Mayflower Care Home (Northfleet) Limited

Mayflower Care 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Mayflower Care Centre is a care home providing accommodation, personal and nursing care for up to 76 older people with nursing needs who are living with dementia. The service provides support to people who are elderly, frail, have palliative care needs and who have complex needs and challenging behaviours. The service is divided into five units. Diamond on the ground floor caters for up to 26 people who are frail. Sapphire and Opal units on the first floor provide care for 30 people. On the second floor Amethyst and Emerald units cater for up to 20 people with complex needs including behaviours that challenge themselves or others and mental health problems. There were 74 people living at the service at the time of the inspection.

The new manager was in post and after the inspection was successful in their application to register with the Commission. They were registered as manager of the service on 4 September 2017. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in November 2016, we asked the provider to take action to make improvements to ensure there were sufficient numbers of staff deployed to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan in May 2017 which stated that they had complied with all Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At this inspection on 10 and 11 July 2017, staffing levels had been increased to meet people needs. However, we found shortfalls in the management of medicines and records.

Staff had been trained and assessed as competent to administer medicines and monthly audits had identified and addressed any medicines shortfalls. However, it could not be assured some people had received their medicines as prescribed by their doctor to maintain their health.

The new care planning system could not be accessed by all senior staff in order to effectively monitor people's health and well-being. Some people's care and treatment records were not accurate which could result in them receiving inappropriate staff support.

The service had increased staff levels since the last inspection and continued to review if there were sufficient staff on duty at all times.

People and their family members said they were cared for in a safe place. Staff knew how to recognise any potential sign of abuse and report them in order to help keep people safe.

Assessments of risks to people's safety and welfare had been carried out and action taken to minimise their occurrence, to help keep people safe. Health and safety checks were effective in ensuring that the environment was safe and that equipment was in good working order. Accidents and incidents were monitored and action had been taken as appropriate.

A schedule of cleaning was in place to ensure the service was clean and staff knew the practices to follow to minimise the spread of any infection.

People accessed health care services when needed and the service worked in partnership with healthcare professionals to ensure people received appropriate care and treatment. People had sufficient food and drink and enjoyed the meals provided at the service.

Staff received relevant training which enabled them to support people with a range of needs. Staff felt well supported but had not all received regular supervision and training. The service was developing staff to address this shortfall.

Staff sought and received people's consent to the support they provided and in line with the principles of the Mental Capacity Act 2005. CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The service had made DoLS applications, to ensure that people were only deprived of their liberty, when it had been assessed as lawful to do so.

Plans were in place to make changes to the environment so it was more suitable for people living with dementia.

Staff were kind and caring and treated people with dignity and respect. Regular staff knew people well and developed positive relationships with them.

People's needs were assessed and a plan of care was developed which included their choices and preferences. Guidance was in place for staff to follow to meet people's needs.

A range of group and one to one activities were available to provide people with meaningful activities. Regular meetings were held to monitor if the activity programme on offer was effective.

Information was given to people about how to raise any concerns they may have. Relatives said that when they had raised a concern, they had been listened to and the issue resolved to their satisfaction.

People, staff and relatives said the management of the service had improved with the establishment of a new management team. The team were approachable and a visible presence in the service.

The views of people were sought through relative meetings. Systems to monitor the quality of care were improving for the benefit of people.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management of medicines did not always ensure that people received their medicines as prescribed by their doctor.

The service had increased staffing numbers to ensure people's needs were met. The service used robust processes to recruit suitable staff.

Potential risks to people's health and welfare were assessed and plans were in place to manage the risks safely.

Staff knew how to identify abuse and the action to take to ensure people were safe.

Is the service effective?

Good

The service was effective.

People received support from skilled and knowledgeable staff. Staff felt well supported and the service was working towards ensuring they received regular supervision.

People gave consent to care and support. Staff supported people in line with the principles of the Mental Capacity Act 2005 and the requirements of the Deprivation of Liberty Safeguards.

People had access to healthcare services when needed. People received sufficient food and drink which met their nutritional needs.

Plans were in place to improve the design and layout of the service which took into consideration the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People's dignity and privacy was respected by the staff team.

Staff communicated with people in a way they could understand and valued their contributions.

Staff showed concern for people's well-being in a caring and meaningful way and responded appropriately to their needs.

Is the service responsive?

