Avidcrave Limited

Braintree Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 30 June and 25 July 2016 and was unannounced. At our last inspection on 12 and 15 May 2015, the service was found to be in breach of regulations 9, 11, 12 and 17 of the Health and Social Care Act 2008. Following the publication of the report the provider sent an action plan to the Care Quality Commission stating, how they would rectify these breaches. We followed up these concerns as part of this inspection to see what the provider had done to address the concerns.

Overall we found that the provider had implemented their action plan, however this was still a work in progress. At the previous inspection in May 2015, we found people were not supported in line with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). During this inspection we found that significant improvements had been made. The registered manager and staff understood their responsibilities in relation to the MCA and DoLS. People's best interests had been considered when decisions that affected them were made and applications for DoLS authorisations had been submitted to the Local Authority where restrictions were imposed upon people to keep them safe. However, we also found that there was a lack of management oversight by the provider and that further improvements were still required in relation to the implementation of governance systems to ensure the service was well led and that records relating to people's care were accurate.

Braintree Nursing Home provides nursing and personal care for up to 51 older people, some of whom have a diagnosis of dementia. On the first day of the inspection, there were 51 people living in the service. The service consists of two separate buildings both of which are spread across two floors and have communal lounge areas. The two buildings have access to a secure courtyard area with seating and flower beds.

The service had a registered manager in post. 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.

People told us that they felt safe living in the service. People were supported by sufficient numbers of staff who had undergone recruitment checks to ensure they were safe to work. Staff understood how to protect people from the risk of abuse and knew what action they needed to take to report any concerns in order to keep people safe. Staff were confident to whistle-blow to the registered manager if they had any concerns and were confident that appropriate action would be taken. Staff also knew how to report concerns to external agencies such as the police or social services if any concerns arose.

Care plans provided information for staff that identified people's support needs and associated risks. However, some care plans and risk assessments required information to be updated to ensure staff provided consistent support that met people's changing needs.

Checks on the environment were carried out and emergency plans were in place so that staff knew how to

support people in an emergency situation. However, there were no procedures were in place to effectively monitor and maintain clinical equipment such as suction machines and nebulizers and quality assurance systems were not always effective at identifying areas of concern.

Medicines were administered safely. However there were areas where more attention to detail in recording would improve the overall management of medication.

New staff received induction training and a training programme was in place to ensure that staff had the skills and knowledge to perform their roles.

Where appropriate, staff supported and encouraged people at meal times. People were weighed regularly and when necessary referred to healthcare professionals for additional advice and support.

Staff understood people's individual needs and received updated information at shift handovers. People looked settled, happy and contented and staff were attentive and responsive when people called for them or indicated that they needed some help. We saw staff treated people with dignity and respect.

Staff were familiar with people's life stories and were knowledgeable about people's likes, dislikes, preferences and care needs. They approached people using a calm, friendly manner which people responded to positively. Staff asked people if they were happy to do something before they took any action. They explained to people what they were going to do and waited for them to respond before providing care.

An effective system was in place for investigating and responding to people's complaints and concerns. People knew how to raise any concerns and relatives were confident that the registered manager would take appropriate action to resolve their issues.

Staff said they felt well supported by the registered manager and were clear about their role and what was expected of them.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. This is so we could check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to there not being effective systems in place to monitor the quality of care. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe.

Some care plans and risk assessments required information to be updated to ensure staff provided consistent support that met people's changing needs.

There were no systems in place to monitor and maintain clinical equipment to ensure it was safe to use.

Staffing levels were sufficient to meet the needs of people in the service.

Staff knew how to protect people from abuse and were aware of the whistle blowing policy.

Is the service effective?

Requires Improvement

The service was not always effective.

Care plans were regularly updated, however, information was stored in a variety of places which made it difficult to obtain a clear overall picture of people's management.

Applications for DoLS authorisations had been submitted to the Local Authority where restrictions were imposed upon people to keep them safe.

