Woodland Healthcare Limited

Mr 'C's

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Mr 'C's is a 'care home', operated by Woodland Healthcare Limited. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Mr 'C's is currently registered to provide accommodation for people requiring both nursing and personal care. However, during 2018 the service began making changes and has ceased providing nursing care for a trial period. People who needed nursing care left the service and so the service no longer had registered nurses working at the service at the time of the inspection. Any nursing needs people may develop were met by the community nursing teams. At the time of the inspection 28 people were living at the service, some on a permanent basis, others were there for short stay respite care, or intermediate care between a period of hospital care and returning home.,

People living at Mr 'C's were mainly older people, most living with physical health conditions associated with older age, or mental ill health. Some people had limited care needs but were awaiting changes to their accommodation or needing support during the ill health of their carer. The service accommodates up to 40 people in one adapted building, set over four floors, but we were told they were not intending to take over 29 people at the present time.

At the last inspection in August 2017, Mr 'C's was rated as requires improvement overall and in the key questions of safe and well led. Key questions for effective, caring and responsive were rated as good.

On this inspection we have rated the service as good overall, but with requires improvement in the key question of safe. This was because we identified some areas of concern about the medicines systems in use and the management of urinary catheters. Between the inspection visits the service changed the way they managed medicines. We have recommended they arrange for an early audit of the new systems to ensure they meet safe standards and good practice. We also saw the service had taken immediate action in the meantime to reduce risks.

The home had a registered manager. 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. Since the last inspection the service's management structure had been strengthened by the appointment of two managers at the service - one looking at the management of the environment and the other looking at people's care. People living at the service and staff were clear about who was 'in charge', and told us they were approachable and supportive.

Systems were being operated to assess, monitor and improve the quality and safety of the services provided, and mitigate the risks to people from their care or the environment. Assessments including those provided through the trusted assessor scheme or intermediate care professionals identified risks to people

and how they could be reduced. For example, from skin damage, long term health conditions or choking. Staff were aware of the principles of safeguarding people from abuse and how to report concerns about people's well-being.

Mr 'C's was continuing to develop the services and care provided. Some people stayed at the service for only 24 hours, while others were there for longer periods of intermediate care following a hospital admission. Advice on good practice was sought and visiting professionals including those from the intermediate care team told us the service communicated with them well, and followed their advice to support people's needs. We heard examples of where people had improved and returned home following a supported stay at the service.

People were supported by sufficient numbers of staff on duty to meet their needs. A full recruitment process was in place which ensured staff were recruited safely. This included the taking up of disclosure and barring service (police) checks, previous employment references, and assessments of risk where some information was not available.

People were supported by staff whose training needs were assessed both individually and as a group. Where there were shortfalls in learning or skills due to staff changes, action plans were in place to ensure learning needs were met.

People's rights with regard to the Mental Capacity Act 2005 and under equality legislation were respected. Staff had received training in the Mental Capacity Act 2005 and applications had been made under the Deprivation of Liberty Safeguards (DoLS) where appropriate to deprive people of their liberty, although none had yet been authorised due to delays at the local authority.

Systems were in place for the management of complaints, including seeking external reviews of improvements needed, and people's views on the service were sought through a series of questionnaires. We have made a recommendation about improving the quality of the questionnaires in use and providing additional information on the complaints form. Mr 'C's management team learned from incidents and accidents, which were analysed and audited to see if a repetition could be avoided; actions were taken where identified.

Activities were provided each day. Visitors were welcome to visit at any time and have a continuing involvement in their relations care if they wished.

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.

Medicines practice was not consistently safe, and some prescribing practice had not been clear. We have made a recommendation about auditing medicines practice.

Risks associated with people's care and the management of long term health conditions were assessed, and actions taken to mitigate risks.

Good practice in relation to the management of urinary catheters was not well understood by all staff. We have made a recommendation about this.

People lived in a safe environment.

Enough safely recruited staff were on duty to meet people's needs.

Is the service effective?

Good

The service remained effective.

Is the service caring?

Good

The service remained caring.

Is the service responsive?

Good

The service remained responsive.

Is the service well-led?

Good

The service was well led.

The service's management structure had been strengthened since the last inspection and roles were well understood.

People's views on the service were sought and acted upon. We have made a recommendation about improving this communication.

People benefited because audits were being carried out and regular monitoring systems were in place from staff wellbeing to the foods served to people.