Good

The service was responsive

People's needs were assessed and support plans gave guidance to staff about how to provide their care.

People were offered a range of meaningful activities.

People and their relatives knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records did not always accurately reflect people's care and treatment and were not easily accessible.

People were supported by a management team who were striving towards making improvements for their benefit.

Staff morale had improved and staff felt valued and well supported.

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Detailed findings

Background to this inspection

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

This inspection took place on 10 and 11 July 2017 and was unannounced. The inspection was carried out by two inspectors, a specialist nurse advisor who was a dementia care specialist and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection reports and notifications about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

We spoke to five people who lived at the service, five relatives and two visitors. We observed how staff interacted with people, joined people in three different units for lunch and observed part of the medicines rounds in two units. We used the Short Observation Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke to the registered manager, deputy manager, operations manager, three shift leaders, five care staff, two nurses, the activity coordinator, trainer, chef and administrator. We received feedback from a commissioner of the service, GP and community dietician.

During the inspection we viewed eleven people's care plans; accident and incident logs; the recruitment records of the last four staff employed at the service; staff rota; staff training and supervision programme; administration and storage of medicines; complaints and compliments log; service user and staff meetings, health and safety and quality audits; activity programme; and the safeguarding, medicines and complaints polices.

Requires Improvement

Is the service safe?

Our findings

At the last inspections in March 2015 and November 2016, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they could meet people's care and treatment needs. We asked the provider to take action to make improvements. The provider sent us an action plan in May 2017 which stated that they had complied with all Health and Social Care Act 2008(Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made to ensure there were enough staff available at all times, to meet people's needs.

People said they felt safe and relatives said that their family member was cared for in a safe environment. "This is as safe a place as any", one person told us. A relative said, "Yes, the place is all safe and if anything happens to my family member they ring me up at home and let me know". People told us there were usually enough staff around to meet their needs, but we received mixed views from relatives. Two relatives commented that although their family member was well looked after and there were staff around to give them the support they required, they thought the service was short staffed at times. "There is more staff today than usual" a relative told us. However, another relative commented, "There has been a great improvement in staffing. There are more staff and more regular agency staff with whom I am becoming more familiar. Agency staff do move around the service, but there is a more stable staff team on each floor".

The provider used a specialist tool to assess the staffing levels required to meet the needs of the people living at the service. Staffing levels were reviewed each month through using this tool and by reviewing any accidents and incidents and call bell response times. Since our last inspection to the service, staffing levels had been increased by one care staff during the day on Diamond unit and additional staff member at busy times including early morning and evening on Sapphire/Opal units. This meant the staff ratios during the day varied between each unit from one member of staff to three people, to one member of staff to six people, depending on people's support needs. Staff told us these changes had had a positive impact on people and most said there were enough of them around to respond to people. They said the management team moved staff from one unit to another at busy times and in response to their requests and in order to meet people's needs. During the inspection there were times when staff were busy, but people were responded to in a timely manner.

People and their relatives said they received the support they need to take their medicines. One relative commented, "They are very diligent about the management of my relative's medicines. There have been a number of changes which have resulted in them stabilising".

The medicines policy stated that, "After each administration, the care worker should sign the MAR (medicine administration record) sheet to verify that the medication has been administered. This must occur immediately after the medication has been administered. A code must be used for non-administration ". However, this policy was not consistently followed which meant it could not be assured that people had received their medicines as prescribed by their doctor to maintain their health. For one person a dot and not

a staff signature was recorded on the MAR on 9th July for two of their mental health medicines and a medicine to prevent nausea. For a second person a dot was recorded on 27 June and 3rd and 5th July for pain medicines and on 2nd and 3rd July for a nutritional supplement. For a third person their medicine to relieve muscle spasm had not been given on 29 June and for a fourth person their medicines for their mental health and irritable bowel had not been given on 8th July. There was no reason recorded why these two people had not received their medicines. For people who received topical medicines (requiring application to a particular place on or in the body) there were no directions or body charts in place which gave guidance to staff as to which part of the body they should be applied.

The manager informed us after the inspection that due to the recording errors identified at the inspection medicines audits had been increased from monthly. MAR charts were now checked daily by the nurse or shift coordinator on each unit. In addition weekly checks were undertaken by the manager or deputy manager. All people who had topical creams had a chart in place to direct staff as to their application. However, this is not a long enough period of time to ensure that the improvement had been embedded and sustained at the service.

