them, to enable staff to understand people's interests and preferences. These were documented in people's care plans to inform staff of activities that may be of interest, and provide topics of conversation. The administrator delivered newspapers to people's rooms in the morning when these had been requested, demonstrating that people's wishes were known and met. One person told us "They ask me about me, they ask what I like, even the hairdresser and the physio are like that, they are very good", and another person told us staff popped in to their room chat with them.

People told us staff listened to their comments and respected their wishes. People were complimented on their appearance after they had been to the hairdresser, and reassured when they were anxious. One person was worried about their hearing. Staff reminded them that they had an appointment booked to review this, and helped them to adjust their hearing aids for comfort. We observed staff discussing clothing choices with people, and complimenting them on their choice. One care assistant commented "I feel like this is my extended family. I love being here".

Although staff did not always engage people in conversation, they were attentive to people's needs, and supported them promptly when they appeared upset. One team leader said care workers were quick to pick up on facial or body gestures that indicated people were distressed, and understood actions to promote people's wellbeing. One care worker who had been focused on a task quickly responded when a person indicated they were unhappy. They spoke kindly to reassure them, and adjusted the person's glasses when they realised this was the cause of their upset. They ensured the person was satisfied and settled before returning to the task.

People's friendships were mostly understood and met. One person said "If you don't like it they move you when people's manners aren't good". Staff told us they tried to support people as they wished. "When they [people] are happy, we are happy". Experienced staff understood people's special friendships, and supported people to maintain these in the home. They encouraged people to sit together when they had similar interests, and were able to chat together.

One person told us "I've been here a matter of weeks but I've been really happy. I was pleasantly surprised, you are encouraged to bring some of your own furniture and there is plenty of room here". Another person had been concerned that their social engagements would be affected when they came to live at Randell House, but "They said 'oh no' and get the mini-bus to take me". These actions demonstrated that people were supported to retain their possessions and maintain activities and relationships that were important to them.

People told us their views were respected, and staff encouraged them to maintain their independence. One person stated "If you want to stay in bed they bring your food up to you", but we heard staff encouraging people to join in meals in the dining room.

People's privacy was respected. We observed staff knocked on people's doors and waited to be invited in, and one person described how they felt comfortable with staff when receiving personal care. People's wishes for male or female only care workers were documented and met. This ensured their dignity was promoted.

Good

Is the service responsive?

Our findings

The provider had taken actions to address the concerns identified at our previous inspection in October 2014 regarding supporting people's dementia needs. Staff had attended dementia awareness training, and some staff were progressing with QCF level three dementia pathway training. The registered manager had liaised with a dementia care nurse specialist to plan delivery of dementia care for a group of people in a 'Retro Room' set up to meet their dementia care needs during a daily programme. The home's library was being decorated to provide an environment specifically designed to promote wellbeing for people living with dementia. Activities focused on reminiscence and people's life histories were planned to meet people's emotional, behavioural and physical needs. This was a pilot scheme set up by the provider, with the plan to develop this in more of their homes.

People's rooms were decorated with their pictures and fittings, and photographs of meaningful items, such as their favourite pet or hobby, helped people to orient themselves to their own rooms. One person told us this had not prevented someone else from entering their room at night. A care worker explained how they tried to provide distractions when people became restless. People who wandered were checked regularly to try to prevent them from disturbing others, and records documented these checks.

Charts were completed to monitor known health or wellbeing needs, such as re-positioning to prevent pressure ulcers, and monitoring people's whereabouts when their wandering may place them at risk of harm should they leave the home unnoticed, or disturb other people. The deputy manager had identified that charts had not always been completed fully, and was implementing a system to ensure senior staff were responsible for checking these were completed on a daily basis. Monitoring checks demonstrated that people at risk had not developed pressure ulcers, and that people whose anxieties made them wander were being supported effectively to reduce their anxieties.

We did not observe people to be distressed or wandering during our inspection. Alarms placed on exit doors protected people from leaving the home unobserved, and pressure mats alerted staff when people at risk got up during the night. These actions reduced the risk of harm to these individuals or others in the home.

