Bupa Care Homes (CFChomes) Limited

The Mellowes Care Home

Inspection report

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Tel: 01747826677

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13 November 2017

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

The inspection took place on 10 November and was unannounced. The inspection continued 13 November and was again unannounced.

The Mellowes is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates 40 people across two floors, each of which has separate adapted facilities.

Our last inspection on 10 and 11 May 2017 found that systems and processes were not in place to ensure robust assessing and monitoring of quality, safety and risks. We found that some people did not receive safe care and treatment. Staff did not receive regular supervision and appraisal. Risks were not assessed or mitigated effectively. People did not always receive personalised care and consent was not always sought. During this inspection we found that improvements had been made.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective, caring, responsive and well led to at least good. We found that during this inspection the action plan had been followed and improvements had been made.

The service had a registered manager in place. 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.

Risk assessments in relation to people's care and treatment were completed, regularly reviewed and up to date. However, risk assessments associated to activities inside and away from the service were not in place.

Specific care plans were not completed to reduce the risk of infections and guidelines to include the use of some personal protective equipment was not always in place. The registered manager told us that this would be completed as a priority.

People, relatives, a health professionals and staff told us that the service was safe. Safeguarding alerts were being managed and lessons learnt by the home. Professionals confirmed that improvements had been made. Staff were able to tell us how they would report and recognise signs of abuse and had received training in safeguarding.

Care plans were in place which detailed the care and support people needed to remain safe whilst having control and making choices about their lives. Each person had a care plan and associated files which

included guidelines to make sure staff supported people in a way they preferred.

Medicines were managed safely, securely stored, correctly recorded and only administered by on duty nurses and team leaders that were trained and assessed as competent to give medicines.

Staff had a good knowledge of people's support needs and received regular local mandatory training as well as training in response to people's changing needs for example some people were receiving end of life care and staff had been trained in this area.

Staff told us they received regular supervisions which were carried out by the management team. Staff told us that they found these useful. We reviewed records which confirmed this.

Staff were aware of the Mental Capacity Act and training records showed that they had received training in this. Capacity assessments were completed and best interest decisions recorded as and when appropriate.

People and relatives told us that the food was good. We reviewed the menu which showed that people were offered a variety of healthy meals. We saw that food was regularly discussed and recorded on food preference sheets. The chef told us that the majority of meals are home cooked.

People were supported to access healthcare appointments as and when required and staff followed professional's advice when supporting people with ongoing care needs. Records we reviewed showed that people had recently seen the GP, physiotherapist, mental health team and a chiropodist.

People told us that staff were caring. We observed positive interactions between staff, managers and people. This showed us that people felt comfortable with the staff supporting them.

Staff treated people in a dignified manner. Staff had a good understanding of people's likes, dislikes and interests. This meant that people were supported by staff who knew them well.

People had their care and support needs assessed before being admitted to the service and care packages reflected needs identified in these. We saw that these were regularly reviewed by the service with people, families and health professionals when available.

People were encouraged to feedback. We reviewed the resident's satisfaction survey results for 2016 which contained mainly positive feedback. Improvements had been made in activities in response to people's feedback.

There was an active system in place for recording complaints which captured the detail and evidenced steps taken to address them. The registered manager told us that lessons were learnt and shared with staff in meetings. This demonstrated that the service was open to people's comments and acted promptly when concerns were raised.

Staff had a good understanding of their roles and responsibilities. Information was shared with staff so that they had a good understanding of what was expected from them. Staff felt recognised and that team moral was good.

People and staff felt that the service was well led. The registered and service manager both encouraged an open working environment.

The service understood its reporting responsibilities to CQC and other regulatory bodies they provided information in a timely way.

Quality monitoring audits were completed by the registered manager and customer relationship manager. The management team analysed the detail and identified trends, actions and learning which was then shared as appropriate.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was mostly safe. People were not at a reduced risk of harm when participating in activities inside and away from the home because risk assessments were not in place.

Policies, systems and equipment were in place to minimise the risk of infection.

There were sufficient staff available to meet people's assessed care and support needs.

Staff had completed safeguarding adults training and were able to tell us how they would recognise and report abuse.

Medicines were managed safely, securely stored, correctly recorded and only administered by nurses and team leaders that were trained and competent to give medicines.

