Millennium Care Homes Limited

Abbey House Nursing Home

Inspection report

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Date of inspection visit: 28 and 29 September and 8 October 2015
Date of publication: 10/11/2015

Ratings

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

Overall summary

The inspection took place over three days on 28 and 29 September and 8 October 2015. The inspection was unannounced.

Abbey House Nursing Home provides accommodation for up to 48 older people who require nursing, respite or end of life care. Some of the people being cared for at the home were living with dementia. The home also works with a specialist community team to provide a rehabilitation service for up to nine older people who are accommodated temporarily at the home for between two and six weeks. This is to enable the people to regain their independence following their discharge from hospital or to prevent their need for admission to hospital. At the time of our inspection, there were 39 people using the service.

Abbey House Nursing Home is an older style house set in large grounds in Hampshire. The accommodation is arranged over three floors with two lifts available for accessing these floors. The home has 34 single rooms and seven shared rooms.

The service had a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

Staff did not have all of the training relevant to their role. Staff were not receiving regular supervision in line with the frequency as determined by the provider. This is important as it helps to ensure that staff receive the guidance required to develop their skills and understand their role and responsibilities.

Not all of the potential risks to be people had been adequately assessed and planned for. For example, substances that would be hazardous to people were not stored securely. Two thirds of the people using the service were unable to weight bear and needed to be hoisted, however, hoist slings were shared between people which was a cross infection risk.

People and their relatives were positive about the care and support they received. Staff knew people well and understood how to meet their individual needs in a person centred way. However, people's records did not always contain sufficient information about their needs and preferences to enable staff to deliver responsive care.

Further work was needed to ensure that each person who lacked capacity had a clear mental capacity assessment and best interest's consultation which supported staff to act and make decisions on their behalf.

Most people told us that the activities provided were good, although some felt that the activities available to people cared for in their rooms could be improved.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were either in place or had been applied for.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect. Staff had clear guidance about what they must do if they suspected abuse was taking place.

There were sufficient numbers of staff deployed to meet people's needs. People were supported by a stable staff team which helped to ensure that they were cared for and supported by staff who were familiar with their needs.

Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised. These measures helped to ensure that only suitable staff were employed to support people.

Staff had developed effective working relationships with a number of healthcare professionals to ensure that people received co-ordinated care, treatment and support.

People were supported to have enough to eat and drink and their care plans included information about their dietary needs and risks in relation to nutrition and hydration.

People told us they were cared for by kind and caring staff who respected their choices, their privacy and dignity and encouraged them to retain their independence. We observed staff offering people encouragement and supporting them in a patient and unhurried manner.

People told us they were able to raise any issues or concerns and felt these would be dealt with promptly.

People and their relatives spoke positively about the registered manager and about the leadership of the home. There was an open and transparent culture within the service and the engagement and involvement of people, their relatives, staff and other professionals was encouraged and their feedback was used to drive improvements.

There were some systems in place to assess and monitor the quality and safety of the service and to ensure people were receiving the best possible support.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

Improvements were needed to ensure that all of the risks associated with the people's needs and the premises had been identified and planned for.

Staff had a good understanding of the signs of abuse and neglect. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place.

There were sufficient staff deployed to meet people's needs. People medicines were managed safely.

Is the service effective?

Requires improvement

The service was not always effective.

Staff did not have all of the training relevant to their role and they were not receiving regular supervision in line with the frequency as determined by the provider.

Further improvements were needed to ensure that each person who lacked capacity had a clear mental capacity assessment and best interest's consultation which supported staff to act and make decisions on their behalf.

People's nutritional needs were assessed and care plans were in place which described the support each person needed to eat and drink.

Is the service caring?

Good

The service was caring.

People told us they were cared for by kind and caring staff who interacted with them in a kind and compassionate manner.

People were supported to maintain their independence. Staff recognised the right of people to take certain risks and understood this could make a positive contribution to people's quality of life.

People were treated with dignity and respect and care was provided in a sensitive and personalised manner.

Is the service responsive?

Requires improvement

The service was not always responsive.

Whilst staff had a good understanding of people's individual needs, this was not always reflected in people's care plans which did not consistently contain detailed and personalised information about their likes, dislikes and interests and their preferred daily routines.

Summary of findings

Improvements were needed to ensure that there were increased opportunities for people to enjoy trips outside of the home and for people cared for in their rooms to have regular and meaningful interactions with staff.

