Fellingate Care Centre Limited

Fellingate Care Centre

Inspection report

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Ratings

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

Overall summary

This was an unannounced inspection carried out on 17 August 2015.

We last inspected Fellingate Care Centre in August 2014. At that inspection we found the service was meeting all legal requirements.

Fellingate Care Centre is an 81 bed care home that provides personal and nursing care to older people, including people with who live with a dementia related condition.

A manager was in post who was in the final stages of the registration process with CQC to become 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.

Summary of findings

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Staff were aware of the whistle blowing procedure which was in place to report concerns and poor practice. When new staff were appointed thorough vetting checks were carried out to make sure they were suitable to work with people who needed care.

Regular checks to the building were carried out to ensure it was safe and fit for purpose.

People received their medicines in a safe and timely way

People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the treatment they needed.

Menus were varied and staff were aware of people's likes and dislikes and special diets that were required.

Staff had received training and had a good understanding of the Mental Capacity Act 2005 and Best Interest Decision Making, when people were unable to make decisions themselves.

Appropriate training was provided and staff were supervised and supported.

Staff knew the people they were supporting well. Care was provided with patience and kindness and people's privacy and dignity were respected.

Care records did not always reflect the care and support provided by staff.

Activities and entertainment were available for people.

People were not always supported to maintain some control in their lives. Information was not available in a format that helped them to understand if they did not read to encourage their involvement in every day decision making.

People had the opportunity to give their views about the service. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

Audits were carried out to assess the quality of the service provided to people.

Staff said the new manager was very approachable. Communication was effective to ensure staff were kept up to date about any changes in people's care and support needs and the running of the service.

We found one breach of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 (Part 3) in relation to good governance with regard to record keeping.

You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service was safe.

There were appropriate arrangements to protect people from avoidable harm and abuse.

People were supported to take their medicines in a safe way.

Staff were suitably recruited and there were enough staff to ensure people's needs were safely met. Regular checks were carried out to ensure the building was safe and well-maintained.

Is the service effective?

Good

The service was effective.

Staff had a good understanding and knowledge of people's care and support needs. They received the training they needed and regular supervision and support.

Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected because there was evidence of best interest decision making. This was required when decisions were made on behalf of people and when they were unable to give consent to their care and treatment.

People's nutritional needs were met and specialist diets were catered for.

Is the service caring?

Requires improvement

Not all aspects of the service were caring.

Staff were kind and caring as they supported people. Visitors said they were involved and kept informed about their relatives care and any change in their condition.

People who lived with dementia were not always helped to make choices and to be involved in daily decision making.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

People did not always receive support in the way they needed because staff did not have detailed guidance about how to deliver people's care. Care plans were not always detailed to meet people's care and support requirements.

Summary of findings

There were activities and entertainment available for people. People enjoyed going out in the community supported by staff.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

Staff and people who used the service told us the registered manager and management team were supportive and could be approached at any time for advice.

Staff said they were aware of their rights and their responsibility to share any concerns about the care provided by the service.

The registered manager monitored the quality of the service and was introducing changes to benefit people who used the service and staff. This included an ethos of involvement amongst staff and people who used the service.

Fellingate Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 17 August 2015 and was unannounced. The inspection team consisted of an inspector, an expert by experience and a specialist nursing advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send the Care Quality Commission (CQC) within required timescales. We also contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We received no information of concern from these agencies.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 19 people who lived at Fellingate Care Centre, eight relatives, two visiting health care professionals, the registered manager, the deputy manager, the director of operations, a registered nurse, nine support workers, an activities organiser and two members of catering staff. We observed care and support in communal areas and looked in the kitchen and a range of bathrooms and lavatories. We reviewed a range of records about people's care and how the home was managed. We looked at care plans for 11 people, the recruitment, training and induction records for four staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and their relatives, the maintenance book, maintenance contracts and the quality assurance audits that the registered manager completed.

Good

Is the service safe?

Our findings

Due to some people's complex needs we were not able to gather their views. Other people said they felt safe and they could speak to staff. Their comment's included, "Yes, I feel safe, the staff are lovely," "I feel safe and I can have the door open or shut and I sleep alright," "I feel very safe here. There's somebody here all the time," and "There's always someone around."