Lessons were learnt and improvements were made when things went wrong.

Is the service effective?

Good

The service was effective. People's needs and choices were assessed and effective systems were in place to deliver good care and treatment.

The service was acting in line with the requirements of the MCA.

Staff received training and supervision to give them the skills they needed to carry out their roles.

Staff were supported and given opportunities for additional training and personal development.

People were supported to eat and drink enough and dietary needs were met.

The service worked within and across other healthcare services to deliver effective care.

The premises met people's needs and they were able to access different areas of the home freely.

People were supported to access health care services and other professionals as and when required.

Is the service caring?

Good

The service was caring. People were supported by staff that treated them with kindness, respect and compassion.

Staff had a good understanding of the people they cared for and supported them in decisions about how they liked to live their lives.

People were supported by staff who respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive. People were supported by staff that used person centred approaches to deliver the care and support they required.

People were supported by staff that recognised and responded to their changing needs.

People were supported to access the community and take part in activities within the home.

A complaints procedure was in place. Relatives, professionals and people told us they felt able to raise concerns with staff and/or the management.

Resident meetings took place which provided an opportunity for people to feedback and be involved in changes.

People were support with end of life care. Preferences and choices were respected by staff.

Is the service well-led?

Good

The service was well led. The registered manager and customer experience manager promoted inclusion and encouraged an open working environment.

Staff received feedback from the management and felt

recognised for their work.

Quality monitoring systems were in place which ensured the management had a good oversight of service delivery

The home was led by a management team that was approachable and respected by the people, relatives and staff.

The home was continuously working to learn, improve and measure the delivery of care to people.

The Mellowes Care Home

Detailed findings

Background to this inspection

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

The inspection was prompted by a number of safeguarding alerts. The information shared with CQC about the alerts indicated potential concerns about the management of risk of catheter care, skin care, medicines, management culture and falls from beds. This inspection examined those risks. Alerts had been brought to the attention of the Local Authority.

This inspection site visit took place on 10 and 13 November 2017 and was unannounced. The inspection was carried out by one inspector, a specialist advisor and an expert by experience on day one and a single inspector on day two. The specialist adviser had clinical experience and expertise in care of older people, medicines and nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience related to older people, people with dementia and complaint investigation.

Before the inspection we reviewed all the information we held about the service. This included notifications the home had sent us. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We contacted the local quality assurance team to obtain their views about the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with six people who used the service and four relatives. We had telephone conversations with four health care professionals who had experience of working with the home. We had discussions with 10 staff including agency workers and the head chef.

We spoke with the registered manager, customer experience manager and regional director. We reviewed five people's care files, policies, risk assessments, health and safety records, consent to care and treatment, quality audits and the 2016 resident survey results. We observed staff interactions with people, a meal time and a heads of department meeting and a care staff handover. We looked at three staff files, the recruitment process, complaints, training, supervision and appraisal records.

We walked around the building and observed care practice and interaction between care staff and people who live there. We used the Short Observational Framework for Inspection (SOFI) at meal times and during activities. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the registered manager to send us information after the visit. This included policies and the staff training record. The registered manager agreed to submit this by Friday 18 November 2017 and did so via our national customer services centre (NCSC).

Good

Is the service safe?

Our findings

During our last inspection on 10 and 11 May 2017 we found that some people did not receive safe care and treatment. The provider was not doing all that was reasonably practicable to mitigate risks, or to ensure risk remained as low as reasonably possible. The provider had sent us an action plan detailing how improvements would take place by 30 November 2017. During this inspection we found that the home was working towards these improvements.

This inspection was prompted in part by a number of safeguarding alerts which indicated potential concerns about the management of risk of catheter care, skin care, medicines and falls from beds.
The service had a safeguarding policy in place which detailed definitions, preventative measures, the investigation process, key contacts and record keeping. Safeguarding alerts were recorded and actions from outcomes either completed or in progress. Advocate services were available to people and learning was shared in staff meetings. We spoke with four health professionals. Two of these told us that they had raised concerns and alerts before and that they had seen improvements made in response to these. Another health professional told us, "I've never had to raise a safeguarding alert and feel the people I have seen are safe". The fourth professional said, "People appear happy and safe. I haven't had to raise any safeguarding alerts at this home before". Each professional told us that they did not have any live safeguarding concerns.
Staff were able to tell us how they would recognise if someone was being abused. Staff told us that they would raise concerns with management. Staff were aware of external agencies they could contact if they had concerns including the local safeguarding team and Care Quality Commission. Staff told us that they had received safeguarding training and that it was regularly updated, training records confirmed this.