Notifications had been made as required to the Care Quality Commission about events at the service.

Mr 'C's

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 was 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 7, 8 and 17 January 2019 and was unannounced for the first visit. The inspection started at 06:55am to allow us to meet with the night staff team, be present at the staff handover and see how duties were allocated for the day. The inspection team consisted of one adult social care inspector and a specialist advisor, with experience of medicines management and healthcare environments.

Prior to the inspection we reviewed the information we held about the service and the notifications we had received. A notification is information about important events, which the service is required by law to send us. The registered manager completed a PIR or provider information return. This form asked the registered manager to give us some key information about the service, what the service did well and improvements they planned to make.

During the inspection we spoke with or spent time with nine people who lived at the service. We met with the registered manager, the head of care, deputy manager, three relatives, the activities organiser, a cleaner and laundry person, maintenance person, administrator and seven members of care support staff. We also spoke with a visiting Registered Mental Health Nurse, a community care worker, and visiting podiatrist. Prior to the inspection we received feedback from the local authority quality improvement team who meet with the service monthly to discuss any issues and develop practice.

We looked at the care records for five people with a range of needs and sampled other records. These records included care and support plans, risk assessments, health records, medicine profiles and daily notes. We looked at records relating to the service and the running of the service. These included policies and procedures, records relating to the management of medicines, accidents, staff training, moving and positioning, nutrition and fluid support, food, complaints and health and safety checks on the building. We looked at three staff files, which included information about their recruitment and training records.

Following the inspection, the registered manager sent us some additional documentation we had asked for.

Requires Improvement

Is the service safe?

Our findings

On our last inspection in 2017 we rated this key question as requires improvement. On this inspection we have again rated the key question as requires improvement.

Following the changes made to the service, assessments had been made of new risks to people's care. For example, the registered manager had told us they would refuse to admit new people after 5pm, due to the risks of not being able to access and update themselves on the person's needs with professionals supporting their care. This could include information about the medicines people were taking, or other risks associated with health conditions.

People told us they felt safe at the service. One person told us they had "not a worry in the world" and a relative told us "I can go home at night and sleep decently knowing he is looked after."

At the time of the inspection the service was changing the way they managed people's medicines. People's medicines had previously been stored in lockable storage in each person's room. Because of the significant number of admissions and discharges to the service Mr 'C's was returning to storing all medicines centrally, with the exception of people who had been risk assessed as being safe to manage their own medicines. This was in line with discussions held with the local authority, and was aimed at reducing the risks of errors, and ensuring all medicines were managed safely.

We identified some potential risks in relation to the way people's medicines were being managed, some of which were due to unclear prescribing practice outside of the service. We did not find evidence that anyone had suffered harm as a result and the service took immediate action to address the concerns. For example, we identified that medicines such as antibiotics were not always being given at evenly spaced time periods throughout the day, for example at eight hourly intervals when prescribed for three times a day. This could mean they were less effective at fighting infections. Immediate action was taken to address this and a new record implemented to ensure this happened. Two different types of prescribed thickeners were in use and guidance was needed to ensure the correct thickness was being achieved to support people with swallowing difficulties and at risk of choking. This was immediately put into place and on display in storage areas for this medicine to remind staff, as prescribing labels just indicated "as directed". The service contacted the prescribing GP practice and pharmacy to clarify the prescriptions and discuss future prescribing guidance.

We found an instance where a medication administration record or MAR had not been signed by two staff when there were handwritten changes, which could also lead to an increased risk of error. This was immediately addressed. There was also no structured plan for assessing the effectiveness of pain relief after this had been administered where there were variable dosages prescribed. One person was to have their pain relief reviewed as they told us they did not always receive sufficient relief from their current medicines which they had been on for many years, and there was some variance in administration between staff. This was addressed with staff, and a new system put in place to give the person more control over their pain management regime pending their review while we were at the service. This was good practice. On our final

visit we saw this was working well. Staff could tell us how people who had difficulties communicating verbally would identify they were still in pain, and told us they would arrange for reviews of their pain relief.

Some prescribing for 'as required' medicines was not clear, for example one person's eye drops had been dispensed to administer "to the affected eye". This was addressed with the supplying pharmacy and GP practice. Clarity in prescription guidance is of increased significance in this service as people may be coming to the service frequently at short notice or from hospital where their familiar medicines may have changed.