There were enough staff to meet people's needs. The registered manager told us staffing levels were determined by the number of people using the service and their needs. At the time of our inspection there were 76 people who lived at the home who were supported by one nurse and 13 support workers including four senior support workers. People commented, "There's always plenty of staff around to help you and I don't wait long if I need any help," I think there are enough staff, they're always about," and "I don't wait long for help, during the night maybe I wait a bit longer but I can manage myself on the commode, and "I have to ask the night before if I can have a bath as it will depend how many staff are on duty, but I usually prefer to shower, and "If you ask you get it, the staff are there on the dot, you're not sitting around for hours waiting." Relatives comments included, "I've never experienced when there hasn't been enough staff," and, "At weekends there don't seem to be enough staff, but most of the time they do very well as the staff are spread out to help people." We told the manager who said they would check people's dependency levels again to look at staffing levels over the home. We checked after the inspection and the manager told us as a result of people's current needs staffing levels had been increased on the nursing floor.

Staff had a good understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and were able to tell us how they would respond to any allegations or incidents of abuse and knew the lines of reporting within the organisation. They told us they would report any concerns to the registered manager. Staff members comments included, "I'd report any concerns to the senior straight away," "We discuss safeguarding at supervision," and, "If I had any concerns I'd raise it with the senior staff on duty." Staff were aware of the provider's whistle blowing procedure and knew how to report any worries they had. Staff members confirmed they had received local authority safeguarding training and could describe the role of the different agencies if a safeguarding alert was raised.

The provider had a system in place to log and investigate safeguarding concerns. We viewed the log and found seven concerns had been logged appropriately. Safeguarding alerts had been raised by the home and investigated and resolved to ensure people were protected.

People received their medicines in a safe way. We observed medicines rounds on two floors. Medicines were administered by the nurse for people with nursing needs and the senior support worker, who was responsible for administering medicines to people with non-nursing needs. We saw they checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. The staff administering medicines explained to people what medicine they were taking and why. They gave the person a drink with their tablets and then remained with each person to ensure they had swallowed their medicines. Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration.

Medicines were appropriately stored and secured. Medicines which required cool storage were also stored appropriately in a fridge. The temperatures relating to the minimum and maximum temperature of the fridge were recorded twice daily to ensure they were stored at the correct temperature. However, the recordings which were between two and eight degrees centigrade did not include the actual fridge temperature. The nurse told us this would be actioned immediately to include the actual temperature. Staff were trained in handling medicines and a process had been put in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care, moving and assisting and nutrition.

Good

Is the service safe?

Regular analysis of incidents and accidents took place. The manager told us learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls, a person who had fallen more than three times was referred to the falls clinic. We saw behavioural incidents were also analysed and three incidents triggered a person's referral to the behavioural team.

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs and it was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

Staff had been recruited correctly as the necessary checks had been carried out before people began work in the home. We spoke with members of staff and looked at four personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before they were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people. Copies of interview questions and notes were also available.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out such as for checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with promptly. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, for the passenger lift, hoists and specialist baths.

Good

Is the service effective?

Our findings

Staff had opportunities for training to understand people's care and support needs. Staff comments included, "There's loads of training," "My training is up to date," "There are training opportunities," "I wouldn't turn down training if it's offered," "I've been on a few training courses since I started work here," and, "I enjoy passing skills on to staff." A visiting health care professional commented, when asked if staff were trained to meet people's needs, "Each floor has some really good switched on staff. If I ask do you know the person, they usually do and they'll tell me if they don't."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. Three staff members told us initial training consisted of a mixture of work books, face to face and practical training. One staff member told us, "I did an induction pack when I started." A senior support worker told us staff were supported by senior staff when completing the work books. They told us new staff were to study for the new Care Certificate in health and social care as part of their induction training. Other staff members' comments included, "The senior will ask us questions to check we understand," and, "I found the booklets very helpful."

The staff training records showed staff were kept up-to-date with safe working practices. The registered manager told us there was an on-going training programme in place to make sure all staff had the skills and knowledge to support people. Staff completed training that helped them to understand people's needs and this included a range of courses such as equality and diversity, nutrition, person centred care, end of life care, dementia care, distressed reaction and mental capacity. Staff told us they had completed or were studying for National Vocational Qualifications (NVQ), now called the diploma in health and social care.

Staff told us they were well supported to carry out their caring role. They said they received regular supervision every two months from senior staff to discuss their work performance and training needs. Comments included, "I've just had a supervision," "I have supervision from the registered manager or deputy manager," and, "I've had training to carry out supervisions, I'm responsible for supervising three people." Staff told us they received an annual appraisal. This helped the service identify further staff training and professional development which staff required. They told us they could approach the management team at any time to discuss any issues. Staff comments included, "The staff team are friendly and approachable," and, "There is always someone to ask."