Risk assessments associated with activities for example, outings and nursery children visits to the home had not been completed. The activities coordinator told us that activities were not risk assessed. We discussed this with the registered manager and regional director who told us that activities away from the home should be risk assessed and that they will review other activities for example, the nursery children visits. We were shown that the recent firework display at the home had been risk assessed. The regional director told us that they would ensure all staff signed to say they have read assessments.

People were protected from the risk of infection. We observed staff regularly wearing Personal Protective Equipment (PPE) such as gloves and aprons throughout the two days of our inspection. There was a comprehensive infection control audit in place and up to date. We observed domestic staff regularly cleaning people's bedrooms and communal areas. Domestic staff worked around people and always asked if they could enter people's rooms to clean them. The home was free from offensive odours. An infection control policy was in place and regular audits took place.

Improvements in relation to risks had been made and staff were following procedures in place. For example, people at risk of dehydration had fluid levels recorded and were supported by staff. Three people were at risk of falling out of bed. Two people had consented to bed rails to reduce this risk and one person had been assessed for a low level bed with a padded slide mattress next to it. This reduced the risk of injury if the person was to roll off the bed and the slid sheet reduced any injury to the person when staff supported them

back into bed. Other risks to people's care and treatment were being managed and appropriate assessments were also completed. Care files identified people's individual risks, and detailed the control measures staff needed to follow to ensure risks were managed, and people were kept safe. For example, people had risk assessments for moving and handling, skin and catheter care, nutrition and falls. Staff were aware of people's risks and controls in place to protect them from harm. A nurse told us that risk assessments are regularly updated and in response to people's changing needs. Risk assessments we reviewed were up to date, securely stored in the nurse's office and available to relevant staff.

People had Personal Emergency Evacuation Plans in place. These plans detailed how people should be supported in the event of a fire. We reviewed the fire safety record which recorded regular fire alarm and equipment tests. A business continuity plan was in place for staff to follow should there be any type of emergency situation. Areas covered included; location of shut off valves, temporary accommodation and key contact numbers. Equipment was regularly serviced and maintained by the service. We noted that the hoists were last serviced at the beginning of November 2017 and that people had their own slings which were regularly checked.

People commented to us they felt safe living in The Mellowes Nursing Home. One person said, "I feel safe here, I have friends here. They all know me and I can walk around". A health professional said, "I think it is safe, I don't think people are at risk of harm". A relative told us, "Safe, yes. (family member) is on the first floor, there is security on the main door".

Staff told us that they believed the home was safe for those who lived there. One staff member said, "People are safe, staff are confident, communication is good, concerns are shared/handed over and people are cared for safely".

Recruitment was carried out safely. Checks were undertaken on staff suitability before they began working at the home. Checks included references, identification, employment history and criminal records checks with the Disclosure and Baring Service (DBS). The DBS checks people's criminal record history and their suitability to work with vulnerable people. Where gaps in employment history were apparent on the member of staff's application form, these gaps were explored and documented as part of the recruitment process.

Staffing numbers were calculated and worked out using a dependency tool. We reviewed four weeks of the rota which reflected the numbers given to us by the registered manager. Staff and the majority of relatives told us that there were enough staff. A relative told us that sometimes staff can seem busier at the weekend when it is quieter. A staff member told us, "I think there are enough staff. The management seem to manage to cover the home". Another staff member said, "We have enough staff. Bupa is different to some other companies. We always have enough staff based on the number of people". A person told us, "There are enough staff for me". This told us that the home promoted safety in recruitment to ensure there were sufficient numbers of suitable staff to support people. We received mixed feedback in relation to staff response times. Some people felt that staff responded promptly to call bells whilst some relatives felt that their loved ones had to wait for long periods of time. The registered manager told us that they carried out call bell response checks regularly. The log recorded location, date, time and type of alarm. We were told that where call systems had not been responded to within five minutes the management would investigate. We observed staff promptly responding to people's call bells on several occasions.