The service was carrying out their own internal medicines audits, but these had been aimed at ensuring stock control rather than consistency in administration practice. Other checks of practice such as staff administration competencies were being introduced following the recent training of staff in medicines administration. The service had organised with their supplying pharmacy for a full audit to be carried out of the new system, being introduced while we were at the service. A previous full audit by the Trust had been scheduled but cancelled, and the service were rescheduling. They also told us they would be contacting their link person from the quality improvement team for support and advice on a new audit tool.

We recommend the service ensures the rapid audit of the new medicines management systems and implements guidance on good practice identified as a result.

We saw good practice in relation to the management and application of creams and lotions, with the use of body maps and clear guidance for staff on when and where they were to be applied. Pain relief patches were clearly recorded in people's notes, along with dates they needed to be changed.

Infection control practices overall were well understood, but we identified some concerns in the way the service was manging urinary catheters, and in particular night bags. There was not consistent clear guidance in place for staff on the management of these, which we found being stored in people's baths for later repeated use. Urinary catheters run a high risk of causing sepsis if not properly managed. We found the home had audited themselves on urinary tract infections and none had been identified, which told us people had not suffered harm because of the practices in place, but there was a potential risk of increased infection if best practice was not followed. The service immediately arranged for updated training to be provided to staff and made sure risks were reduced by night bags being for single use only until this had been provided. One person managed their own catheter with advice from and under the supervision of their GP practice nurses.

We recommend the service seeks and implements current best practice advice and guidance on the safe management of urinary catheters.

Care and support plans were being reviewed in conjunction with Care Trust, with an aim to reduce the duplication in paperwork. Risks to people from their care or the management of long term health conditions was reduced because risks and actions taken to mitigate them were identified through their care plans. For example, one person was living with diabetes. The person's care plan included a clear care support plan and risk assessment in relation to the management of this condition. Another person had previously been known to have minor seizures. Their care plan contained information about how these impacted on the person and what actions staff were to take in case of an escalation in their symptoms. Some records guiding staff on how to manage health conditions would in some instances have benefitted from additional detail, and the registered manager told us this was happening as a part of the care planning reviews.

One person was living with early Parkinson's disease. Their care and support plan contained information about the condition including potential risks, and information on how staff could support the person when

they were experiencing symptoms. The person told us how they were happy with the way they were supported by the service and monitored by specialist teams at the local hospital. We saw the service had approached the specialist team for advice and overall training for staff in the condition. They were working with the person to develop ways to manage their symptoms that met their wishes. Other assessments were in place for reducing risks from pressure damage to skin, poor nutrition or falls. One person was assessed as being at risk of choking. We saw their care plan contained detailed information from the speech and language service on how to support the person to eat safely. We saw this was carried out by staff.

Risks to people from the environment were being well managed. Mr 'C's is an adapted and extended period property, and has been registered for many years. Regular audits were carried out for health and safety, call bell soundings and fire precautions., which had identified the call bell system needed updating. This was due to happen in the coming months. Water temperatures were restricted, window openings restricted and hot surfaces protected. We saw one area of the ceiling had suffered water damage and was about to be replaced. During the inspection we saw and heard staff reporting minor areas needing attention by the service's maintenance person, which were quickly being attended to. Some people living at the service were smokers. The service had risk assessments in place for smoking, and were revising these in view of recently issued guidance. Equipment was regularly serviced and where people needed this each person had an individual sling to help them be supported to move with a hoist.

People were protected from abuse because the service had systems in place to identify, report and prevent abuse. Policies and procedures were available to identify what constituted abuse and how to raise concerns about people's welfare. Staff were clear about the need to raise concerns about any potential abuse, and told us they would do so. Information about whistleblowing was on display. We discussed with the service safeguarding concerns or issues that had arisen during the last year where action had been taken or learning taken place. These were also reviewed with the local quality improvement team at monthly meetings.

The service learned from incidents and accidents. Numbers of falls had decreased in the months prior to the inspection where people being admitted had less complex needs. Any falls were reported to the local authority falls team. The registered manager told us that any issues were picked up quickly by GPs and referred to visiting professionals.

Staff had access to personal protective equipment such as gloves and aprons and we saw these being used throughout the inspection when providing care. Staff wore blue aprons when serving food or entering the kitchen areas. The service was clean and free from odours. Personal laundry was managed internally, with sheets and towels provided on a contract basis. One person told us sometimes things got lost in the laundry system. We spoke with the person who managed the laundry systems at the service. They told us about changes being made to staffing practices and the laundry to reduce this happening.