New staff received an induction and shadowed established staff to ensure they were competent before working on their own.

People's nutritional needs had been assessed, and people told us they enjoyed the food.

Is the service caring?

Good

The service was caring.

Staff were supportive, patient and caring.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and were responsive to their needs.

The manager had a robust complaints procedure in place and people knew how to make a complaint and raise concerns.

Is the service well-led?

Requires Improvement

The service was not well-led.

Care records relating to people were sometimes disjointed.

Quality assurance audits were carried out to ensure the quality and safe running of the home. However, these did not identify short falls in record keeping.

People and their relatives spoke positively about the leadership at the home and staff felt supported.

The management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC).

Braintree Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 29 June and 25 July 2016 and was unannounced.

On the first day of the inspection the team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service, on this occasion their expertise was in dementia care. On the second day of the inspection the team consisted of one inspector and a specialist professional advisor in nursing care for older people.

Before the inspection the provider completed a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including previous inspection reports and the details of any safeguarding events and statutory notifications sent by the provider. A notification is information about important events which the provider is required to tell us about by law, like a death or a serious injury.

During the inspection we focused on speaking with people who used the service and the staff who cared for them. We observed how people interacted with each other. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We spoke with eight people living in the service, eleven relatives and ten members of the care staff, two nurses, the maintenance person and the deputy manager. We also spent time with the registered manager and toured the buildings looking at the safety and cleanliness of the environment. We also looked at three staff files to see whether staff had been recruited safely and looked at complaints and compliments received by the service.

We looked at ten people's care plans and risk assessments, medicine records, and operational records that included staff training records, staff rotas, accident and incident reports, servicing and maintenance records, complaints information, policies and procedures and survey and quality audit information.

Some people living at Braintree Nursing Home could not easily talk to us about their views or give us opinions about their care. To help us gain a better understanding of people's experiences of living in the service we used 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 talk to us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 12 and 15 May 2015, we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because risks to the health and safety of people at the service had not been assessed and measures were not fully in place to mitigate any risk. During this inspection we found that the improvements required to meet the legislation had been made.

Risks to people's wellbeing had been assessed by the registered manager; they identified people's specific needs, and contained information about how risks could be minimised. These were recorded and regularly reviewed within each person's care plan. Individual risk assessments included: risk of skin breakdown for people with limited mobility, not having enough to eat and drink and using mobility equipment. One relative told us that, with the assistance of the staff, their loved ones mobility had improved since moving into the service. They said, "[They] fell twice whilst getting to walk. But as a family we're happy with the risk. It happens when [they are] tired. Staff told us about it and we trust them."

However, we found that although potential risks had been identified care plans did not consistently reflect what staff were putting into practice. For example, we looked at the care plan for one person who had a diagnosis of diabetes. The person was also living with dementia and the service had completed a MCA to ascertain whether or not they had they capacity to safely make informed decisions about their care. The assessment stated that the person had fluctuating levels of capacity. Their care plan contained clear instructions for staff about how to support them to make best interest decisions when choosing meals and snacks. During the first day of the inspection we did not see staff offering the person any alternative diabetic options as a snack. We spoke to the manager about this who informed us that when the person did have capacity they chose to eat non-diabetic food, therefore staff would be going against their expressed wishes if they were to give them diabetic food at times when they did not have capacity. The person had appointed someone to act as their Lasting Power of Attorney (LPA). An LPA is a legal document that allows someone to appoint one or more people to help them make decisions or to make decisions on their behalf. In this incidence the LPA was appointed to help with decision making regarding the person's health and welfare. The manager told us that the service had also liaised with the person's LPA, who supported how the service were managing the person's diabetes. We discussed with the manager that this was not reflected clearly in the persons care plan. When we returned for the second day of the inspection we saw that the manager had taken on board what was discussed and the persons care plan had been updated to reflect this.