People and relatives told us they were confident they could raise concerns or complaints and these would be dealt with.

Is the service well-led?

Good

The service was well led.

People and their relatives spoke positively about the registered manager and about the leadership of the home. They told us the home was well led and well organised.

There was an open and transparent culture within the service and the engagement and involvement of people, their relatives, staff and other professionals was encouraged and their feedback was used to drive improvements.

There were some systems in place to monitor and improve the quality and safety within the service.

Abbey House Nursing Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place over two days on 28 and 29 September and 8 October 2015. On the first day of our visit, the inspection team consisted of two inspectors. On the second day the two inspectors were joined by an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. Our expert had experience of caring for people living with dementia and of using health and social care services.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection. We had not asked the provider to complete a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with twelve people who used the service and eleven relatives. We also spent time observing aspects of the care and support being delivered. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not express their views to us. We spoke with the registered manager, the deputy manager and the training manager. We also spoke with nine nursing and care staff, a cook, a laundry assistant, an activities co-ordinator and the person responsible for maintenance. We spoke with four health and social care professionals who were visiting the service. We reviewed the care records of four people and four staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection we sought feedback from a further four health and social care professionals and asked their views about the care provided at Abbey House Nursing Home.

The last inspection of the service was in April 2014 when no concerns were found in the areas inspected.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe living at Abbey House Nursing Home. A person told us, "I feel very safe here and get on well with all the staff. They are all very kind to me. They look after my medication for me and I get it as regular as clockwork." Another person told us, "I love it here. The best thing is the security". Visitors also felt that their relatives were safe. One said "This is 100% fine, I can walk away happy that she is attended to, they always have plenty of staff and are really nice and happy in their work". Whilst people told us they felt safe, we found some aspects of the care provided needed to improve.

Not all of the potential risks to be people had been adequately assessed and planned for. For example, there was a hot water boiler mounted on the wall in the dining room. There was a risk of people using this without assistance and therefore being at risk of being scalded. Products used to thicken drinks for people who had swallowing problems were readily available in the dining room, but the risks associated with this had not been fully assessed. NHS England issued a patient safety alert in February 2015, warning of the need to ensure that individualised risk assessments and care planning were in place to ensure that people were not at risk of accidentally ingesting the thickening products.

The laundry was unlocked and unattended, however, we found substances that would be hazardous to people stored on the floor. A cupboard containing harmful substances was also unlocked. Two thirds of the people using the service were unable to weight bear and needed to be hoisted, however, hoist slings were shared between people, which was a cross infection risk. There was no regular washing schedule for these shared slings which increased the risk of cross infection.

This is a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014 safe care and treatment.

Appropriate systems and processes were in place for obtaining and storing people's medicines. Medicines were stored securely within locked trolleys which were kept within locked treatment rooms. The temperature records for the medicines refrigerators provided assurance that medicines were stored within their recommended temperature ranges. People's medicines were administered safely. People had an individual medicines administration record (MAR) which included their photograph, date of birth and information about any allergies they might have. The MARs we viewed had been completed accurately which indicated people were receiving their medicines as prescribed. We did note that whilst some information was available for "variable dose" and "if required" medicines, this only replicated the medicine label and did not provide sufficient personalised guidance for staff about when these should be given. This is an area which could improve.

The service had an agreed list of homely remedies which had been approved by the GP. Homely remedies are medicines the public can buy to treat minor illnesses such as headaches and colds. We completed an audit of the controlled drugs in stock and found records were accurate. Controlled drugs are medicines that require a higher level of security in line with the requirements of the Misuse of Drugs Act 1971 as there can be a risk of the medicines being misused or diverted. Arrangements were in place to ensure that unwanted medicines were disposed of safely.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Information including the contact details of the local safeguarding team was readily available within the home. Staff had a positive attitude to reporting concerns and to taking action to ensure people's safety. One member of staff told us, "If I saw a colleague mistreating a resident, I would ask them leave the room immediately. I would then report it to the nurse in charge. The management would absolutely address the safeguarding concerns; there is a zero tolerance from management and staff".

Staff were mostly aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager of the home. They were also aware of other organisations with which they could share concerns about poor practice or abuse. One staff member told us, "If you have used all the procedures in the home and nothing gets done, then you can go directly to adult services".