The provider had not ensured the safe management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medication was safely stored in a locked room which was clean and well organised. Controlled drugs (CD's) which are at higher risk of misuse and therefore need closer monitoring were stored securely and their destruction undertaken and recorded appropriately. The temperature of medicines rooms and fridges were recorded daily to ensure medicines were safe to use, with the exception of Sapphire unit where although staff said they checked the temperature it had not been recorded. Protocols were in place for people who were prescribed their medicines to be given 'as required' (PRN) and these were followed by staff. Staff recorded when patches for pain relief were applied to people and when they were rotated to ensure they were regularly moved to maintain people's skin. Where medicines audits had identified any shortfalls action had been undertaken to address these through additional staff supervision and competence checks.

Regular recruitment days were held to encourage people to work at the service as there were a number of staff vacancies. These gaps in the staff rota were filled by agency nurses and care staff. The service employed a number of agency staff who regularly worked at the service and so were familiar with the way it was run and the people who needed support. Each unit had its own staffing rota and the manager used a weekly staffing sheet to give an overview of the whole service. This was so they could highlight any gaps in staffing that needed to be covered by additional staffing. The rotas on each unit did not accurately reflect the name and numbers of staff on duty. The manager confirmed after the inspection that unit staffing rotas had been reviewed and continued to be monitored to ensure they were accurate.

The service had a comprehensive safeguarding policy which set out the definitions of different types of abuse, staff's responsibilities and how to report any concerns. Staff had received training in safeguarding, understood what signs to look out for such as changes in people's behaviour, or unexplained bruising and knew how to follow the service's policy to ensure people's safety. The policy included the contact details of the local authority who are the lead agency in safeguarding investigations. Staff knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. They felt confident if they raised a concern they would be listened to and action would be taken by the new management team. However, if their concerns were not taken seriously, they said they would contact police or Care Quality Commission.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role.

This included obtaining a person's work references, a full employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Each person's care plan contained individual risk assessments in which risks to their safety were identified, such as their risk of falling, when moving around the service, of developing pressure areas, allergies, nutrition and continence. Guidance about any action staff needed to take to make sure people were protected from harm was included in the risk assessments. For people who were at risk of choking guidance was in place giving clear directions to staff about how to support the person to eat. This included the preparation instructions for any prescribed thickening powders for liquids. Staff demonstrated they knew which people were at risk of choking and required closer monitoring at mealtimes. For people at risk of developing pressure ulcers the specialist equipment they required, including airflow mattresses and cushions had been provided. These were regularly checked to ensure they were at the correct pressure to provide effective relief. Turn charts were in place which specified how often it had been assessed the person needed to be moved to help keep their skin healthy.

A record was made of any accident, incident or near misses including the details of what occurred and what was done in response to the situation. Near misses are events that might have resulted in harm to a person but the problem did not occur because of timely intervention. A near miss in relation to medicines was discussed at the morning head of department meeting. The manager reviewed all events to see if there were any patterns or trends. Through this process it had been identified that one person had had a number of falls and this had resulted in them being referred to the falls clinic.

Regular checks on the premises and equipment were carried out to ensure the service was safe for people and staff. This included weekly walk arounds by the manager and regular servicing and visual checks of fire-fighting equipment, beds and mattresses, gas and electricity supply, and hoists and slings. Each person had a personal emergency evacuation plan (PEEP). These identified the individual support and/or equipment people needed to be evacuated in the event of a fire. The service had identified that staff would benefit from more in depth fire training and had booked all staff on fire marshal training in addition to fire training. This training equips staff with the knowledge of what to do if a fire occurs, to use a fire extinguisher and to take the lead to ensure people and staff remain safe.

Infection control audits were carried out to ensure staff practices minimised the spread of any infection. Staff undertook training in infection control. Cleaning staff were given specific tasks to carry out each day to make sure the service was clean. The service was clean and staff had worked hard to ensure there were no unpleasant odours. A professional who regularly visited the service told us that there were never any issues with unpleasant odours at the service. Personal protective equipment and hand-washing facilities were available for all staff. There was a separate laundry room and a sluice to deal with soiled laundry. All these actions helped to minimise the spread of any infection should it occur.