The service kept a record of accidents and incidents and we saw evidence of the action that was taken to resolve the incident or to prevent future occurrences were recorded. For example, one person had fallen out of bed. Staff reviewed their risk assessment and as a result of this a low-rise bed was provided and a sensor mat was placed on the floor next to the bed.

People appeared relaxed and happy with staff. One person we spoke with said, "Yes I feel safe and the staff make me feel safe." A relative told us, "[Relative] and I think it is fantastic here, the food is good and the care is ok. Staff seem to be looking after [them] well. [They] are safe if people are with [them] and there seems to be quite a lot of staff to me"

Staff showed a good awareness and understanding of different forms of abuse and knew what to do if they witnessed or suspected abuse. One staff member said, "I know that if you see something that is wrong you need to respond to it. I'm not just a carer, I'm here to protect people as well and keep them safe." Training in safeguarding people was provided to all new staff and there were refresher courses for the whole staff team to keep everybody up to date. Staff were aware of the whistle blowing policy and knew how to blow the whistle on poor practice to agencies outside the organisation. The staff that we spoke with knew how to report concerns to external agencies such as the police or social services if any concerns arose.

On both days of the inspection there were no agency staff in use. We looked at rotas for the six weeks leading up to the inspection and saw that the staffing was consistent. On the first day of the inspection we observed that there were staff present in the service that were not named on the rota. We spoke to the manager and the staff about this who told us that some staff had a dual role which involved them having some hours each week when they were not providing direct care to people but instead were working as mentors or updating care plans. They told us that when they were completing these hours they were not included in the staffing rota. However, we saw some staff who were working in their non-clinical roles assisting in providing care to people. When we spoke to staff about this they told us that they occasionally helped colleagues if staff were on breaks or if "no-one else was around." Although it is understandable that staff would want to assist people at busier times of the day the fact that they were not included on the rota made it difficult to establish whether or not the actual number of staff on duty was sufficient to meet the needs of the people living in the service. We did however, see that staff were visible around the home and that they took their time when providing care and talking to people. The service used a dependency tool to calculate staffing numbers and call bells were answered promptly. If people were asking to use the toilet or move from one place to another staff were quick to respond to them and carry out their requests.

Throughout the inspection there was a calm atmosphere within the home. Staff told us that the service had recently been divided into four units and that in the morning the staff worked in smaller teams which were based on each of the units. Staff explained that this had resulted in an increased continuity of care for people and consequently staff were able to get to know the people, their preferences and how they wished to be cared for. We observed staff using manual handling equipment to assist people to move from wheelchairs to lounge chairs in a safe, confident and calm manner.

We looked at the recruitment files of three staff members. Safe recruitment and selection processes were followed. Files contained the relevant documentation required to enable the provider to make safe recruitment choices. Each file references, proof of identity and a copy of the staff members completed induction paperwork. Prior to starting employment, new employees were also required to undergo a DBS (Disclosure and Barring Service) check, which would show if they had any criminal convictions or had ever been barred from working with vulnerable people.

Medicines, including controlled drugs, were administered safely. Medication was stored in individually locked boxes in people's rooms. Medicines administration records (MAR) were completed properly and there were no unexplained gaps. We looked at the MAR chart for a person who was prescribed daily clexane injections and another person who required three monthly vitamin B12 injections and saw that both people were receiving them as prescribed. Clexane injections are given for the treatment and prevention of blood clots. Staff used body maps to show where on the body they had applied transdermal patches and staff had clearly indicated if and when the patch needed to be removed and reapplied to a different area of the body. There were robust procedures in place for booking in, storage, administration and disposal of medicines. Staff who administered medication had completed the required training and their competencies were reviewed every six months. The manager and deputy manager also completed monthly medication audits.

We looked in the treatment room and saw that the temperature of the room and the medication room were checked daily and were within the recommended limits. However, both of the sharps bins were overfull and one had a syringe sticking out of the top of it. The overfilling of sharps bins is unsafe and places staff at risk of a needle stick injury. We discussed our findings with the nurse on duty who told us that they would arrange for the bins to be emptied and highlight the problem to the nursing staff.