Staffed employed to work at the home included a manager and deputy manager. During the early shifts the current target staffing levels were two registered nurses and nine care workers and during late shifts it was two nurses and six care workers. Night shifts were staffed by one nurse and five care workers. We reviewed the rotas for a four week

Requires improvement

Is the service safe?

period; these confirmed that the home was staffed to at least these target levels. The registered manager also employed a team of housekeeping and laundry staff, administrators and reception staff, chefs and kitchen staff and two part time activities co-ordinators. There were also two maintenance staff. Many of the staff team had been employed at the home for a number of years which helped to ensure that people received continuity of care from staff who knew them well.

Most people felt that the staffing levels were adequate. One person said, "Yes they come quickly when I need them". Another person said, "I sometimes need a little help but they are always around and ready to be here". Most of the relatives we spoke to said that the staffing levels appeared adequate. One relative said, "They answer all the alarms very quickly". Some people did say there could sometimes be a delay in their call bell being answered at busy times. This was echoed by some of the relatives we spoke with, some of whom also expressed a wish that staff had more time to stop and chat with people. Staff told us there were usually sufficient numbers of staff to ensure that people's needs were met. They said the management team worked hard to cover gaps in the rotas, but that at times, they could be left short if workers called in sick with very little notice. One care worker said, "Sometimes, we are short but there is good teamwork so everything gets done". Another said, "You do get sickness, but we all work as a team and just work harder, the nurses are good, there is no divide, they just muck in". Overall though the staff team felt that staffing levels were adequate and were improving. Our observations during the inspection indicated that people's needs were being met in a safe and responsive manner. We saw that staff consistently responded in a timely way to an emergency alarm that was triggered several times during the day by a person going outside. The registered manager told us that they had plans to improve the staffing levels by introducing a twilight shift to provide additional support to assist people to bed. They told us that the provider was supportive and would increase staffing numbers if it was evidenced that this was required. Whilst no particular tool was used to calculate staffing numbers, they said daily discussions were held with the nursing and care staff and she was confident that the current staffing levels were safe.

Appropriate recruitment checks took place before staff started working at the home. Records showed staff completed an application form and had a formal competency based interview as part of their recruitment. The manager had obtained references from previous employers and checked with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. Checks were made to ensure the registered nurses were registered with the body responsible for the regulation of health care professionals.

There were a range of systems and processes in place to identify and manage risks to people's wellbeing. Handover meetings were conducted daily during which staff shared information about any new risks or concerns about a person's health. Detailed pre-admission assessments were undertaken which helped the management team reach informed decisions about whether they could safely meet the person's needs. Each person had a health and safety risk assessment which considered which aspects of a person's care could present risks to their health, safety and wellbeing. A range of individual risk assessments were in place with most being evaluated regularly. For example, people had moving and handling risk assessments and dementia risk assessments which considered the person's risk of self-neglect or of leaving the home unsupervised. Risk assessments were also in place which helped predict whether people were at risk of falls, developing pressure ulcers or becoming malnourished. Where people were at risk of choking, risk assessments had been completed and a choking care plan was in place. We did note that whilst most of the risk assessments had been reviewed regularly, a small number had not. Others had been reviewed but not updated to ensure they accurately reflected the person's needs. For example, we saw one person's risk assessment in relation to choking had not been updated since October 2014. This person's health and safety assessment had been reviewed monthly, but had not been updated to reflect the fact they no longer had a catheter in place. This is an area which could improve.

Records were maintained of incident and accidents within the home. These were monitored each month by the registered manager so any trends or patterns could be identified. For example, the number, type and times of falls was noted. The registered manager was required to note what action had been taken if a person had fallen three or more times in the month. The analysis also considered whether the incident might have been preventable or was for example due to equipment failure. Each person had a personal emergency evacuation plan which detailed the

Requires improvement

Is the service safe?

assistance they would require for safe evacuation of the home or whether a 'stay put' plan was in place. The provider also had a business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service.

Requires improvement

Is the service effective?

Our findings

People and their relatives told us the service provided effective care. One person said, "They are fantastic, they look after me really well". Another said, "I am happy, it's served me very well, I can't walk but they do everything for me". A third person said, "They always make sure I have lots of drinks, they are always asking". We met one person who was being visited by their daughter. They both told us that the nurses were very good and provided effective care. Another relative said, "I give it A+. The nursing care is very good and so is their level of support…there is always a drink at hand and the food is good". A social care professional told us, "The rehabilitation team are very good at getting people back on their feet…as a [staff] team we have a lot of confidence in them".