Improvements had been made at The Mellowes Nursing Home to make sure effective systems were in place to ensure proper and safe use of medicines. Daily, weekly and monthly audits were now completed. Medicines were stored securely and keys to medicine storage were held by authorised staff. Medicines were

only administered by trained nurses or trained team leaders who had been assessed as competent. People's medicines were signed as given and absent from the medicine packages indicating that they had been administered. Records were legible and complete. We identified two entries where a person had refused their medicines. Reasons were clearly recorded on the back of the chart but we found that there had been no attempt to administer the medicine a little later. The medicine was one that was required to be administered at regular times to reduce any symptomatic impact on the person. We reported this to the registered manager who identified the two different nurses' concerned and arranged supervision for both.

No one was receiving covert medicines. There was a clear comprehensive medicines policy in place which highlighted the requirement for discussion and best interest meeting with family, pharmacy and the importance of clear instructions for administration and review. This was in line with guidance and the mental capacity Act 2005.
Staff told us that they felt an open and transparent culture was promoted.

Staff felt able to raise concerns and report incidents and said that the management were supportive. The manager was able to give us examples of reviews of incidents and practice which had gone wrong and what the service had done in response. Professionals told us that they felt able to raise concerns and meet with the service to discuss these openly. Heads of Department meetings showed that lessons learnt were discussed.

Good

Is the service effective?

Our findings

Our previous inspection on 10 May 2017 found concerns relating to the need for consent and supervision The provider did not ensure people were consulted in regards to their care and treatment or that staff received appropriate on going and periodic supervision. The provider had sent us an action plan detailing how improvements would take place by 30 November 2017. During this inspection we found that the home was working towards these improvements.

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.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests and legally authorised under the MCA.

During this inspection we found that MCA and best interest paperwork had improved and was in place, complete and up to date. Capacity was assessed during pre-admission and where variable capacity had been identified. Best interest meetings involved relatives and other relevant parties. A relative told us, "My sister is involved in best interest meetings. We receive regular updates and are well in the picture regarding care. (Family member) is consulted regarding care. The staff explain discussions and decisions that have or will take place". Another relative said, "They always involve me in decisions and choices if my loved one can't". Applications for three people who required Deprivation of Liberty Safeguards (DOLs) had been completed, one of which had been authorised with no conditions and the other two were pending assessment by the local authority. People with DOLS and or variable capacity were discussed during weekly clinical risk meetings.

Staff were aware of the Mental Capacity Act and told us they had received MCA training. The training records we reviewed confirmed this. A staff member told us, "MCA is in place to protect people who lack capacity or are vulnerable to harm due to their condition". A person told us, "They (staff) do ask my permission. When I first came here I had to sign my consent to care". A health professional said, "Staff always seek consent from people before we deliver care".

Each floor had a nurses station which had an effective system for keeping log of key workers, assigned nurses, people who had DOLS and DNARs in place. A DNAR stands for do not attempt resuscitation (DNAR), and allow natural death. People who required positional changes and had any health professional appointments booked were also identified in the nurses stations. Staff knew where to find up to date information and were aware of people's needs.

We found that improvements had been made in relation to staff supervisions. New staff received regular probation review meetings and dates were set in advance by the administration team. These meetings gave

the new starter and registered manager an opportunity to reflect on the induction process, raise any concerns and discuss further learning required. Supervisors had been given a list of supervisees and a supervision tracker was in place for management overview. Supervisions took place bi-monthly and end of year appraisals were taking place. A staff member told us, "I receive regular supervisions. They are very useful. They help me".

The Mellowes Nursing Home provided staff with regular training which related to their roles and responsibilities. Staff were knowledgeable about people's needs, preferences and choices. We reviewed the training records which confirmed that staff had received training in topics such as health and safety, moving and assisting, infection control and prevention and first aid. We noted that staff were also offered training specific to the people they supported for example; mental health and dementia, fluids and nutrition and pressure ulcer care. A staff member told us, "There are good training opportunities and I have achieved my level 3 in health and social care". A person said, "Staff training, yes I think so. There is a mix of junior and senior staff. I have not seen anything that leads me to think they don't know what they're doing". A health professional told us, "Staff always come across competent within their roles".