Several people had 'as directed' topical medicines creams prescribed. A record was made when and where these were administered but they did not have the date that the creams had been opened clearly marked on them.

The environment was regularly audited and risks assessed to ensure that it was safe for people to use. Personal electrical appliance (PAT) testing had been carried out to ensure that electronic equipment was in safe working order and the water temperature was monitored to ensure that it was maintained at a safe temperature for people to use. The maintenance person had a diary where staff could record problems or faults. We saw that this was checked daily and the date by which the fault had been fixed or what action needed to be taken to resolve the problem was recorded.

Records showed that the fire alarms, emergency lighting and fire extinguishers were all checked on a weekly basis. Before the inspection the manager had notified the CQC of two fires that had started in outbuildings at the service. We saw that appropriate action had been taken to mitigate the risk of reoccurrence including; a fire risk assessment from a private company, the installation of CCTV cameras and altering some of the structure of the building from wood to brick. The fire service had also provided fire safety and awareness training for staff and the staff that we spoke with knew what action to take in an emergency and we saw that personal emergency evacuation plans (PEEP) were in place for all people using the service. These plans provide staff with guidance on how to support people to evacuate the premises in the event of an emergency.

We looked in laundry room and saw that part of the floor consisted of exposed concrete which would not be able to be cleaned effectively. We also saw that red bags which contained soiled laundry had been placed in front of hoist slings that were hanging on the wall. The hand washing basins were not accessible to staff because equipment had been placed in front of them and there were no paper towels in the dispenser. We spoke with the manager about our findings and immediate action was taken to clear the room. Since the inspection the manager has informed us that the service has an on-going maintenance plan and improvements to the laundry floor are part of this.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 12 and 15 May 2015, we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because DoLs applications had not been applied for appropriately when required by people using the service. At this inspection we found that the improvements required to meet the legislation had been made.

Some people living in the service were not able to make important decisions about their care and how they lived their daily lives. The manager understood her responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff had completed training in respect of the MCA and DoLS and the staff we spoke with understood their responsibilities to ensure people were given choices about how they wished to live their lives. Where people did not have the capacity to consent themselves we saw that the service had operated in line with the requirements of the MCA. Where people lacked capacity, the care plans showed that relevant people, such as their relatives or an appropriate health or social care professional had been involved in making decisions about their care. Any decision made on behalf of a person was done in their best interest and the least restrictive option was chosen. The manager had completed a number of DoLS referrals to the local authority in accordance with new guidance to ensure that restrictions on people's ability to leave the home were appropriate. If people had appointed someone as their Lasting Power of Attorney (LPA), who this was and in what capacity was clearly documented in their care plans.

People's electronic care plans were regularly updated by care workers. This is an effective designation of tasks for certain aspects of the care plans. However, in order to prevent the omission of important information and to ensure an effective overall management plan is in place clinical information, such as changes to people's catheter care management or wound care, should be updated and recorded by the healthcare professional who has been responsible for providing that support.

Staff used a board to plan peoples wound care and a code to indicate when dressings had been changed and the date that the next change was due. However, we found that staff were not accurately and consistently documenting when wound care was given. For example, on the 10th, 12th and 16th July one person was coded as 'to do' but there was no indication on body maps or in the persons notes that their dressings had been changed on these dates. We saw that the last recorded entry was on 13 July 2016, which recorded that the dressing had been changed as planned, but there was no further information regarding the wound care after this date. The wound care plan for this person stated that they should have their dressings changed every four to five days but there was no documentation to support that this was

happening. We looked at another person's wound care plan which stated that staff should observe their wound daily for 'bleeding and signs of infection.' Staff had recorded that dressings had been changed for this person on 2, 7, 11, 13, 15 and 21 July, there was no recordings after this date.