Good

Is the service effective?

Our findings

People and their relatives told us the staff team had the skills and knowledge they required to support people. One relative explained how their family member could become aggressive and that staff knew how to effectively respond to diffuse the situation. "Sometimes they can become quite aggressive lashes out at me", the relative told us. "I buzzed for staff and they calmed me down and they calmed him down".

People and relatives said that people's health was monitored. They said they had regular appointments with the visiting GP, other health services such as the dentist and optician and that they were kept up to date with any changes in their health. "The staff always let me know if my family member has had a minor accident or if there are any changes in their care", a relative told us.

The service provided nursing care, but the staffing rota evidenced there were a number of occasions when there was only one nurse on duty to provide advice and support. Nursing staff said this put extra pressure on them as although they were based in Diamond unit they were required to help on other units with some medicines and dressings. Shift leaders said they managed people's health care as much as possible within their skills and knowledge and only contacted the nurse when it was necessary. The manager reviewed the staff rota after the inspection and provided records to confirm there were two nurses on duty on each shift.

People's day to day health needs were managed by the staff team with support from a range of health care professionals. Concerns and changes in people's health were discussed at regular meetings with the nurses and shift leaders from each unit. This gave staff the opportunity to discuss the best treatment plan for people and for the manager to check that people's health needs were being appropriately met. The service sought advice and made referrals to other professionals such as the person's GP, practice nurse, hospice staff, speech and language therapist and dietician when required. Health care professionals told us the service made appropriate referrals. Nursing staff undertook regular observations and checks of people who had been identified as requiring this level of input to monitor their health and well-being. Care staff understood their responsibilities in reporting any changes in a person's condition to the nurse or shift leader. Any changes in a person's needs or treatment were recorded to ensure guidance about their care was kept up to date.

People's care plans gave written guidance about how to support people's health needs with regards to their mobility, skin integrity, nutrition and hydration. Where people required specialist input, detailed plans of care were in place to ensure the person's health needs could be managed safely. For example, for people with a percutaneous endoscopic gastrostomy (PEG) their plan included the times and rate of the feed and how the person should be positioned. There was also information about how to care for the PEG site and clean the tube. PEG is a tube that feeds directly into a person's stomach. For people with pressure areas a record was made of any treatment provided, such as a dressing being applied. Wounds were photographed and a record kept to monitor any improvement or deterioration.

The service understood the important of offering people food and drinks throughout the day and encouraging them to eat and drink. People's need in relation to food and fluids were assessed and the

support they required was detailed in their plan of care. For people at risk of dehydration or malnutrition a record was kept of the person's daily food and fluid intake and any increases or decreases in their weight. When there had been concerns about people losing weight, the service had appropriately responded. For example, one person had lost weight and they had been put on a fortified diet with milky drinks to increase their nutrition. A referral had been made to the speech and language therapist and this was being chased as no response had been received. Due to the person continuing to lose weight a referral had been made to the community dietician.

People and their relatives said the menu on offer gave people a number of meal choices. "You get a menu and a choice of two or three things on it. Sometimes it's fish and chips which is good as this is my favourite", one person told us. Another person told us, "Since the new manager has been in place the food has improved as we have a choice on the menu". Relatives said their family members enjoyed the food provided by the service. Comments included, "The food is very good. He eats very well" and, "I say the service have revived him here. He enjoys the food and has gained weight".

The dining room was situated in Diamond unit and people sat at a table which was well presented. Staff were busy throughout the mealtime serving people in the dining room and in their rooms and did not have time to chat to people. By contrast on Sapphire and Emerald units there was a calm and relaxed atmosphere and people were able to eat when they wanted to and at their own pace. People were gently coaxed and encouraged to eat at the table. However, if people preferred to eat standing or walking around, they were enabled to do so. Staff supported people who required assistance to eat and engaged them in conversation and explained what they had to eat. For people who were asleep at lunchtime, their meal was plated and named and returned to the kitchen for when then awoke.

The service had contracted an external company to provide all meals. There was a four week rolling menu with a number of options at each meal. Information about each person's dietary requirements such as if they required a soft diet, pureed food, diabetic diet, thickened fluids or if they had any allergies was on display in the kitchen to guide staff. The chef also knew people's individual likes and dislikes. The manager regularly met with the chef to discuss ways to improve people's meal experience. At the last meeting discussions had taken place around changing the physical dining environment and the presentation of meals for people with pureed diets.