There were sufficient numbers of suitably qualified and experienced staff to meet people's needs. A senior staff member such as the care manager, or a team leader was always on duty and the registered manager told us they were always available for advice and support. Their phone number was available directly to staff in case of emergency. During the day there were five care staff in the morning, four in the afternoon and two waking night staff, for 28 people, supported by cleaning, catering, maintenance and laundry staff. Some of these people had very limited need for physical support or were substantially self-caring. The service had an assessment tool in place to identify the numbers of staff needed on duty, based on people's needs. Staff told us the service was busy, but they enjoyed this and felt there were enough staff. The registered manager told us they had flexibility to bring in additional staff at any time if needed, and could demonstrate where this had recently happened. A relative said there were "always staff around, and they are always popping in".

The service continued to operate safe recruitment procedures. The three staff files we reviewed showed evidence safe recruitment procedures were in place. This included the taking up of disclosure and barring service (police) checks and previous employment references. The registered manager told us that there were no staff requiring 'reasonable adjustments' to be made to their working conditions because of disability or other protected characteristics under the Equality Act 2010. This is legislation that protects staff from discrimination in the workplace and in wider society.

Good

Is the service effective?

Our findings

On our last inspection we rated this key question as Good. On his inspection we found this had been sustained and the service was again rated as good.

On the previous inspection of Mr 'C's in August 2017 the service was providing nursing care and had registered nurses employed in the staffing team. At the time of this inspection the service told us they were not providing nursing care as part of a trial and was therefore not employing registered nurses. They told us they would do so if they had any people living at the service needing nursing care.

Staff told us the service placed a high priority on training and they were 'always doing training courses'. We found some staff did not always have the skills and experience they needed to support people. For example, we identified people living with conditions staff had not received any training in supporting, for example early Parkinson's disease or catheter care. We did not see this had impacted on people's care and support. The service told us they had been trying to access specialist training in Parkinson's support, and recent catheter care training had been provided in September 2018. Updates and additional new training for staff was booked for January 2019. A senior staff member told us "It's great, we can always get advice from visiting staff and nurses." Each staff member had a training matrix and there was an overall matrix for the service. Each staff member also had a personal development plan and training needs analysis which covered updates they needed regarding their skills and training. New staff would be supported to undertake the care certificate, which is a national qualification for Induction standards in care. Staff had undertaken NVQ levels 2 and 3 and there was an overall annual training plan for the service.

Good practice guidance states that staff administering medicines in care homes receive an annual update and competency assessment. The service had assessed the training previously undertaken by staff and found this had not addressed all the areas needed, for example the administration of medicines as eye drops. They had sourced a new medicines training package which staff administering medicines had completed. Competency assessments were due to be undertaken before these staff were able to administer medicines safely, and we were told these would be undertaken yearly as a minimum in line with good practice.

We found, and the service sought additional expert or professional experience when needed, for example from visiting district nurses or mental health professionals. As a result of providing intermediate care the service was visited daily by community support services such as physiotherapists and nurses which meant they could rapidly seek any advice needed. Staff received regular supervision to discuss any areas of difficulty or identify training needs. Staff told us they felt well supported and worked well as a team. One staff member said "It's a good staff team. It's a good place to work" and another told us "Everyone helps everyone else out."

Assessments carried out before people moved to the service identified if the home could meet people's needs and if they would be likely to be compatible with people already living there. The service contacted people's GPs and other healthcare professionals at the point of admission to ensure they had an up to date

list of medicines the person was taking, and had a clear understanding of people's needs. The registered manager told us they insisted on this even if it meant the person's discharge from hospital might be delayed. On the second day of the inspection they had been referred two new people. The registered manager told us they would be going to the hospital to assess one person as they wanted more information than had been provided on the initial referral and 'Trusted' assessment. 'Trusted Assessor' schemes are a national initiative designed to reduce delays when people are ready for discharge from hospital. It is based on providers adopting assessments carried out by suitably qualified 'Trusted Assessors' working under a formal, written agreement.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had received and understood training in the MCA, and we saw good practice in place in relation to its implementation. For example, we saw people being asked about choices and having their wishes recorded and acted upon. One staff member told us they understood people "have capacity until deemed not to", and told us what this meant in practice. Where people lacked capacity, the service had undertaken a two stage capacity assessment process, and recorded where decisions were being made in people's best interests. Staff could tell us about how they would support people to communicate their choices - for example for one person they would understand the person would roll their eyes and move their face away if they did not want to get up. Staff would then make them comfortable and return later to see if they were ready.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguarding (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. The service had made applications for authorisations to deprive people of their liberty to maintain their safety, but none had yet been authorised, due to delays at the local authority.