There were five new staff starting their induction on day two of the inspection. There was a clear induction programme for new staff to follow which included shadow shifts and practical competency checks in line with the care certificate. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training.

Nursing staff were aware of their responsibilities and supported to re-validate with their professional body, the Nursing and Midwifery Council. Nurse re-validation is a requirement of qualified nurses. This process ensures they provide evidence of how they meet their professional responsibilities to practice safely and remain up to date.

People's needs and choices were assessed and care, treatment and support was provided to achieve effective outcomes. Care records held completed pre admission assessments which formed the foundation of basic information sheets and care plans details. There were actions under each key area of care which detailed how staff should support people to active their agreed goals and outcomes. As people's health and care needs changed ways of supporting them were reviewed. Changes were recorded in people's care files which each staff member had access too. A nurse told us, "Monthly care plan reviews take place and are led by the us (the nurses). We know if people's needs change. For example, I reviewed and reassessed a person following a fall in regards their discharge from hospital. The person was independent and mobile before going into hospital. Their goal was to become mobile again. When they came back to the home they were supported in bed for a while and had regular visits from a physiotherapist. The person is now mobile again and walking with a frame".

Changes relating to people's care, treatment and support were discussed within daily heads of department (HODS) meetings, and noted on staff handover records. These records were under review to make them more specific and personalised. We observed both the HODS meetings and a care staff handover. We found that each person was discussed and a summary of their day given. This included any changes, concerns or observations. These meetings also gave all staff an opportunity to seek further advice and ask questions.

People were supported to maintain a healthy diet and food and fluid charts were maintained where appropriate. A person told us, "The food is good and I have a choice". We were shown the menu for the day which one person had on their bedside table. Another person said, "Yes I have enough to eat. I can't eat a lot". A relative told us, "Everything is Ok (family member) gets a choice. Outside of mealtimes there is tea and coffee". The head chef told us that there was a four week menu in place with two choices each day. We

reviewed the menu, which was in a written format and contained a variety of nutritious food. The head chef told us that most of the meals were home cooked with fresh meat and vegetables. We were told that alternative options were available to people on request. We found that food preference sheets were completed on admission. These detailed people's likes and dislikes and were reviewed monthly.

The kitchen staff had a good understanding of people's dietary requirements and the safe swallow plans which were in place. We were told that there was a comments book and that the chef attends regular resident meetings and daily HODS meetings. These provided the chef with opportunities to gather updates and seek feedback from people and care staff. Birthday cakes were made for people. The chef told us that they know people's favourite cakes and make these for their special day.

We observed people eating and found that there was a relaxed atmosphere. Food looked appetising, was plentiful and overall it appeared to be a pleasurable experience. Tables were nicely laid and drinks were available to people. People requiring assistance were helped in a manner which respected dignity and appeared to demonstrate knowledge of individual dietary and food consistency needs.

A number of staff were deployed in individual rooms to assist people unable to feed themselves. This was carried out with appropriate protective clothing and at a respectful pace. We saw staff members assisting people to eat in their rooms. We noted that they knocked on people's door and said hello. We found that staff were aware of people's safe swallow plans which included, positions, consistency and supervision.

We found that the kitchen had been awarded their five star food standards rating and that all kitchen staff had received food hygiene training.

People had access to health care services as and when needed. Health professional visits were recorded in people's care files which detailed the reason for the visit and outcome. People were supported by care staff to attend outpatient appointments at local hospitals. Information was shared with the person and staff member prior to these appointments. A person said, "Health care appointments are arranged by the home. It has worked well". Recent health visits included; District Nurse, GP, out of hours GP, Chiropodist and hospital appointments. A health professional told us, "Calls are always genuine. Staff are waiting for me when I visit and know why I am there". Another health professional said, "People have comprehensive care files. We record our visits and update the staff who follow any guidance and advice we give".

People were able to move around the home freely and request staff support as and when. We were told that the provider had agreed a refurbishment budget for the home and that ideas and plans had been discussed in resident meetings. The customer experience manager told us that plans would be put in place to make sure that there would be minimum disruption to people during building work. There was a garden area which people had access to and two quiet lounges for people to use either when family are visiting or during the day if they wished. A person told us, "I can go to the garden and around the home. I stay in my room, quite happy with that and go down for lunch". Another person said, "I think it is good that they are considering improving the facilities". A health professional told us, "People are able to move freely around the home with no restriction. The environment always seems clean and the home is set in pleasant grounds".