Where people may present behaviour that challenges themselves or others, a plan of care was in place. This identified the nature of the behaviour, the potential triggers for the behaviour and guidance for staff on the appropriate action to take to minimise the occurrence. An incident report was completed of any occurrences. Staff gave examples of how they supported individuals who may become distressed or showed behaviours which could challenge. For example, they explained how one person needed reassurance, to be given their own space and to carry a favourite item. During the inspection staff recognised the signs that one person was becoming unsettled and took them for a walk, which had a calming effect and minimised the risk of their behaviour escalating.

New staff completed an in-house induction which included reading policies and procedures, shadowing more senior staff and understanding their roles and responsibilities. Staff said this gave them the skills and knowledge they required for their role. The in-house trainer arranged the training programme which provided face to face training for staff in key areas such as fire, food hygiene, health and safety, infection control, safeguarding, moving and handling and first aid. This training was refreshed on a regular basis to ensure staff kept up to date with the skills and knowledge necessary for their roles. Training was flexible and additional training was given to staff who required it in specific areas. Specialist training was provided based on the needs of people using the service. All staff completed training to support people living with dementia

and who presented behaviour that challenges. The dementia training included staff experiencing visually what it is like to live with dementia and a presentation from a person with early onset dementia. Staff gave positive feedback on this training and how it helped them to better understand the people who they supported. Some staff had undertaken training in end of life care and nurses had received training in skin integrity, catheterisation, PEG feeding and certifying expected death. The nursing team were supported through the revalidation process with the Nursing and Midwifery Council (NMC) through ongoing training opportunities and clinical meetings. The NMC sets standards of education, training and performance so that nurses can deliver high quality healthcare.

Care staff also completed the Care Certificate. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised. 30% of staff had completed level 2 Health and Social Care Certificate which is part of the Qualification and Credit Framework. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

Staff felt well supported by their colleagues and the new management team. Staff said there was good communication in the team and between staff with different roles. The provider told us before the inspection that supervision was provided to all staff within the service at least six times annually through individual, observational or group supervision. However, there was inconsistency in the frequency of supervision amongst the staff team. New staff had received regular one to one supervisions and observations, some staff had received no supervision and others said they had not been supervised for over five months. No one had received an annual appraisal within the last year. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. The manager told us senior staff were being trained in how to effectively supervise staff so supervision could be cascaded throughout the staff team. Once supervisions had commenced staff appraisals would be re-established.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in the best interests and as least restrictive as possible. Staff attended training on the principles of MCA during their induction and this was refreshed every three years. Staff had a basic understanding of the principles of the act but acknowledged they were not confident in this area and could benefit from additional training. They demonstrated that they understood people had capacity to make daily choices and decisions but sometimes they were not able to do so and made these in their best interests, such as what to wear or to eat. Staff gained people's consent and explained how they were going to support people before giving them their medicines and supporting them to eat. An Independent Mental Capacity Advocate had been involved in a best interest decision with regards to one person who was not taking medicines essential to their health, but had been assessed as not having the capacity to make this decision. People's wishes in relation to being resuscitated had been sought and comprehensively completed in consultation with the person and/or their relatives.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Applications had been made for those people who may be restricted in their freedom and these were incorporated into people's plans of care.

The environment was bright and well lit, but a similar colour scheme was used throughout most of the service so it was not easy for people to identify where they were. Some signage was available to direct

people to their rooms or toilets and bathrooms. Bathrooms were equipped with hoists and baths that people with mobility difficulties could use. People who liked to walk during the day were able to do so due to the design of the corridors. The service had plans in place to make the environment more suitable for people living with dementia. This included clearer signage, memory aids, tactile features and destination points based on specific themes. Destination points help people to orientate themselves and offer stimulation or a place to relax. Those planned included a waterfall feature and sports and babies area. A refurbishment programme was underway which included replacing carpets and plans were in place to make changes to the kitchenette areas so people could safely make their own drinks. Improvements had been made to the garden by painting the fence and introducing plants. Seating was available so people could sit and enjoy the area and finance had been sought to develop a small reminiscence garden.

Good

Is the service caring?