As part of their pressure care assessments for people nursing staff had completed body maps to show where on the body the wound was located. However, there was no evidence to show what action staff had taken and no indication of if the bruising had resolved. The forms that we looked at were not in date order and the disorganisation of the 'planning' board meant that it was difficult to see what wounds people had and when dressings were due to be changed. We saw that in some cases photographs had been taken of the wound however, this was not consistent practice and on the photographs that we observed there were no recording of the size of the wound. Without this information it is not possible for nurses to effectively asses and monitor the progress of a wound.

Care staff had the skills and knowledge they needed to provide effective support to the people that they cared for. People told us that they had confidence in the staff and that care was provided according to their expressed preferences. Staff told us that they felt supported by the manager and that the training provided enabled them to do their job effectively. The manager maintained a detailed record of training that staff had undertaken. We reviewed the 'training matrix' and we saw training had been carried out for staff in health and safety, medication, safeguarding, infection control and fire awareness.

New members of staff were required to complete an induction programme before working on their own with people. Staff told us that their induction had included a period of time working alongside more experienced members of staff as well as completing core training, such as safeguarding, moving and handling, fire safety and infection control.

The staff that we spoke with said that they received annual appraisals and all but one staff member told us that they had regular formal and informal supervision sessions. One staff member said, "This place is very supportive." The manager told us that supervision sessions took place every two months and comprised of both one to one sessions with manager or the deputy manager and group sessions. In addition to this staff told us that they also received support and advice through a mentoring programme. A mentor is a more experienced member of staff whose role is to provide support and guidance to staff. We spoke to one of the mentors who told us, "It's important that [staff] recognise that these are people. And that they know what to do in situations like if you are short staffed not to ignore people and how to manage their time."

Systems were in place for monitoring the incidence of falls, urinary tract infections and pressure areas in the service. On the first day of the inspection, the manager told us about a person who had a fall the previous day. We saw that this had been recorded by staff and that they were planning to take a urine sample from the person to ensure that they did not have a urine infection.

People told us that they enjoyed the food and there was plenty of it. We observed lunch time in the main building and in the White House and saw staff supporting and encouraging people in a patient and appropriate manner. In the main building a majority of people ate their meals in their lounge chairs with a small table placed in front of them. Lunch time in the White House was a very sociable occasion with people talking and laughing together and with the staff. After people had finished their meals there were several positive comments including, "That was lovely, delicious."

Nutritional assessments had been completed and where people were found to be at risk of not taking enough food or drink, appropriate measures were put in place to support them. We saw that staff gave people the time to eat at their own pace and that where necessary staff supported people with their food or

prompted them to eat. Some people who were nursed in bed ate their meals in their own rooms and some of these people required assistance from staff with their meals. We observed staff moving people's beds away from beside the wall and placing chairs next to the bed on the side that they were facing to assist them in a caring and dignified manner.

Staff knew about people with specific dietary needs, such as if they required pureed meals. One staff member told us, "We know who's on a soft diet from their care plans." We also saw a list of people's dietary requirements was on display in the kitchen to act as a further prompt to staff. The pureed meals served looked appetising and were well presented.

Throughout the day people were offered a wide selection of drinks and snacks were available and accessible to people. A member of staff was employed as a hydro-nutritional support worker; their role was to ensure that people received enough food and fluid throughout the day. The service was committed to the Prosper project, a Local Authority scheme aimed at promoting the safer provision of care for elderly residents by promoting awareness in pressure care and nutrition and reducing urinary tract infections and falls. We saw that staff had introduced a variety of new ideas to encourage people to increase their fluid intake including a variety of flavoured ice lollies and jellies. Different coloured mats were also placed on people's individual tables, each colour was coded to indicate to staff whether people drank well or needed assistance or encouragement to drink. However, although we saw people being offered snacks and drinks throughout the day staff were not consistently following the procedure for recording people's food and fluid intake. We looked at the food and fluid charts for a person, dated from 21 July to 25 July. On each day the person had refused food at one of the meal times and on 22 July no fluids had been recorded for the entire day. There was no evidence to show that staff had offered the person any alternatives to the food that they refused or snacks in between meal times. We looked at the fluid charts for another person for the previous four days. On the 22 July 2016 only 175 mls of fluid was recorded for the day and the lunch section was left empty with no explanation given.