People's care records included guidance for staff to manage known health conditions. This included signs that would indicate that their health condition had deteriorated, and the actions required to address these symptoms when they were identified, for example if people with diabetes experienced high or low blood sugar episodes. This ensured that staff were able to promptly identify changes to people's health, and took appropriate actions to improve their wellbeing.

People and those lawfully able to represent them had been involved in discussions and reviews of their planned care. This was reflected in their documented plan of care. For example, people's likes and dislikes, and support required to promote their independence or support them to maintain activities they enjoyed, were recorded.

Indicators of people's wellbeing, such as body posture, humour and socialisation preferences, were documented, to help staff understand when people were experiencing discomfort or distress. Specific risks, such as falls, pressure care needs or malnutrition, were assessed. People's care plans documented how these risks were managed, for example through effective implementation of falls protocols, equipment to reduce the risk of developing pressure ulcers, such as pressure-relieving mattresses and cushions, and monthly weight reviews.

As people's needs changed this was reflected in their care plans. For a person with a known health condition, their care plan reflected how their needs were changing as the disease developed. Staff were guided on how to support this person to maintain their independence safely. Care plans were reviewed and updated with people on a monthly basis, to ensure they reflected people's current care needs. People's comments were documented to ensure their wishes were also updated.

Staff were attentive to changes in people's behaviour or demeanour. One person was very sleepy and unwilling to respond during a morning medicines round. The team leader immediately informed the deputy manager, and the GP attended to them later the same day. This ensured this person received support and care that was responsive to their changing needs.

Good

Is the service responsive?

Effective handovers between shifts, and daily information sharing meetings, ensured staff were aware of people's changing needs, and actions required to support them. For example, staff were aware of planned hospital appointments, expected visitors such as health professionals, and events that may affect people's wellbeing. For example, following blood tests completed by the district nurse in the morning, the team leader informed staff of those people who may have bruising or sore arms.

People and relatives told us the activities coordinator was "Amazing" and "Marvellous". A wide range of activities were planned each week, including trips out, games and puzzles in the home, visiting entertainers and light exercise programmes. Planned activities were not always delivered when the activities coordinator was off duty. One relative stated "It falls apart a bit when she [the activities coordinator] is not here and that's down to staff numbers".

A therapeutic gardening club provided people with opportunities to maintain their interests in horticulture. One person told us "They let me do the flower beds in the garden which I love and they encourage me to do this, the handy man helps me". Community and spiritual links were promoted. Religious services were held in the home on a monthly basis, and local schools and colleges performed musical entertainments for people and supported with art and craft events. Photos around the home showed people engaged in a range of activities, and people's art work was displayed for people and visitors to admire.

The registered manager's open door policy ensured people and their relatives could discuss issues or concerns informally. One person explained how an issue they had raised with the registered manager had been addressed to ensure they received the care they required at a time they wanted. Events such as the summer fete and BBQ presented opportunities for people and their relatives to mix informally with staff, including the managers. People's views, for example on the menu selection, were sought, and changes implemented to reflect people's preferences.

People and their relatives told us concerns they raised were usually addressed. One person said "My daughter complains about things and they try to always put it right", but a relative stated "They write things down and say they will do it but it doesn't always happen". Although they did not have sufficient concerns to raise this formally, they told us they did not feel that issues were communicated effectively between staff shifts. We observed effective communication handovers between shifts and departments, and saw documentation that meant information was appropriately shared with staff who were off duty.

The provider's complaints policy was displayed in reception. Only one formal complaint had been received since our last inspection, and this had been dealt with in accordance with the provider's policy. Cards were displayed thanking staff for the care people experienced. Emails demonstrated that staff kept people's relatives informed of changes to their health and wellbeing as appropriate. Although feedback had not been formally requested since our last inspection, people and their representatives had opportunities to raise issues or request changes to their care and support.

Good

Is the service well-led?

Our findings

People's talents were recognised and celebrated. Arts and crafts were displayed in the home, and one person was planning to lead an arts and crafts workshop in the home. They told us of their plans, and explained how the deputy manager had discussed the equipment that would be required to ensure this was in place. This demonstrated that people's interests and skills were valued, and people were empowered to use their talents. Activities had been planned to reflect national events. For example, a dementia workshop was planned for people and their relatives during Alzheimer's Month in September 2015. The registered manager had considered events where people and their relatives could develop their understanding of conditions that affected them, demonstrating an inclusive and person-centred outlook.