Our findings

People and their relatives said that staff were caring. One person told us, "Staff treat you like friends". A relative said, "The staff are all very nice. They always ensure they have time to talk to my family member". Another relative described how the caring nature of the service had had a positive impact on their family member. "I am so thrilled with the service as it has helped improve my family member's mental well-being as well as their physical health". People and relatives informed us that they were always treated with dignity and respect and gave examples of how staff always knocked on people's doors before entering and gave people privacy and space when supporting them with their personal care.

The service had received a number of compliments from relatives about the caring nature of the service. Comments included, "She was treated with such compassion, dignity and respect by the staff"; "Thank you for the care you gave and for making us feel welcome"; and "The nurses and support staff were very dedicated to patient care. There will always be challenges with multiple person care, but the staff worked in a professional and caring way to deliver to very diverse needs".

Staff showed concern for people's well-being in a caring and meaningful way and responded to people's needs. When people became agitated staff immediately approached them, gave verbal reassurances and stayed with them until they had calmed. When speaking with people they used physical touch to reassure them. When a staff member approached a person from behind so they could not see them, they touched their arm so they knew they were there. Another person took a staff members hand and they walked together and then sat down holding hands. When one person was not sure about opening their mouth to receive their medicines, the staff member used a kind, gentle approach to encourage them to do so. When people were reluctant to take their medicines, staff did not rush people, but explained the reasons why it was important for them to take them and returned to them later on.

Staff helped to make people feel they were valued. One person chatted to staff, explaining in detail a task they had undertaken in a previous work role. Staff listened attentively and responded that they were so knowledgeable in this area. Another person told staff about what they had been doing that morning and staff acknowledged that they had been very busy. When a person stroked a staff member's hair, the staff member thanked them for brushing their hair. People were treated with dignity and their privacy was respected. Staff knocked and waited to be invited into people's rooms. Where people needed support with using a bathroom this was done discreetly.

Staff listened to people and talked to them in an appropriate way so they could understand. They adjusted themselves so they were at the same level and maintained eye contact when speaking with people. They gave people time to express their wants and needs. Some people found it difficult to find the right word when talking to staff. Staff showed patience and understanding and advised people to take their time and did not rush them. Staff were guided by what people wanted to talk about and were skilled at changing swiftly from talking about the present to talking about the past.

Positive relationships had developed between people and regular staff members. They knew people's

preferences and personal histories and therefore were able to talk to them about things that were important to them. People valued these relationships. One person touched a staff member's shoulder when they saw them. Another person was sitting and talking to a staff member. The staff member smiled at the person and they smiled in response which resulted in both of them bursting into laughter.

People were supported to celebrate special events and to maintain relationships with people that mattered to them. Birthdays were celebrated with a cake and families and friends said they were able to visit when it was convenient to them. The service had taken part in National care home open day with a themed event based on Alice in Wonderland. A tea party was held and some people were involved in making cakes, dressing up and making hats. A summer BBQ was planned for people, staff and their families and also representatives from the local community.

Care plans in relation to people's future decisions included where they wished to spend their last days and their aims for a comfortable and dignified death. For people at the end of their lives, their choices and preferences had been sought, but they were not specific about their wishes and choices in their last days. Anticipatory medicine was in place for people coming to the end of their life to manage their symptoms and pain at the time it was needed. The service was in a pilot scheme with the local hospice whereby they informed the hospice of each person who had a life limiting condition. This meant people had immediate access to palliative care advice and support when they needed it and staff to relevant training and support.

Good

Is the service responsive?

Our findings

People and their relatives said staff responded when they asked them for assistance. "Staff come quickly. You only have to wait a few minutes when you call them", one person told us. A relative said, "If my family member calls or puts his hand up, staff always go over to him". People and their relatives said there were a range of activities on offer each day. "A guy and a lady bring these lovely little dogs that come in. I'm pleased when they come in you get to hold and stroke them", one person told us. Another person said, "They have fantastic quizzes here". A relative told us, "The activities have got better as there are a number of smaller events, which involve people and relatives so everyone can participate in them".