People told us the meals were good and they ate well. One person told us they could have whatever they liked for their breakfast "from a full English to sausages and poached eggs on toast" and "They'll make you a cup of tea anytime." We heard of people having meals and snacks at differing times of the day to suit their wishes. Specialist diets were provided, such as for people with swallowing difficulties. The service had a rolling menu plan, to which people were asked to contribute their suggestions.

Mr 'C's is a large period building set in a central position in Torquay. The service was set over four floors, with passenger lifts to access all areas. On this inspection one bathroom was out of action and was due to be remodelled as a wet room. We were assured people could use the bathing facilities on other floors if needed. Some rooms had en-suite baths and toilets, but not all of these would have been accessible to some mobile hoists. Communal areas were on the ground and first floors. The service also had a salon for hairdressing and a dedicated quiet lounge where people could spend time.

Good

Is the service caring?

Our findings

On our last inspection we rated this key question as Good. On his inspection we found this had been sustained and the service was again rated as good. All the care we saw, observed or overheard was kind, gentle and empathetic.

People told us they were satisfied with the services provided by the home. People told us staff were friendly and supportive. People made comments such as "I call them flowers – they are all good to me- like family" and "I don't know what I'd do without them." One person told us they had initially felt a little patronised by staff but they had a discussion with them and this was soon remedied. They told us they now felt they were treated much more respectfully and could enjoy a more equal relationship, with teasing and affectionate relationships in place. For example, we saw one person had been out with staff during the morning to go shopping. They had bought chocolate which they took pleasure in sharing with the staff on duty. We saw lots of positive support and humour in evidence during the inspection.

We saw many examples of staff providing caring emotional support to people. For example, one person was missing their spouse. The registered manager enabled the person to use a phone based video link to speak with them, and see they were being supported and were not distressed themselves. This helped give them comfort and re-assurance.

We heard evidence of people on respite or short-term care building positive relationships amongst themselves and with some people there for longer term care. Some people were awaiting assessments for long term accommodation elsewhere and needed support and assistance until this happened. Staff and people told us about how some of these people gathered together in the evenings in the lounges for what they called the 'midnight club', despite having very different needs and diagnoses. For example, the night staff told us the night before the first inspection day a small group of people had been up until the early hours of the morning eating quiche and pasties, watching TV together and socialising. Two people who had been a part of the group were still engaged in banter and gentle humour the next day concerning football results and their respective teams. One person told us "there is not one person here you could say is horrible." A visiting healthcare professional told us "We get generally good feedback from ex-residents who have been here."

We saw staff supporting people in ways that maintained their dignity. Audits were carried out to ensure staff respected people's dignity, for example whether people's bedroom doors were left open for no reason. We heard staff speaking positively to and about people they were supporting. We also saw and heard of positive practice when people left the service, where the registered manager told us people being discharged were given a small package of provisions such as sandwiches, cake, milk and tea to help in case other services had not managed to provide this. One person told us they had been to the service before and were back again while their carer was having an operation. They told us they were quite happy to return as "they knew what it was like."

Staff knew people well. They could tell us information about people and their life history, people who were

important to them and how they liked to be supported. For example, one staff member told us about a person they had got up that morning. They told us how the person liked to be supported to dress and put on makeup, and co-ordinated clothing. They were clear about what the person could do and wanted to do for themselves to maintain their independence. They told us the person would tell staff what days they wanted to be showered, and how they liked their nails painted.

Visitors were welcomed to the home at any time, and the registered manager told us they could stay at the service if their relation was near the end of their life, providing comfort to both parties. The registered manager told us about a recent example of this, which had proved to be a positive support. A dedicated room was set aside for family members use. We saw a file of thank you cards from people whose families had received support from the service.

The registered manager told us the service was open to people of all faiths or none, and they would not discriminate against people protected under the characteristics of the Equality Act. This is legislation that protects people from discrimination, for example on the grounds of disability, sexual orientation, race or gender. We did not identify any concerns over discriminatory practices, but discussed with the service making this more widely known. The service took immediate action to display information about their anti-discriminatory practice, in particular with regard to sexuality and gender.