Training and induction of staff was overseen by the organisation's full time training manager who was based at the home. They had been in post for just under a year but were also, at times, called upon to provide care and so they were still in the process of developing the training programme and the systems to support this. Training records were kept in staffs' individual files and so it was difficult to get a clear overview of all of the training undertaken by the whole staff team. However we were able to see that at least half of the care staff held a level two nationally recognised qualification in health and social care and that staff completed a basic training programme which consisted of safeguarding training, infection control, fire safety and manual handling training. Records we viewed showed that this training, which was specified as mandatory training by the provider, was generally up to date.

Whilst staff told us the training provided was good, we found some improvements were required. We could not be assured that staff responsible for the management and administration of medicines had the necessary training and competence to safely manage people's medicines. Records showed that only one of the eight staff responsible for the management and administration of medicines had completed training which helped to ensure they continued to have the correct skills and knowledge to manage people's medicines safely. These staff had not had an annual review of their competency to administer medicines safely as recommended in guidance from the National Institute for Health and Care Excellence (NICE). This is important as it helps the registered manager to be confident that staff understand how to maintain safe practice in relation to medicines management.

Most staff did not have training on the Mental Capacity Act 2005. Training was not currently provided on subjects such as person centred care and equality and diversity. Only one care worker had training on diet and nutrition and only four had training on caring for people living with dementia. Only five care workers had completed training in basic life support. The training manager did tell about some improvements which were planned. For example, they were studying for a qualification so that they could train staff in managing behaviour which challenged. The registered nurses had recently undertaken training in end of life care and in the use of equipment which helps to manage people's pain when dying and some had completed training on caring for people with diabetes and recognising and managing wounds. Work was also underway to devise a programme to support the registered nurses to gain their revalidation. Revalidation is the way in which nurses demonstrate to their professional body that they continue to practice safely and effectively and can therefore remain on the nursing register. However, we could not be assured that staff had all of the training relevant to their role and which enabled them to meet the needs of people using the service.

Whilst staff had received an annual appraisal in 2015, none of the staff we spoke with said they were receiving regular supervision in line with the frequency determined by the provider. The provider's policy stated that supervision should take place at three monthly intervals. One staff member said they had supervision "Every six months or so". Another said, "I've had one supervision this year, but I can always go to my team leader". We looked at the available supervision records and saw that only 17 of the 35 care workers had received supervision so far in 2015. All of the staff we spoke with told us they felt well supported but having formal supervision is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities.

The induction of new staff was overseen by the training manager. They had developed an induction programme during which staff completed some mandatory training, shadowed more experienced staff and had an opportunity to learn about people's needs and routines. The induction

Is the service effective?

was mapped to the Care Certificate which was introduced in April 2015. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should ideally be completed within the first 12 weeks of employment. We did note that staff were not being required to complete their induction within these recommended time scales. Some staff had been employed at the service for over a year but had still not completed the Care Certificate or its predecessor, the Common Induction Standards.

We could not be assured that staff had all of the training relevant to their role. Staff were not receiving regular supervision in line with the frequency as determined by the provider. Staff had not completed an induction programme that ensured they were suitably skilled and assessed as competent to carry out their roles. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing.

Where people had capacity to consent, staff sought their consent before providing care and support and respected their choices. We saw staff asking people where they would like to sit, what drink they would like and whether they would like to join in activities. Staff were clear they would respect people's decisions and choices and described how they tried to support and empower people to make decisions for themselves. One care worker said, "It's important to give people choice about what they want to do. They explained that if a person was to refuse care or assistance, they would try again a little while later. They said, "You can't force them, I would report it to the nurse". People had a care plan which contained guidance about how staff could support people to make decisions and we saw that some people had signed consent forms for having photographs taken of skin damage or wounds.

We found some people's capacity to make decisions and choices about their care and support had been assessed. However we found that where people were deemed to lack capacity, there was no evidence that appropriate consultation had been undertaken with relevant people such as GP's and relatives to ensure that the support plan being delivered was in the person's best interests. The registered manager was aware that further improvements were needed to ensure that each person who lacked capacity had a clear mental capacity assessment and best interest consultations which supported staff to act and make decisions on their behalf.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards are part of the MCA 2005 and protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. Relevant applications for a DoLS had been submitted by the home and they were waiting for these to be assessed by the local authority.