People's healthcare needs were monitored effectively and people said they were supported to obtain treatment if they needed it. Relatives we spoke with told us that staff worked well with health professionals to ensure their relations got the best and most appropriate care. One relative told us, "They ring me if there's a problem and I can always talk to them." People's care records showed that their day to day health needs were being met and that people, where appropriate, had access to the healthcare professionals including the optician, dentist, chiropodist and GP. We saw evidence that when necessary people were referred to specialist healthcare professionals such as Speech and Language Therapists (SLT) and Dieticians and records showed that people were supported to attend hospital and other healthcare professional's appointments away from the service.

Good

Is the service caring?

Our findings

People that we spoke with told us that they were well cared for and that they enjoyed living at Braintree Nursing Home. One person told us "It's one of the best places I have been and I chose to come here. Staff are fine and the girls dance around and always have a smile on their faces and they treat me respectfully, it's exceptional care." Another person said, "We want for nothing." One relative of a person who had recently moved into the service told us how they had initially been concerned about coming to the service but that the staff had helped them to settle in quickly and that now they did not want to leave. They went on to say that, "Nothing was too much trouble and staff are always smiling." Another relative said, "[Relative] is always clean and tidy and they are always changing [their] clothes and bedding. The carers are really ever so caring and good."

Staff were very caring and treated people with kindness making sure that their dignity was maintained. We observed staff knocking on people's doors and waiting to be invited in before entering and we heard staff gently explaining to people what they were going to do before providing care. One member of staff told us, "The main thing I like to do is involve the family as much as I can. When they have been caring for someone they can feel redundant when they go into care." They went on to tell us how they had recently telephoned the relative of a person who had recently moved into the home because they were concerned that they were lonely. Another staff member told us, "I always have the resident's interests at heart and do love the care side of my job."

Staff were enthusiastic and positive about their roles and it was clear that they had built meaningful relationships with the people that they cared for. All the staff that we spoke with told us that they had the opportunity to read the care plans of the people that they were caring for.

Although formal meetings were not arranged with people and their relatives to review care plans, people told us that they felt involved in planning and making decisions about their care. The manager told us that staff spoke to people and their relatives on an 'as and when' basis rather than formally meeting with them to review care plans and we saw staff updating care plans on the computer on both days of the inspection.

The service had a Dignity Champion in place. They were enthusiastic about their role and explained to us how they liaised with other services to share ideas and in turn shared this with staff to promote best practice in the service. People told us they were involved in managing their daily care and that staff respected their privacy and dignity. One relative told us, "Staff care. I know most of the staff and they treat [them] respectfully." Throughout our inspection we saw staff knocked on the doors to people's rooms and communal bathrooms and always waited for permission from people before they entered.

Good

Is the service responsive?

Our findings

At our inspection on 12 and 15 May 2015, we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the care and treatment of people was not always appropriate and did not always meet their needs. At this inspection we found that the improvements required to meet the legislation had been made.

Staff knew people well and were responsive to their needs. Care plans contained information about how people wished their care to be provided, their likes and dislikes and details about their life history. One member of staff told us that they had started to compile 'life maps' with people, they explained that this involves sitting with a person and talking about their life and plotting significant events and places that they have been on a map. They went on to say, "The past is very important. I don't just want to look at the person in front of me as they are now."

People's needs had been assessed before they moved in to the service to ensure that the staff could provide the care and treatment they needed. Pre-admission assessments recorded people's needs in areas including health, mobility, communication and nutrition and hydration. We looked at the care plan for a person who had recently moved into the service. Staff told us that in order to develop a care plan that best met the persons needs they had visited them in hospital before they came to the service, obtained a copy of the persons assessment from the Local Authority and had been caring for and talking to the person and their relative since they moved into the home.