A structured programme was in place to deliver a range of activities to people in each unit on a daily basis. Activities were provided by two activity coordinators and a third activity coordinator was being employed. An activity champion had been assigned to each unit to oversee activities provided. Regular meetings took place with the activity coordinator and activity leads to discuss what had gone well and any challenges that people experienced on a particular unit. The head of activities had completed a 'ladder to the moon' programme and was rolling out these key principles to care staff. Ladder to the moon is an organisation which develops creative activities involving people living with dementia and staff in care settings. Activity coordinators also observed staff undertaking activities to assess their effectiveness and the ability of staff to deliver them. The activities on offer included balloon tennis, afternoon tea in the garden, quiz, pamper session and exercises. During the inspection a themed activity session took place around Hawaii. People were asked if they would like to wear a flower garland, given a colourful band to hold and took part in upper body exercises to Hawaiian music. 'Pets as therapy' dogs visited where people were able to stroke and pets dogs or to race against a dog turning a wheel. The activity coordinator chatted with people whilst discussing what they might want to buy from the mobile shop. The activity team were aware of which individuals preferred one to one activities and one to one sessions were included in the activity programme. These sessions were based on each individual's preferences. For example the activity coordinator explained how one person could not verbally communicate so they looked at photographs together. External sources of entertainment were also booked such as musicians.

Before people came to live at the service a member of the management team visited the person and their relatives where possible to make a joint assessment as to whether the service could meet their needs. People were also invited to visit the service and meet the staff team. Assessments included aspects of people's health, social and personal care needs including their mental well-being, mobility and nutrition. A plan of care was developed with each person, once they had moved to the service. This contained guidance for staff about the support people required in relation to their assessed needs. Where a need had been identified a plan was in place for staff about how to support the person. For example, one person had been assessed as usually sleeping well and that this was important to them as they could become irritable if they did not get enough sleep. Sometimes this person walked around the unit at night time and guidance was in place to offer milky drinks as this helped them relax and to ensure they knew the correct time, as sometimes they were not able to recognise it was bed time.

People's changing needs were monitored and observed by staff on a daily based and a record was made in

their daily notes. The service operated a 'resident of the day' system whereby one person's care record in relation to all aspects of their care was reviewed to ensure it was up to date. A keyworker system was in place so each person was allocated a staff member as their main point of contact. Most relatives and people said they did not know who their keyworker was, but their name was written on some people's bedroom doors. Relatives said they used to be invited to care review meetings about their family member's care on a regular basis and these were being re-established.

The service had recognised that life histories were important in providing people with care which met their choices and preferences. The service had written to each person's relatives to ask them to provide them with this information, where it had been omitted at the admission stage. This included where people grew up, people who were important to them, their likes and dislikes, how they liked to spend their time and any triggers to mood change

Staff supported people's needs in relation to their faith. The local church provided a monthly service for people at the service and individual spiritual support was also available.

People knew how to raise a concern or complaint and felt comfortable doing so. "If I had any concerns I would talk to any of the carers", one person told us. Another person said, "There were problems with an agency staff been rude and abrupt, but we moaned about them and they stopped coming here". A relative commented, "There are issues time from time, but they are all resolvable".

Information about how to make a complaint was displayed throughout the service. The service had a complaint, suggestions and compliments policy which set out that complaints could be made verbally or in writing and the timescales for response. It included the right for people to direct their concerns to the Ombudsman if they were not satisfied with the way the service had handled their complaint. Also contained were the contact details of the local authority and clinical commissioning group for people funded by these organisations. A record was kept of each complaint with the details, actions and progress of the complaint investigation.

Requires Improvement

Is the service well-led?

Our findings

The majority of people and their relatives were positive about people's experiences at the service. Comments included, "I don't think anything needs changing. The staff and nurses are very nice"; "It's great. People come here and say it's beautiful''; and "Management do listen. There is a new manager here and all staff members are very accessible with lots of communication. The last relative meeting was very open". A health care professional said the manager was quick at taking action when it was required. A commissioner of the service told us they had not received any concerns about the service from visiting professionals or relatives.

The service had introduced a new computerised care planning system to improve the accuracy of record keeping. Care staff recorded information about all aspects of a person's care on a hand held computer at the point of delivery. A clear picture of the care that had been provided to each person, at what times and by which member of staff could also be accessed on the main computer. However, there were inconsistencies in staff's abilities in accessing the information they required in order to monitor people's care. Some shift leaders and nurses did not know how to log onto the system to review records but others were very competent and could access quickly the detailed information they required. Shift leaders told us that some agency nurses did not know how to use the system so they had to input any information for them which was time consuming and could lead to inaccuracies. Senior staff needed to access this information daily in order to ensure people's care needs were met such as ensuring people had received sufficient food and fluids and to identify any increases or decreases in their weight. Health professionals confirmed some senior staff were not able to give them the information they required in order to monitor people's health.