People told us they enjoyed the food provided. A person told us, "They cater for my diet here. They make sure the food suits me. The cook comes round every day. She knows I can't have onions and will make special portions for me, or they will make an alternative meal". Another person said, "We have a choice for all our meals….I can always change my mind at the table, it doesn't worry the carers". A visitor told us, "[the person] is a vegetarian…they are very aware of that and have always provided an appropriate diet…they have gained weight since they have been here".

People's nutritional needs were assessed and care plans were in place which described the support each person needed to eat and drink. People were assessed using nationally recognised risk assessment tools to determine whether they were at risk of malnutrition. Where people were at risk of malnutrition, or were experiencing difficulties with eating or swallowing their food, they were referred to specialists such as speech and language therapists in a timely manner. Kitchen staff had detailed information about people's specialist diets including those that required diabetic meals and those that needed soft or pureed food. Each of the elements of the pureed meals had been prepared separately so that the person could still taste the individual flavours. A staff member told us, "The kitchen staff are very versatile, chef communicates well with people, they pay attention to detail". Drinks were readily available throughout the day, including to people who were being cared for in their rooms.

Staff provided personalised support to people who needed help to eat and drink and did this in a sensitive manner. Where appropriate we saw that people were provided with suitable cutlery so that they could eat independently. We

Requires improvement

Is the service effective?

observed one care worker had noted that a person was not eating their meal; they offered to help, then offered an alternative. The care worker brought some soup and then very kindly and patiently encouraged the person to eat which she did finishing the whole bowl. The lunch service did not feel rushed and staff were supporting people at their pace. This all helped to ensure that the meal time was a pleasurable and dignified experience for each person.

Where necessary a range of healthcare professionals including GP's, community mental health nurses, dentists and speech and language therapists, had been involved in planning people's support. This helped to ensure that they received co-ordinated care, treatment and support. Each week, a GP attended a 'ward round' at the home, during which they were able to review people about whom staff had concerns or who were presenting as being unwell. Nine of the 48 beds at the home were set aside for people receiving a rehabilitation service commissioned by the NHS. Feedback from the professionals involved in service was very positive. We were told staff worked hard to achieve good outcomes for the people and supported them to work toward achieving their goals.

Good

Is the service caring?

Our findings

People told us they were cared for by kind and caring staff. One person said, "It's a nice friendly place, I wouldn't want to go anywhere else". Another person told us, "They are ever so kind, there is nothing they could do better". A visitor said, "The staff are very pleasant, they have good end of life care, the residents always seem happy in their last days. I would have no hesitation in coming here myself, but I'm not ready yet!" One relative said, "They are very good to us all as a family, we can go anytime and I can bring in [their relatives] dog and the home are happy to see us". Another relative said, "Everyone is very nice, it's like an extended family". A social care professional said, "Abbey House always has a positive atmosphere and the staff are very welcoming. I always hear positive interactions with the residents".

Our observations indicated that staff interacted with people in a kind and compassionate manner. We saw a considerable number of warm and friendly exchanges between staff and people. Staff provided people with gentle encouragement and praised them when they ate well or managed a task independently. They did this in a patient and unhurried manner. Staff made eye contact with people when speaking with them and chatted positively whilst completing care tasks. The atmosphere in the communal areas was good natured and sociable. A relative told us, "We visit every other day, the nursing staff are really dedicated, they have a definite rapport with people, they provide a birthday cake on people's birthday and make a bit of a fuss of them…all the staff are approachable, they will talk with people, they seem genuinely interested in people". A social care professional told us, "The staff are always making themselves available to residents and family. They are always speaking to residents politely and have good relationships. It is clear that staff know their residents well…the residents are always smiley at the staff".

Most people told us their decisions were listened to and their choices respected. People told us they could choose what to eat, where to spend their time or whether to join in the planned activities. One person said, "You can always stay in bed if you don't want to get up". Another person said, "They always get me up at 7am which is when I like to get up". Two people did say staff did not always ask them what they wanted to drink. One person said, "I get tea when I want coffee, they just come in and say cuppa tea?" The other person told us, "They don't really ask what I want, they just bring it along, but I drink anything". There was some evidence that people were involved in planning their care. For example, we saw that some people had signed a form to confirm their inclusion in the care planning process, in most cases though this was signed by a relative. Whilst we saw that care plans were reviewed each month, it was not evident that this was with the involvement of the person or their relatives. A small number of relatives did express a wish that there were more opportunities to talk things through with staff. However, most relatives told us they were kept well informed and that communication with the home was good. One person said, "They always inform us if there is anything un toward or if [their relative] has seen the GP…they inform us very quickly, we've never had concerns about communication".