Daily handover sheets were used to provide staff with up to date information about the people that they were caring for. We looked at the handover sheets and saw that they contained information about people's significant medical conditions and nutritional status such as if they were on a soft diet or required thickener in their fluids, this enabled staff to provide care which met people's needs.

We spoke with the Home Welfare Officer who explained their role to us. Each morning before the early shift starts they spoke to people to determine who would like to get up early and who would like to be left until later in the morning. One person told us, "I can get up when I want and go to bed when I want." A daily check sheet was completed to ensure that people had received their care in their preferred way.

The manager told us that the service provided some organised group activities for people but that their main focus was on providing a person centred range of activities which met people's specific interests and preferences. Two members of staff were employed in the role of Well Being and Life Style Facilitators to facilitate this and on both days of the inspection we saw a variety of activities taking place in the communal lounge of the main building including flower arranging and foot and hand massages. People were clearly enjoying the activities that were taking place and staff engaged with people and encouraged participation. We heard the massages therapist asking each person in turn for consent before they provided a massage and several people told them how much they were enjoying the experience.

A timetable of organised activities was visible in the lounge in the main building. It showed that a variety of

events including; cake making, reflexology, a coffee morning, a clothing shop and an external singer had all been planned for the week. Staff supported people to access the local community, during the inspection staff went into the local town with people.

We did not observe any one to one activities or organised activities taking place in the White House. There were several people seated around the lounge and the television was on but most people were sitting quietly in the room. We spoke with the manager and staff about our findings, all of whom told us that people living in the White House were able to attend the activities in the main building if they chose to, but that only a small number of people usually did. Staff told us that they had tried in the past to introduce activities in the White House but that people did not want to participate, therefore most of the activities continue to take place in the main building and people who wished to attend could do so.

People said that they were able to talk to the manager about any issues that may arise. We looked at the complaints file and saw that there was a system in place for handling and responding to complaints and that the manager investigated and responded to concerns and complaints that were raised. Relatives told us that the manager had "an open door policy" and this combined with the role of the family liaison officer meant that any concerns that they raised were dealt with promptly. The manager had established the role of Family Liaison Officer to provide a link between people using the service, relatives and the home. They explained that because the care staff worked a shift pattern the role had helped to provide a consistent staff member for people and their relatives to speak to and they felt that this had helped in managing people's concerns at the earliest opportunity.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 12 and 15 May 2015, we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider did not have effective systems in place to monitor the quality of care provided and make improvements.

There did not appear to be a clear clinical lead who took responsibility for ensuring that effective plans were implemented and recorded for the management of wound care, catheter care or for cleaning and maintaining clinical equipment. We asked the nursing staff who took responsibility for maintaining and monitoring the electrical clinical equipment such as syringe drivers, suction machines and nebulizers, they told us that it was the responsibility of the maintenance person. However, when we spoke to the maintenance person they told us that they did not check any of the clinical equipment. There were no records to show that the equipment was being regularly cleaned, monitored and checked to ensure that it was in safe working order.

During this inspection we found that whilst there were now systems in place to monitor people's care staff did not use them consistently. Information about people's care was disjointed and held in several places including, folders, daily note books and the computer which made it difficult to easily obtain a clear overview of people's care For example, systems were in place to monitor people's weight on a monthly basis, or weekly if they were seen to be losing weight. Staff recorded people's weights on charts which were stored in a folder and then transferred onto the electronic care plans. We looked at one person's summary of care that had been printed off the computer, weights were recorded for December 2015 and January 2016 but there were no weights recorded after this date. When we looked in the weights folder we saw that the person had been either unwell or had declined to be weighed in April, May and June. We asked staff why this information had not been recorded on the computer system, they told us that it was not possible to record when a person refuses onto the computer system.