Some records in respect of people's care and treatment were not accurate which meant that people may not receive the support and treatment they required to meet their needs. One person's care plan stated they were happily married and had not experienced any losses, but staff said their partner had passed away and they were devastated. For two people who required staff to move them regularly to maintain healthy skin there were inconsistences in their records. One person's mobility plan stated they should be turned 2 hourly, which contradicted their care plan which stated they should be turned 4 hourly. Staff confirmed their care plan was the accurate record. For the second person there were no notes about assisting the person to move at regular checks. Staff said this person continuously refused to be moved, but this had not been recorded as advised in their plan of care. Records did not evidence a person's urinary catheter had been washed three times a day in accordance with guidance in their care plan. Staff said this was no longer necessary, but their care plan had not been updated to reflect this.

The provider had not ensured people's records in respect of their care and treatment were accurate or accessible. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A new management team was in place which consisted of the manager and deputy manager. They were passionate about their roles, had a visible present in the service and were assessable. They had taken actions to make improvements to the service and had identified further areas of development which

benefited people. They were supported by a new operations manager. Staff told us there had been a significant improvement in staff morale and culture since these changes. They said the management team had an open door policy, they were regularly consulted about their views and these were listened to and acted on. Comments included, "I would go to the manager for anything. She and the deputy are both regularly on the floor chatting to residents"; "The manager encouraged me to change roles and I love the new challenge"; and "The management is so supportive both personally and professionally".

A range of meetings were held to aid communication in the service and ensure people's needs were being met. These included head of department meetings, clinical meetings with nursing staff and general staff meetings. Staff said these meetings were useful as they were able to share information and gain advice and support. At the last staff meeting in June 2017 there was a balance between guiding staff in areas they could improve and positive feedback on areas in which they had done well. For example, staff had been praised for taking part in a piece of work to create a seascape using art and craft on each unit. One unit had won the overall competition and staff told us how proud they were of this achievement. A staff award scheme was in place to recognise staff contributions to people's care and support. Nominations were made by people, relatives, staff and visitors for a 'Rising Star' and 'Carer of the Month'. At the end of the year an award and prize was given to the staff member who had received each award on the most occasions. The awards were on display in reception for everyone to see.

The aims of the service as posted on the provider's website were, "To offer residents the highest possible quality of life while providing them with an exceptional standard of residential, respite and nursing care". Not all staff fully understood these principles and how to put them into practice on a daily basis for the benefit of people. For example, staff did not always have time to sit and talk to people and one staff member gave a person living with dementia too many choices which resulted in them responding to staff that they were confused.

A programme of audits and checks were in place to monitor the quality of service delivery. Audits included fluid charts, pressure mattresses, medicines, infection control, accidents and incidents, care plans, complaints, call bell responses and staff training and supervision. The manager also carried out direct observation of care by daily walks around the service and unannounced visits at night time. The operations manager undertook monthly provider visits. These had changed to a new format and were based on the Commissions key lines of enquiry. As a result they had been more effective in identifying shortfalls in areas where previously they had not been raised. For example, that people needed to be assessed in regards to whether they were being deprived of their liberty and that the supervision and training matrix was out of date. Where areas for development had been highlighted an action plan was in place which identified the key people responsible for making the necessary changes and the timescales required. For example, some people with diabetes had not had their blood sugar levels monitored regularly and key staff had been identified to complete this task and monitor it had been actioned.

Relative meetings had been re-introduced to gain the views of people at the service. The last meeting had been held in June 2017 and two further meetings were booked for later in the year. At the last meeting people had discussed equipment, how to improve the dining experience and plans to recruit a clinical nurse lead to oversee the service. A monthly newsletter was sent to relatives to keep them up to date with what was happening at the service and any changes.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements. We found the provider had conspicuously displayed their rating in the reception area and on their website.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration and recording of medicines did not always ensure people were given their medicines as directed by their doctor. Regulation 12 (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People's care and treatment records were not all accurate, nor could all staff access them to ensure people received the care they required. Regulation 17 (2) (c)