Care workers felt included and empowered in their roles. One care worker told us "The manager is always trying to encourage us to keep up the good work and she has really encouraged me to try and get myself trained. I love that. She says 'if you have any ideas I am here to listen'". Another care worker described managers as "Open and transparent. I feel I am listened to".

Staff champions led on specific areas of people's care, for example pressure care or falls management. They were supported through training and liaison with health professionals to guide staff understanding and promote effective strategies to manage people's care in these areas. Where staff learning styles affected their ability to complete training electronically, they were supported by managers to achieve the learning required. Staff were supported to develop their skills and knowledge to support people effectively.

The provider required staff to demonstrate key values, such as providing people with personalised and individualised care, and to treat people with kindness, empathy, integrity, respect and trust. The provider's 'heart and soul' and 'employee of the month' awards recognised and rewarded staff excellence when they displayed and excelled in these values. Awards were celebrated in staff meetings in the home, and at the provider's formal awards dinner.

Staff told us regular staff meetings provided opportunities to discuss concerns and effectively address issues. One care worker said staff "Spoke about problems, it was open and upfront, not angry or stressed. It's been nice as [staff] have picked up on those areas mentioned". The layout of the staff room had been altered to encourage staff to sit together during breaks. This encouraged effective communication, and provided opportunities to share learning and observations on a daily basis.

One care worker told us "I feel like the managers are there for me if I need them, the deputy is brilliant". A specialist nurse confirmed the impact the new deputy manager had made in the home, explaining that they had embedded changes to improve people's care. The deputy manager and registered manager worked as a team to concentrate on different managerial aspects of the home. The deputy manager focussed on day to day staff management and care delivery, leaving the registered manager free to focus on high level aspects of home management. The managers discussed issues together to ensure their ideas for development would effectively drive improvements to people's care.

Weekly team leader meetings reviewed 'tracker' documentation to ensure people identified at risk of specific harm, such as falls, developing pressure ulcers or malnutrition, received effective care to reduce the risk of harm. An action plan ensured required actions were implemented when the risk of harm increased, for example if a person's weight dropped. Care plans reflected that these actions were implemented effectively to protect people from known risks.

Accidents and incidents were reviewed to identify trends, and ensure known causes of harm were addressed. For example, care workers had liaised with health professionals to identify an underlying cause for one person's recurring infections. Their treatment had been changed to ensure their health needs were effectively managed.

Learning from incidents was shared with staff to drive improvements. For example, following a recent viral infection in the home, infection control processes had been reviewed, and discussed with staff to ensure the risk of re-occurrence was reduced.

The managers conducted ad hoc visits out of hours to ensure people received their planned care. Records demonstrated that any shortcomings were discussed with staff. Audits reviewed specific management of risks such as falls and infection control. The provider's quality assurance team conducted audits to review the overall quality of care

Good

Is the service well-led?

people experienced. Results from audits were compared month by month to evidence improvements made, and identify further improvements required. The service development plan logged actions required to address identified issues, and progress towards completion. For example, a requirement to cross reference risks to people's health and wellbeing within their care plans had been identified. We observed progress towards this was evidenced in people's care plans. A completed action identified that people and their representatives had not always been involved in care plan reviews. People's involvement was now documented. Drivers to improve people's care and support were identified and actions implemented to ensure people experienced high quality care.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **People were not supported by sufficient numbers of staff deployed to meet their identified needs.** Regulation 18 (1) HSCA 2008 (Regulated Activities) 2014

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **People had not been protected from the risks of inappropriate care and support, because the provider's recruitment procedures did not effectively ensure applicants were of good character. Satisfactory evidence of conduct in previous employment positions in health and social care, or supporting people vulnerable to abuse, had not always been identified or verified, and a full employment history, with explanation of gaps, was not always documented.** Regulation 19 (2)(a)(3)(a) HSCA 2008 (Regulated Activities) 2014