We looked at the care plan for a person who was requiring regular bladder washouts and catheter changes to manage their catheter care. There was no easily accessible, clear guidance for nursing staff to follow about the size of the catheter and frequency that it needed changing. We asked one of the nursing staff on duty about this, they told us that the person's catheter was changed every three months and that following a recent review by the GP the size of the catheter had changed. We asked if there was any record of this in the care plan, they replied, "No." We also asked the nursing staff if there was a system in place to record when the leg bags were changed they replied, "I don't think so, some carers may write it in the daily note books." People who use a urinary catheter are at increased risk of getting an infection. Therefore, NICE guidelines (2003) recommend that healthcare workers keep a record of catheter care, including insertions and changes, and that urinary drainage bags are changed weekly to prevent infection and deterioration of the bag. However, we saw that the nursing staff had recorded in several different locations, including daily notes and the multidisciplinary visit record, when they had performed bladder washouts and catheter changes but there was no clear contemporaneous record of the events to show the time between changes and washouts which would have assisted clinical reasoning and the formulation of an effective management plan for nursing staff to follow.

The quality assurance system in place to identify and address areas for improvement were not always effective. We saw copies of audits and reviews that were completed by the manager and deputy manager including; medication, infection control, catering and care plan audits. Each completed audit had an action plan in place to address any issues that were raised. However, we noted that there were gaps in people's food and fluid charts with no explanations given and a person's care plan had not been updated to reflect a change in their catheter management plan. The monitoring system used by the manager had not highlighted or addressed any of these concerns.

The lack of good governance within the home was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had an informal and relaxed culture. People, staff and relatives were complimentary about the manager and described them as approachable and supportive. One staff member said, "I feel like I can talk to my manager about anything, work related or personal." Another staff member said, "I love it here, the manager is really supportive and it's like one big family. "

The manager was supported by a deputy and an administration manager whom they also shared an office with. We asked staff if this made it difficult for them to speak to the manager privately, they all told us that they did not find this to be a problem and that alternative rooms were available if they wished to speak to someone in private.

On both days of the inspection the manager was not at the service when we arrived. Staff told us that is was usual for them to arrive at the service at around mid-morning and then stay later in the day so that they were able to meet with both the staff working both the early and the late shift. Staff told us that in the absence of the manager situations such as staff allocation for covering unplanned sick leave or lateness were managed by the deputy manager, the nurse on duty or the care co-ordinator.

It was clear that there was a good rapour between the manager and relatives. On both days of the inspection we saw staff and relatives coming in and out of their office and chatting openly about any concerns that they had and their relatives care. Staff said that the manager listened to them and responded promptly to any issues that they rose. One member of staff told us that they had raised an issue with the manager and that they had immediately arranged a meeting with them to look at a way to resolve the problem. One staff member said, "I can go and ask the manager anything and she will make time for me." The manager told us, "I think that the thing that I am proudest of is the staff. The atmosphere, it's not accidental."

People knew the manager and deputy manager and we observed people saying hello to them and greeting them by their names as they walked around the building.

Regular staff meetings were held. The manager told us that the day and time of the meetings changed each month to give as many staff as possible the opportunity to attend.

The manager told us that in the past they the response to person and relative satisfaction surveys and attendance at resident and relative meetings had been poor. In response to this they had created the role of Family Liaison Officer with the aim of providing a consistent face for people and their relatives to speak to about any concerns that they may have. The manager also held coffee mornings every Thursday when they were available for residents and relatives.

The manager promoted good links with the local community and had developed links with other care

homes in the region. The manager was an active member of 'My Home Life,' this is a UK-wide initiative that promotes quality of life and delivers positive change for people living in care homes.

The service had a statement of purpose in place, which outlined the services key aims and objectives. The management team were aware of their responsibility for reporting significant events to the Care Quality Commission (CQC). We used this information to monitor the service and ensure they respond appropriately to keep people safe.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective identifying and addressing areas of concern.