Good

Is the service caring?

Our findings

People were treated with kindness and feedback we received about the caring attitude of staff was positive. We observed staff being respectful in their interactions with people. During both days of the inspection the atmosphere in The Mellowes Nursing Home was relaxed and homely.

People were able to see visitors when they wished. There were a number of relatives and friends visiting people in the home during the inspection. Relatives told us that they are always made to feel welcome. A person said, "Yes, I have no cause for concern. The staff are personable, friendly and helpful". Another person said, "The staff know what's important to me. They always bring me hot chocolate before bed. I asked once and since then it always comes. They know me well". A relative told us, "Staff are caring and really good. Staff reassure my loved one as and when they may get upset". A health professional said, "People are treated with kindness and compassion when I visit". Another professional mentioned that staff were, caring and compassionate. They also told us that they would place their family member there. A staff member told us, "I refer to people by their preferred names. This is more personable. I care for people in the same way as I would want my parents to be cared for, or me when I am old".

People were acknowledged by staff and management as they entered the communal areas. Staff got down to people's level or sat down when in conversation with them. People seemed comfortable in staff and management company and often engaged in conversation. This showed us that positive caring relationships were established between people and staff at The Mellowes Nursing Home.

The home promoted choice and decision making. Staff supported people to make these in relation to their care and support as much as possible. For example, we observed people being asked for choices of food, drink, activities and places to sit on several occasions. Staff told us that they provided information to enable people to make informed decisions. A staff member told us, "I give people options to choose from for example colour of clothes and shoes. I use a mix of verbal and visual prompts. I promote independence". A person said, "I make my own decisions (regarding care) it makes me feel better". Another person told us, "I decide when I go to bed, get up, have a drink. I just say to them (the staff) I've had enough and they help me". A third person said, "Staff ask me for my opinion. I like that, it makes me feel important". We observed people being talked through tasks such as support with food drinks and a mid-morning snacks. Where people needed additional support to move around the home they were carefully assisted

Care files held pen profiles of people, and recorded key professionals and relatives involved in their care. The registered manager told us that information about advocacy services, external bodies and community organisations was made available to people and relatives as and when required. They said that information would be discussed with people who had capacity and with relatives for those who may not be able to understand the information.

Staff were polite, treated people in a dignified manner throughout the course of our visit and knocked on doors before entering people's rooms or communal bathrooms. We asked staff how they respected people's privacy and dignity. A health professional said, "Staff respect people's privacy and dignity. They knock on

people's doors, introduce me and explain why I am there".

Care files identified people's preferences in relation to male or female carers with intimate care, and staff were aware of people's preferences. People's individual records were kept securely in locked cabinets to ensure sensitive information was kept confidential.

Good

Is the service responsive?

Our findings

Our previous inspection on 10 May 2017 found concerns relating to person centred care. Systems were not in place to ensure people received person centred care and treatment which was appropriate to meet their needs and reflect their personal preferences. The provider had sent us an action plan detailing how improvements would take place by 30 November 2017. During this inspection we found that the home was working towards these improvements.

People received personalised care that was responsive to their needs. Staff were able to tell us how they put people in the centre of their care and involved them and / or their relatives in the planning of their care and treatment. A nurse said, "We always involve people and ask for their input into care plans. We also talk to families and or phone them for their input too". A person told us, "Care planning? Yes, we always discuss. My son comes in on Saturdays – I am involved in my day and how it goes".

Care plans were up to date, regularly reviewed and audited by the management to ensure they reflected people's individual needs, preferences and outcomes. A health professional told us, "People have sections in their care plans which cover areas such as emotional, physical and mental health needs. I feel people are assessed holistically". We found that care plans contained photos of people and information about the person, their family and history.

An activities coordinator was employed and worked across the home. They had a good understanding of people's social needs and what people's hobbies and interests were. There were people's notice boards in the main living room and reception area. These displayed photos of previous activities and listed upcoming events. We observed people being given the choice to take part in making poppies for remembrance Sunday. People who chose to participate appeared happy to be involved.