Staff told us how they supported people to maintain their independence by encouraging them to complete small tasks such as brushing their teeth or washing their face. A person told us, "I prefer to have a go myself, they [the staff] respect that". The service had a policy which recognised the right of people to take certain risks and the positive contribution this can make to their quality of life. A staff member told us how one person was "Fiercely independent" and wanted to be able to perform aspects of their personal care without assistance. To address the risks involved, staff ensured the person was supported to have everything to hand in the bathroom, but then they stepped outside, staying close in case they were needed. The care worker said, "These little things mean a lot".

People's relatives and friends were generally able to visit without restrictions, although for those people in the rehabilitation unit, it was suggested their visitors come between certain hours so that it did not interfere with people receiving their rehabilitation therapy. We observed relatives visiting throughout the day and sharing in aspects of their loved ones care. One relative said, "They always offer us a tea or coffee when the drinks trolley comes round, they always greet us in a nice friendly way".

Upon admission to the home, people were given a service user guide which included a 'Resident's Charter'. This stated that people had the right to retain their dignity and independence, to have their religious and cultural needs met and to have skilled, sensitive and understanding care which enabled them to achieve the highest possible quality of life. Our observations indicated that these rights were

Good

Is the service caring?

respected. One person said, “They always close my curtains and door when they are helping me”. Staff told us they used privacy screens in the shared rooms to maintain people’s dignity and kept people covered up as much as possible during personal care. A health care professional told us, “They treat people well, keep their dignity”. We saw staff acted quickly when a person needed support to change stained clothing and managed this in a sensitive and person centred manner. A care worker said, “I want to be proud of the care we provide, people should look nice, be shaved and have their hair brushed, I would want this”.

Requires improvement

Is the service responsive?

Our findings

Most people told us that staff were responsive to their needs. One person said, "They don't leave me if I am unwell, they get a doctor for me". Another person told us, "If I was at home, I would be on my own, here the staff all talk with you, they get me audio books, I am very happy here". Relatives also felt that their loved ones mostly received responsive and attentive care. One relative told us, "As soon as there are signs that Mum is under the weather, they let me know, they keep me informed…Mum is prone to infections at the slight sign they call the doctor and this nips it in the bud, they keep a constant eye on her".

Staff had a good understanding of people's individual needs. Staff were able to give us examples of people's likes and dislikes which demonstrated that they knew them well. We were given examples of the types of food people liked to eat, for example, staff knew whether people liked their toast cut into two or four portions. Staff knew people's preferred daily routines, when they liked to get up and go to bed. They knew which people loved animals and enjoyed visits from the therapy pets. One member of staff said, [the person] loves to be asked about what's in the newspaper and [another person] loves my dogs so I bring them in to see her". Staff were also able to tell us about people's needs and how they met these. They were, for example, able to tell us how one person had begun to experience increased difficulty in swallowing and about the measures that had recently been put in place to manage this. We saw that one person's GP had been contacted following concerns that they were losing weight and about their low mood. Staff has requested a referral to specialists when another person started to have increased problems swallowing. One relative said, "[the person] is eating well and gets 24/7 support, she is much better that a year ago, she was very poorly when she came here, but has improved no end".

Whilst staff were able to demonstrate an understanding of people's needs and their preferences, this was not always reflected in people's care plans which did not consistently contain detailed and personalised information about their likes, dislikes and interests and their preferred daily routines. For example, we looked at one person's activity plan. The person was no longer able to communicate verbally. The plan did record that the person liked looking at photos and used to like to watch the TV, but there was no real sense of what the person valued before becoming unwell or what activities could be used to try and provide meaningful interaction with the person. A care worker told us, "Knowing more about [a person's] life history might be helpful to use as distraction when they become agitated". The activities co-ordinator told us that they were starting to do some life story work with people and 15 families had been given the Dementia UK life story template to complete. They told us, "It will be helpful to me as I can talk to people about their lives. It is a valuable tool. It is about us learning about who people were and what they enjoyed".