CQC monitors the operation of the Mental Capacity Act 2005 (MCA). This is to make sure that people who do not have mental capacity are looked after in a way that respects their human rights and they are involved in making their own decisions, wherever possible. Staff were aware of and had received training in the MCA and Deprivation of Liberty Safeguards (DoLS). DoLS are part of the MCA. They are safeguards put in place by the MCA to protect people from having their liberty restricted without lawful reason. We checked with the registered manager that DoLS were only used when it was considered to be in the person's best interests. They were aware of a supreme court judgement that extended the scope of these safeguards. We found as a result that 36 people were currently subject to such restrictions.

Records showed assessments had been carried out, where necessary of people's capacity to make particular decisions.

Staff asked people for permission before delivering any support. A person told us, "The staff always explain things and tell you what's happening." Staff told us they would respect the person's right to refuse care. They said if a person did refuse they would offer alternatives or leave the person and try again later. For example, if a person refused to bath or to receive assistance with personal care. A person told us, "They (staff) always ask about a bath or shower-they don't force it on you."

We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. We saw people who required a pureed diet had it appropriately served in individual portions rather than all the ingredients being blended together. People were positive about the food saying they had enough to eat and received a choice of food. Their comments included, "The food is lovely and you're always getting drinks. We have a choice of three things," "The food is lovely. It's very nice. It's always well

cooked and enjoyable" "The food varies, today it was steak but it was tough," "On a night time if I don't like the sandwiches I have a little fridge and my relative brings in a little salad and pork pie," "The food is smashing, fantastic food," and, "I can get food when I like." Two relative's commented, "The food is fair. It's a lot of people to cook for," and "There's plenty of choice and plenty of food. (Name) gets plenty of drinks."

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Regular contact was maintained between the service and health care services and we saw evidence of letters, referrals and other correspondence within the files. Staff received advice and guidance when needed from specialists such as the dietician, speech and language teams, behavioural team and GP. A staff member commented, "There's a new community challenging behaviour team. We put in a referral and they came the next day to do an assessment." Records were kept of visits and any changes and advice was reflected in people's care plans

People's needs were discussed and communicated at staff handover sessions when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of risks and the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. A staff member commented, "The handover is helpful, staff explained things and I went on a round to see people one to one." Other staff members told us they thought communication was really good.

The manager told us a GP visited daily so people's medical needs could be attended to promptly. A visiting GP commented, "I do the round with the seniors, they know people really well. Staff seem pretty responsive to what I've asked them to do."

Relatives told us they were kept informed by the staff about their family member's health and the care they received. Some relatives commented, "If anything goes on the carer tells me," "We are kept informed," "Communication is very good," "I'm told about any hospital appointments," "We're always involved," and, "I have no worries, I'm kept informed." Two visiting health care professionals commented, "Communication has improved," and, "If you ask for a message to be given to a relative it gets through quickly."

We saw no pictorial aids or orientation aids, such as activity boards, calendars and newspapers to help remind people of the date and time and to keep them orientated. The registered manager told us this was being addressed as the different units were being redesigned, especially the unit for people who lived with a dementia related condition. New signage and other orientation aids were to be provided following advice and guidance from Stirling University dementia design school. They also told us different areas of the home were to be decorated and themed for the benefit of people who lived with dementia. Local history photographs were to be displayed to help with people's orientation.

Requires improvement

Is the service caring?

Our findings

People who lived in the home and their visitors were positive about the care provided by staff. People's comments included, "The staff are very friendly and helpful," "The younger staff are lovely," "The staff are nice and polite," "The staff are very good, not bossy, they're nice people," "Staff are very courteous," "The staff are very caring and attentive and they're always on hand." "It's the atmosphere in here, everyone is so happy," "Staff listen to you," "It's a nice place this, it's comfortable," and, "It's a nice place to be. I can't see any worries at all." A relative commented, "My (Name) has been here for X years and I'm thrilled to bits with the place and the care, staff give them."

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. A staff member said, "We are assigned to a particular floor of the home and stay working on this floor so it helps provide consistency and continuity of care to people." One person told us, "Staff seem to know us." People were supported by staff who were warm, kind, caring and respectful. They appeared comfortable with the staff who supported them. A person told us, "They're good staff we are looked after as good as at home."