On day two of the inspection a person told us about an event that had taken place at the weekend to celebrate remembrance day. They said that a singer had come to the home and that lots of people living in the home had come down to the living area to join in. The person told us, "I like to sing and the singer came up to me and asked me to so I did. I enjoyed it". We noticed that people had also been involved in pumpkin carving, Halloween and bonfire night .

The activities coordinator told us that they plan and arrange a variety of activities in response to people's feedback, interests, hobbies and cultural beliefs. For example, baking, flower arranging, manicures, external musicians and singers. Photos of activities were displayed in the communal living area. They went on to explain how the home was networking with the wider community. For example an Elf trail was being arranged where the home and local residents of the town would make Elf's and hide them in their gardens. Community links also included students from the local high school who had completed work experience at the home. People were also supported with their cultural needs and different religious services took place.

A nursery school visited the home during our first day of inspection. Whilst some people told us that they enjoyed the children coming to the home others found them too noisy. There was limited interaction

between the children and people who lived there. The activities coordinator told us that this was a new activity which was in its early stages and that they have seen the sessions lift people's mood, bring back memories and encourage interaction. We were told that further thought and assessment would be made to identify what people really wanted to get from these visits and how they could have a real meaningful impact on people's lives.

Information provided to people in the home was mainly relayed via verbal communication or written text. For example, the menu's, activities timetables and resident meeting notes were all written in a standard size text font with no supporting images. We discussed this with the customer experience manager, registered manager and regional director who told us the provider was looking at how they could improve communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. We were told that the home would look at using larger font and images to support those with sensory loss and communication needs.

Technology used within the home included call bell systems, sensor mats and low level beds. People who requested a telephone in their rooms were provided with one. We observed one person who had a telephone within easy reach with a large numbered dialling pad. People who were in the living area had pendants which they could use to call for support whilst they were away from their rooms. People told us that these were easy to use.

People were provided with opportunities to feedback to the service. Resident meetings took place quarterly and the last meeting took place on 2 November 2017. These were led by the customer experience manager and representatives from housekeeping, kitchen, activities, care staff and nurses attended. This meant that people could feedback to the different departments about their experiences, views and concerns. We found that a number of developments had taken place in response to people's feedback. For example, men who lived at the home had requested a gentleman's club which had now started and was led by a male team leader. People had requested to be informed prior to fire alarm tests; the maintenance person now went round the home and informed people before testing the alarm. People had fed back that they wished to go out for lunch. We saw that people had been supported to go to the local garden centre, restaurants and pubs.

The activities coordinator told us that they were looking at ways of involving those who either choose not to attend the resident meetings or those who are unable to. We were told that the customer experience manager and activity coordinator visit people in their rooms and ask for ideas or feedback however, there wasn't a robust system in place to ensure this information formed part of the meetings.

The customer experience manager told us that they welcomed complaints and saw these as a positive way of improving the service. They said, "If we aren't told how can we improve". The service had a complaints system in place; this captured the nature of complaints and steps taken to resolve these. We noted a number of complaints raised over the past 12 months and found that the service had taken actions to address these, respond to people concerned and learn from them. Relatives, people and staff we spoke with all said that they would feel able to raise any concerns they may have. A relative said, "I would discuss a complaint or concern with the registered manager or nurse". A professional told us, "I have never had to raise a concern or complaint at The Mellowes. If I did I believe that it would be listened to and dealt with promptly". We were told that compliments were also recorded and noted that most were from families expressing their appreciation of the care provided to their loved ones.

Resident surveys were sent out to people living in the home twice a year. The registered manager told us

that they were waiting for 2017 results to be populated by the provider. We reviewed the results for December 2016 and found that nine people had completed and returned their surveys. The analysis report reflected that 100% of the people felt safe, listened to by staff, treated with dignity and as individuals. We noted that only 33% of people were satisfied with activities. In response to this we found that the home had increased the activity hours to give seven days cover a week and that people had been involved in the planning and arrangement of activities which interested them. The report also highlighted the home strengths which included staff and people feeling happy. One comment from read; "I have found that staff cannot do enough for me. They never ever hesitate to help in any way possible. They are kind and helpful in anything I need. They make me feel happy".