Good

Is the service responsive?

Our findings

On our last inspection we rated this key question as Good. On his inspection we found this had been sustained and the service was again rated as good.

Since the last inspection there had been a significant change in the needs of the people living at Mr 'C's. Each person had a care plan that described their care needs and guided staff in the delivery of care and support to people. We saw the service was in talks with the local authority team to link their care planning tools to avoid duplication and reduce risks of people' needs being missed. At the time of the inspection the service was operating two related care planning tools. One was for short stay people with less complex needs. For example, while we were inspecting the service a person was admitted and then discharged the next day. Their care support plan was proportionate, based on an initial assessment but comprising mainly a tick box list with information supplied on their needs, medicines and reasons for their admission. Risk assessments and fire evacuation plans were updated for each new admission. For longer term or permanent people care plans were more extensive. We identified some areas where plans would benefit from additional information, and the registered manager told us this was being addressed as a part of the review.

Care plans and assessments were reviewed regularly with the person and/or their relatives as appropriate. Plans guided staff on how to assist people with moving and positioning, supporting their mental well-being (including avoiding the risks of social isolation) and maintaining personal hygiene. Information about people was used to support and understand their care. For example, where people had histories that involved addiction or significant mental health needs agreements with the person were in place to help the service keep them safe and understand where they were when they had left the premises. Plans were in place to help staff understand and manage inappropriate conversations or topics where needed.

We saw people were given support in accordance with their care plan. For example, one person's plan identified a life history where their previous work had meant they were up early each day. Now the person made choices not to get up before 11am. Staff understood this and made sure the person was not disturbed until they wanted to get up. Another person enjoyed going out of the service very early to collect their papers from a local shop. One person told us they chose to spend time in their room rather than be in communal areas. Staff bought them their meals and spent time with them as they wanted on a one to one basis. Professional support from community teams had led to enhancements to people's health and wellbeing. For example, we heard one resident's mobility had increased greatly with regular physio support, and they had progressed from being 'bed bound' on admission to now walking with a frame. Another person who had a diabetic ulcer was healing well.

All providers of NHS and publicly funded adult social care must follow the Accessible Information Standard. The Accessible Information Standard applies to people who have information or communication needs relating to a disability, impairment or sensory loss. We looked at how the home shared information with people to support their rights and help them with decisions and choices. People's communication needs were understood and included in their care plans. For example, one person had some hearing and sight loss. The planned changes to the call bell system were to take this into account, to ensure appropriate

systems were in place to help the person summon assistance. Where people were not able to use a call bell additional checks were put into place. Information could be provided in larger fonts or shared verbally when people needed this. Discussion was held on placing a copy of the 'service users guide' in each room for intermediate care so people could better understand the choices available to them at the service.

The service had planned activities available for people throughout the week, and a programme was on display in the hallway. The service had an activities co-ordinator who spent time with people individually as well as organising group activities. For example, on the second day of the inspection one person had been supported to go shopping and have a coffee out as that was what they enjoyed doing. They told us they had greatly enjoyed this. Another person told us how they enjoyed music sessions. Other recent activities had included a pantomime, visiting entertainment, an exercise group, reading groups, musical afternoons, bingo, films, carol singing, and cake decorating. When they were not available visiting activities came to the service, for example pet therapy services, art and craft sessions and musical entertainment. People's care files contained information about their hobbies and interests.

At the time of the inspection no-one was receiving end of life care. However, one person had been prescribed medicines in advance of a physical decline, to ensure they were available in the case of a sudden deterioration. The person had since made some recovery. Senior staff had received training in supporting people at the end of their life and ensuring their needs and wishes were known and implemented through the local hospice. They told us this had helped them have more open conversations with people or their relations about any end of life care wishes.

The service had a complaints procedure that ensured complaints were listened to. This was on display in the service. People would also have access to the local authority complaints procedures if their stay at the service was funded. People and relatives told us they would feel able to raise any concerns or issues with the service's staff or management. One person told us "I know what to do, but I would tell (name of relative) who would sort it out for me. I wouldn't be afraid if that's what you mean." Complaints were audited to ensure any patterns or themes were identified and any issues were discussed with the local authority quality team who visited the service every month to review any issues and help develop practice. The registered provider had also commissioned a local independent complaints management person whose details were on the notice board. During the inspection we reviewed records about concerns that had been shared with us about the service, along with safeguarding issues that had been investigated. Where concerns had been identified, action plans were in place to improve practice.