During the inspection we saw staff were patient in their interactions with people and took time to listen and observe people's verbal and non-verbal communication. The staff on duty met people's needs in a competent and sensitive way. Good relationships were apparent and people were very relaxed. One person told us, "Staff will always help you if you want them to. This morning they got me my hat and brought me a book," and another person said, "The cleaner comes into my room every morning. They are canny and we have a bit of a chat."

Staff described how they supported people who did not express their views verbally. They gave examples of asking families for information, showing people options to help them make a choice such as two items of clothing. This encouraged the person to maintain some involvement and control in their care. One person's care plan for personal hygiene stated, "Staff to choose (Name)'s clothing, but show them first." Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. A person's care plan for pain stated, "If (Name) shows any signs of pain or discomfort to their mouth or teeth staff to report to the senior who will call a General Practitioner (GP) who will make a visit."

Staff engaged with people in a calm and quiet way. They were enthusiastic and made time to sit and talk to them. Staff bent down as they talked to people so they were at eye level. We observed the lunch time meal being served in the dining room. The atmosphere was pleasant and unhurried and staff provided people with assistance as necessary. We saw that when staff members assisted any people to eat they explained what they were doing and reassured them using words of encouragement such as, "Good, I'm glad you're enjoying it," and, "Open your mouth,(Name) and I'll give you another spoonful."

Tables were set with tablecloths and specialist equipment such as cutlery and adapted colourful dementia care crockery was available. This helped people, who were able to maintain some independence as they ate their food. We saw people who lived with dementia were not encouraged to make a choice or be involved in decision making with regard to their food. Menus were available but they were not available in any other format, for example, pictorial or photographs if people no longer understood the written word. This may help people be aware of the meals to be served. Staff members did not show two plates of food to help a person who lived with dementia choose what they wanted to eat. The manager told us this would be addressed with staff at supervision.

We saw that most care was provided in a flexible way to meet people's individual preferences. For example, a care plan stated, "(Name) likes breakfast in bed but to be encouraged to get up for lunch and tea in dining room," and another care plan stated, "(Name) likes a long lie and has breakfast at 11:00am." However, some people's comments indicated the care was not delivered flexibly. One person we spoke with after lunch complained of the length of time left sitting in their wheelchair in the lounge, when they wanted to go back to their room. We observed the person was sitting in their wheelchair for the afternoon. We spoke to a staff member about this but we were told the relative wanted the person to remain in the lounge to reduce the person's social isolation. However, a care plan was not in place that balanced the wishes of the person suggesting certain times out of their room and recording any activities that could take place with the person to keep

Requires improvement

Is the service caring?

them engaged and to want to remain out of their bedroom. Other comments with regard to people's rising and retiring routine included, "Yesterday they asked us if we'd like to get ready for bed before television then we'd be ready for bed at 9:30ish," and, "You can go to bed when you want but we don't want to go to bed at 9:30pm," and, "We're usually up at 7:00 am to get ready for breakfast." Other comments included, "I like the shower but it's mainly just once a week, I like staff to shower me rather than the bath," and, "If anything could be improved I'd like more showers, I miss it but that's just due to staff availability." The manager told us this would be discussed with staff and emphasised at supervision about person centred care and people's choice.

Staff respected people's privacy and dignity and provided people with support and personal care in the privacy of their own room. However, one person commented, "Often two men get me ready. I wouldn't say I was all that happy when it's two of them. I'm used to it from hospital but I would prefer a female and male. It's just the odd time and at the moment they're busy with people on holidays." The manager told us this was unusual and must have happened on night shift but it would be addressed to ensure it didn't happen again. People's care preference for male or female staff would be recorded as part of their care plan. We saw staff knocked on people's doors before entering their rooms and staff ensured any personal care was discussed discretely with the person. We observed that people looked clean and well presented. Most people sat in communal areas but some preferred to stay in their own room. A person commented, "They (staff) always pop in when I'm in my room." One relative told us, "They always treat (Name) with privacy and dignity. If I had any issues then I would see the staff."

Important information about people's future care was stored prominently within their care records, for instance where people had made Advance Decisions about their future care. Records looked at where these were in place showed the relevant people were involved in these decisions about a person's end of life care choices. The GP told us, "End of life care is really well dealt with by staff." The manager told us about an 'end of life care' box that had had been introduced. The box contained items to ensure a person had a comfortable and dignified death. Items included for example, a bible, toiletries, towels, pretty bed linen and bereavement cards to be sent to relatives.

There was information displayed in the home about advocacy services and how to contact them. Advocates can represent the views for people who are not able to express their wishes. We were told one person had the involvement of an advocate.

Requires improvement

Is the service responsive?