People were supported with end of life care and preferences were recognised, recorded and respected. One person had requested a visit from a priest which had been arranged. Another person who loved horses had wished to see some, the home had arranged for horses to come to the home. There was an end of life lead at the home who took part in palliative care meetings at the local doctor's surgery. A family member told us about their involvement with end of life care planning in regards their relative. The staff were described as "very good and compassionate". The person said they were "well in the picture with care". The level of care was seen as "the same for everyone with no other families showing signs of distress or concern".

The registered manager told us that the home was working towards the Gold Standards Framework (GSF). The Gold Standards Framework is a programme care homes use to improve end-of-life care by offering staff training and a framework to help identify, assess and deliver good care.

Good

Is the service well-led?

Our findings

Our previous inspection on 10 May 2017 found concerns relating to governance. The systems in place to assess, monitor and improve the service provided were not always effective in identifying shortfalls in the care and support provided to people. The provider had sent us an action plan detailing how improvements would take place by 30 November 2017. During this inspection we found that the home was working towards these improvements.

The registered manager and customer experience manager had made improvements since the last inspection to develop and embed more robust quality monitoring systems. Staff told us that there have been a number of positive changes introduced by the management team. For example, activities, more robust recording systems and outings. We reviewed a number of audits and checks the management team carried out which included; infection control, medicines, health and safety and nutrition. We also looked daily clinical walk round records. These checks were carried out by either the registered manager or customer experience manager and followed a three step process which consisted of reviewing shift handovers, walking around the home and escalating and acting on any significant issues found. Areas covered included clinical concerns, falls, hospital admissions/discharges, GP requests and safeguarding concerns.

In addition to these audits the management carried out unannounced monthly night visits at the home. The last visit took place on 26th October 2017 at 3am. The registered manager told us that this gave them an opportunity to check how night staff supported people, whether staff were sleeping on duty and if records were being completed. We were told that findings were recorded and shared in Heads of Department (HOD) meetings the following day or any specific concerns relating to individual staff were addressed formally via supervisions. Provider audits also took place and were completed by the regional director.

The provider had an equality and diversity policy in place. The recruitment process was open and equal to all. The regional director told us that they would and have in other services, made adaptations for staff in relation to cultural beliefs. For example, uniforms, flexible shifts to allow for prayer times, food and holidays. Other adaptations may include staff who are pregnant or have a disability. The Mellowes Nursing Home encouraged an open culture and we were told by the management and staff the there was a 'Speak Out' scheme which encouraged and enabled staff to raise concerns.

Incidents were recorded and analysed to identify trends and triggers. Actions were set where trends were identified and closely monitored by the management team. These were reviewed in weekly risk meetings with the management and nursing staff.

Staff had a good relationship with each other and told us that there was good team work and staff moral in the home. Staff told us that the registered manager was visible on the floor, supportive and approachable. However health professionals fed back that they did not often see the registered manager. One health professional told us that they would work with the registered manager to develop a better working relationship with them.

Staff meetings took place regularly for each department. The registered manager attended meetings, minutes reviewed showed the registered manager began the meetings by a thanking the staff for their work and reviewing actions set from previous meetings. Items discussed in meetings included learning points from complaints, safeguarding outcomes and feedback from relatives, professionals and people. We found that recent learning and improvements included; medicines and record keeping. The registered manager told us, "We strive to continuously improve and work with our quality manager to monitor and improve".

Staff and people's feedback on the management at the home was positive. One staff member said, "The registered manager is very good. Approachable, fair, flexible and supports staff with work and personal issues". Another staff member told us, "The management are really good. Helpful, approachable and good at signposting me to available resources". Other staff told us that they felt able to speak to management as and when they needed to. A person said, "The service is run well. I've had a lot of dealing with the manager. It has worked well, I've been kept up to date, the communication has been pretty good".
The service worked in partnership with other agencies to provide good care and treatment to people. Professionals fed back that they felt information was listened to and shared with staff. The provider had recently started to work in partnership with the local nursey to establish meaningful visits and interactions between people and the children. The registered manager understood the requirements of duty of candour and had fulfilled these obligations where necessary through contact with families and people in response to incidents, injuries and or things that may have gone wrong.

The registered manager told us that they understood their legal requirements and that managers and staff were sent key updates on legislation by the provider. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.