We recommend the service adds onto their complaints form information about the Duty of Candour Regulation. This is legislation which ensures that where something has gone wrong people or their relatives are kept informed. This will help ensure there is a clear audit trail of where concerns have been discussed with people.

Good

Is the service well-led?

Our findings

On our last inspection in 2017 we had rated this key question as requires improvement. This was because although improvements had been made, some changes had not yet been embedded into practice. On this inspection we found improvements had continued and changes to the people using the service had reduced some of the risks associated with their care. Although this had introduced other risks the service was aware of them and taking steps to manage and reduce them.

The service had a series of audits to be carried out each month. Audits of incidents, falls, infections, dignity and respect and other care needs was carried out, and any actions identified taken as a result. The manager could tell us about how they were using the key lines of enquiry as used by the Care Quality Commission in assessing the quality of care. They were also supporting staff through meetings to understand quality issues were the responsibility of everyone at the service.

The registered manager told us they had been on a 'steep learning curve' since the changes to the service, and acknowledged there were areas that "still needed tweaking" to ensure best practice in every area. They were taking advice from sources including the quality improvement team, care trust, local hospice, local manager forums and training opportunities. Action plans were in progress to address issues identified, for example the installation of a wet room in a bathroom. The service told us they listened to feedback from the local authority quality team, who told us they did not have any significant concerns over the service and were working with them on developing best and shared practice. Where we had identified the service's auditing systems for medicines management had not been sufficiently thorough immediate action was taken. The service had already identified risks and was making changes to the overall system as a result. Concerns over the management of catheters had not been identified by the service previously, but they took immediate action to reduce risks and ensure training in best practice could take place. This was then being used to improve their internal auditing systems.

Feedback from visiting professionals we received was positive. They told us communication was improving, and shared records were leading to increased understanding of staff and visiting professionals' roles. One said "To be fair staff here are very approachable with a good handover to us. They are very honest - if they don't know they tell us. They constantly review and are always happy to discuss care…I have no concerns" and another said "Whenever I have been in it's good. (name of manager) tailors care to fit individual needs. I find it really positive here. It's a different environment from some of the homes I visit. It is especially good for younger people here."

The service had a registered manager in post, who managed both this and other local services for the same provider. This had been strengthened since the last inspection and they were supported at the service by two managers - one looking at the maintenance of the premises and another being head of care. People and staff told us the managers were approachable, kind and good at their job. One person said "(Names of managers) are good as gold" and a staff member told us "(name of manager) is lovely. Any questions I can go to her." Staff completed wellbeing surveys and questionnaires about their wok to help make improvements or identify any concerns.

The head of care told us the service was aiming for a culture and "Care service that is person centred to the individual's needs - their personality cultural beliefs, background, non-discriminatory." They acknowledged the challenges they had experienced in the transition from a traditional nursing home service and said "We would hope staff say we are supportive. We aim to provide a service that is person centred to the individual, and helping people to be respected."

Staff told us they had regular team meetings, worked well together and felt supported in their role. Staff understood their roles and lines of accountability were clear within the management structure. They also told us they worked well as a group, for example understanding childcare issues and the registered manager was understanding of the need to balance people's personal lives with their work. There had been a turnover of staff following the changes at the service in 2018 and the registered manager told us they now felt the staff working there were positive about the change in approach and differing needs. Staff we spoke with were enthusiastic about supporting people. A staff member told us "So many people need respite care, they come here to return to their baseline. They get their confidence back to being independent at home. Physio can come in each day but we can continue when they're not here."

People were encouraged to give their views about how well the service was working and what could be improved. This was carried out through a series of questionnaires, carried out regularly, but did not always capture the views of people on short stays or respite which might have occurred between cycles. The questionnaires used would have benefitted from review, for example to make questions more open, and the registered manager immediately assigned a senior staff member to do this.

We recommend the service ensures they seek the views of people using the service for short stay or intermediate care to help improve the quality and safety of the services provided.

The service had ensured notifications had appropriately been sent to the Care Quality Commission as required by law. These are records of incidents at the service, which the service is required to tell us about. The service' statement of purpose needed minor attention to reflect changes at the home. This was done while we were at the service and an updated version sent to us as a notification.