Our findings

People we spoke with said they were involved in discussions about their care and support needs. A person told us, "I think I have a meeting with staff and the social worker next week," and a relative commented, "We've had meetings and a social worker was once there."

We had concerns that records did not always accurately reflect people's care and support needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

People's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Care plans were developed from the assessments that outlined how these needs were to be met. One person's initial assessment had identified the requirement for referral to the dentist and chiropodist and we saw that this had been arranged.

Record keeping for some people was not consistent. Records showed that monthly assessments of people's needs were carried out but the records did not always reflect the changes that had taken place. For example, for one person we saw their care plans had last been reviewed on 30 June 2015. When we asked the manager we were informed the staff member had been on holiday and would update them on their return. A person's care plan for nutrition had not been reviewed since June 2015. We did not see a choking risk assessment in place to identify any risks associated with the person's eating and drinking. As the person was at risk of weight loss the person was to be weighed weekly. However the person's weight chart did not reflect that this was happening regularly. For another person, who we were told could no longer ask for a drink, their care plan did not accurately reflect their needs as a nutritional care plan stated, "(Name) will tell staff if they want a drink." Another person's risk assessment for mobility and moving and assisting had not been up dated since January 2015.

Daily records were completed by staff. The charts included provision for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. The turning charts recorded the positional changes of the person as they were nursed in bed. Most were accurately completed. However for one person we saw positions were not specified and timings were inconsistent. Food and fluid charts were also completed to monitor people's dietary and fluid intake each day where it had been identified there were possible issues with nutrition. A consistent record was not always available over the 24 hour period as night staff did not always record their interventions in the person's care. Fluid records did not accurately record and add up the daily fluid intake of the person so their hydration could be monitored.

Staff knew the individual care and support needs of people, as they provided the day to day support, but this was not always reflected in people's care plans. The care plans did not give staff specific information about how the person's care needs were to be met. The care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For example, "Needs a lot of prompting and at times assistance at meal times." "Full support required with personal care. Manages bottom half with lots of clear prompts," and, "Reassurance to be given by staff when feeling anxious." The care plans did not detail what the person was able to do to take part in their care and what prompts the staff needed to give to ensure consistent instructions were provided. The manager said a new care plan format was being introduced and all staff including people who provided the daily support to people were to be involved. This was to ensure the records reflected how people wanted and needed their care to be provided.

Some people with distressed behaviour were referred to the behavioural team when more advice and specialist support was needed to help support the person. This advice was incorporated in some people's behavioural plans to help staff provide care to the person. However, care plans were vague, or not in place for some other people who may have shown agitation or distress. For example, two personal hygiene care plans stated, "(Name) needs assistance of two carers in all aspects of personal hygiene," and, "(Name) is a proud and smart person. (Name)'s privacy and dignity to be upheld. Full support is required for personal care." The care plans did not give staff detailed instructions with regard to supporting people when personal care was carried out. A recent review of one of the care plan's stated, "(Name) has on several occasions been very confrontational and physically abusive to staff when giving assistance." Information was not always available that included what might trigger the distressed

Is the service responsive?

behaviour and the staff interventions required. This would help ensure staff all worked in a consistent way with the person to help reduce their anxiety and distressed behaviour. The manager told us a referral had been made to obtain some advice and assistance to help support the person.

Risk assessments were not in place nor care plans to advise what staff should do and when a referral to a specialist behavioural team would be triggered if people refused to accept any assistance or refused to carry out their own personal care.

Detailed information was not always available to help staff provide care and support when a person was no longer able to tell staff how they wanted to be cared for. Some people had a 'This is Me' profile but it was not available for everyone. The information had been collected with the person and their family and gave details about the person's preferences, interests and previous lifestyle. This was important information and necessary for when a person could no longer tell staff themselves about their preferences.

Information was not available with regard to all people's wishes for care when they were physically ill and reaching the end of their life, or arrangements for after their death. The manager told us for one person their condition had deteriorated very quickly and the GP had started end of life medicines and they had not had the opportunity to discuss or implement the care of the dying patient care plan. However such a care plan although it would include information such as spiritual and arrangements for after death was not available before the person was reaching the end of their life. We saw some completed emergency health care plans that were put in place by nursing staff. They were completed in collaboration with people and their GP to anticipate any emergency health problems and did contain some of this information. However, as this information was not already available for all people and was only collected when they were dying not all of the person's wishes may be made known to staff at such an important time.

People confirmed they had a choice about getting involved in activities. An activities plan advertised what was available. An activities person was employed to organise activities across the home and we saw staff were engaged in the provision of activities when the activities organiser was not on duty. Staff on the unit for people who lived with dementia spoke of ideas and plans to stimulate and engage with people who lived with dementia. For example, staff had created a pamper corner where people could borrow scarves and jewellery that were placed on a sideboard for their use.

We saw notices that advertised the entertainment and seasonal parties that took place in the home. Staff told us people were assisted to follow previous interests and hobbies. One person told us, "Yesterday I went to church and staff waited until the taxi came. I meet my (Name) there and they bring me back". Other people's comments included, "Sometimes there's entertainment, not all the time but it's very good," "There is plenty to do, we sit and have a gossip and there are singers on," "They have things going on like library, bingo and things like exercises, we can go on other floors for entertainment if we want," "I like to read. I have television and Sky so I can watch what I want in my room," "Some of us sit in the lounge and watch television and chat," and, "I like quizzes. They played bingo yesterday and everybody joined in, it was fun." Relatives commented, "(Name) joins in the entertainment here. They do things like arts and crafts and keep fit on all floors and they've had animals in," "(Name) doesn't like to go to other floors for entertainment but they have some here," "I'm not here that often but they always have music on," "The entertainers go down very well with everybody," and, "The garden is lovely to sit in." The activities organiser told us people went out with staff in small groups. One person commented, "I go out with my relative."

The complaints procedure was displayed in the entrance to the home. People said they knew how to complain. People's comments included, "I would just tell them," "I would definitely know what to do and who to go to," "I would make a complaint if I wasn't happy," "Maybe the food could be improved a little but I've nothing to complain about," "I don't think there is anything they could do better," and, "I know what to do but I haven't had any reason to complain." A relative told us, "I know there is a formal procedure. I think generally the staff can sort anything out, they are always around and go out of their way to help." A complaints log was kept and six complaints had been received since the last inspection and these had been investigated appropriately.

Good

Is the service well-led?

Our findings

A manager was in place who came into post in May 2015. They were in the final stages of the Care Quality Commission process to check their fitness and suitability to become the registered manager of Fellingate Care Centre.

The manager said they were introducing changes to the service to help its smooth running and to help ensure it was well-led for the benefit of people. They responded quickly to address any concerns and readily accepted any advice and guidance. Staff and relatives said they felt well-supported. Comments included, "If we need anything we can talk to the manager," "The manager is very approachable," "The manager will get back to if you have any concerns," "I can talk to the new manager," "You only have to ask and its done."

Staff meetings were held three monthly to keep staff updated with any changes within the home and to discuss any issues. A member of staff commented, "We have regular staff meetings" The registered manager told us support worker meetings, qualified nurse meetings, health and safety meetings, catering staff meetings and housekeeping meetings were held approximately two to three monthly to improve communication within the home and keep people informed about the running of the service.

Relatives told us meetings were held for people and relatives. A meeting had taken place in April 2015. One relative said, "They have resident and relative meetings about every quarter I think it is, if I have any concerns I will say." We saw the last meeting minutes had shown two meetings had taken place on the same day, one in the afternoon and also in the evening to accommodate people who may not be able to get to an earlier meeting.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people. A relative told us, "We get asked to comment about the home." We saw copies of the surveys of the quality assurance audit for July 2015 where 42 replies were received from the 102 surveys which had been sent out to everyone in the service. The registered manager told us the results were analysed by head office. We saw findings from the survey were positive. People's comments included, "The staff who care for (Name) are worth their weight in gold, "Very satisfied all round, all the staff are lovely," "(Name) assures me the food is excellent and they have put on weight since arriving which I'm pleased about." Where suggestions for improvement were made action was taken to try and address the issues. The actions taken as a result of people's comments included, "Would like a better understanding of the keyworker system." The resulting action showed this was to be added to the agenda to discuss at a resident and relative's meeting. "Improving the telephone system to make it easier to contact the home." We were told that after the administrator's office was closed telephone calls would now divert to the different floors of the home.

Records showed audits were carried out regularly and updated as required. Monthly audits included checks on, care documentation, staff training, medicines management, accidents and incidents, infection control, nutrition, skin integrity and falls and mobility.

Daily and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. The registered manager told us monthly visits were carried out by the director of operations to check on the quality of care being provided by the service. A financial audit was carried out by a representative from head office annually. These were carried out to ensure the care and safety of people who used the service.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.** **Records did not all accurately reflect people's care and support needs.**