Some aspects of people's records did not contain detailed and personalised information which would ensure that staff were always able to provide responsive care. For example, one person with insulin dependent diabetes did not have a clear escalation plan which described the action that should be taken if their blood sugar levels were outside of safe parameters. Escalation plans are important as they help staff to provide appropriate interventions and also assists them to recognise and respond to changes in people's health. Another person had a choking plan in place which advised that following a choking incident, staff should monitor for signs of inhalation or a chest infection. The plan did not, however, describe what these signs might be. A person's epilepsy plan did not contain information about the type of seizures the person experienced.

Some of the tools being used to monitor and review risks to people's health and wellbeing were not being consistently used. For example, we reviewed the fluid charts for four people who had been assessed as being nutritionally at risk and found that there were gaps in each. We observed staff assisting one of these people to take some fluids, but they did not record this on their chart. The fluid charts did not include a target fluid intake. This is important as it helps staff to assess whether people are taking in the recommended fluid level and take remedial action where needed.

Some people who were cared for in bed were at risk of developing skin damage or pressure ulcers and had care plans which said they should be repositioned every two to three hours. We viewed four people's repositioning charts and found gaps in each. For example, one person's records suggested they had not been repositioned in the 24 hour period prior to our inspection. Staff assured us that the person would have been repositioned, but could not

Requires improvement

Is the service responsive?

explain why the records did not reflect this. No-one in the home was currently being treated for any pressure ulcers which would suggest that despite a high number of people being nursed in bed, that the skin care provided within the home was good, however, some of the records did not reflect this. Improvements are therefore needed to ensure people's care records, contain all of the relevant information to support the delivery of responsive and person centred care.

The service employed two activity coordinators who provided a range of both group and one to one activities on week days for people living at the home. A schedule of activities was advertised and during our visit we saw that people enjoyed a visit from an outside entertainer and a coffee morning. We saw that the activities staff spent time engaging people in conversations about current affairs; for example, the new labour party leader was discussed. People were generally positive about the activities. Comments included, "There is lots of entertainment" and "The activities are brilliant". A person told us, "Every day I have my newspaper, I like to keep abreast of things". The activities staff told us that other activities provided included sing a longs, comedy clubs, exercise, crafts, cooking and gardening. Some people had been involved in growing potatoes and beans, which had then been used in meals at the home. A Christian communion service was held one a month and other religions also visited people on a regular basis. At any one time at least half of the people using the service were cared for in their rooms.

Some people expressed a wish for more trips outside of the home. We spoke with the registered manager about this; they acknowledged that this was a challenge as the home did not have a mini bus and so trips had cost and resource implications. Some people and their relatives also felt that improvements could be made to the nature and frequency of the interactions and activities provided to people cared for in their rooms. We were told that currently people cared for in their rooms received a visit from the activities staff at least once a week who listened to music with them or read to them or just had a chat. An activities co-ordinator said, "Even if they are unable to communicate, I can talk to them about their photos. Sometimes it is about sitting with people and holding their hands". They told us the entertainers would visit people, if they wished, and that the therapy cats and dogs also spent time with people who were cared for in their rooms. However, this is an area where further improvements could be made.

Complaints policies and procedures were in place and information about the complaints policy was available in the service user guide and around the home on notice boards. People and relatives told us they were confident they could raise concerns or complaints and these would be dealt with. One relative told us they had raised a concern with the manager who had treated it very seriously and fully investigated the matter to their complete satisfaction. Records showed complaints or comments were used as opportunities for learning or improvement. For example, the manager was able to describe to us how practice and procedures had changed within the home in light of a recent incident to prevent a similar reoccurrence. A care worker told us, "If someone raised a concern or a complaint, I would raise it with the nurses or manager. We look at what we could do to improve".

Good

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered manager and about the leadership of the home. Comments included, "It is all well run" and "The manager and deputy will both come and have a natter". A health care professional told us the home was "Well led, well organised, the manager is always approachable, always available, communication is good". Another professional said, "[the registered manager] is very open and honest and will report any issues to the commissioners and leads her team well".

There was an open and transparent culture within the service and the engagement and involvement of people, their relatives, staff and other professionals was encouraged and their feedback was used to drive improvements. Meetings were held twice a year with people and their relatives to obtain their views about the service and update them on developments and changes. A satisfaction survey had been undertaken with people. The responses were being formulated into an action plan so that any areas for improvement could be addressed. We saw that some changes had already been made. People had commented that the sausages used could be hard and so the provider of these had been changed. A request had been made for a pull cord above a person's bed and this had been actioned within seven days. Other improvements were planned. For example, some people had expressed a wish to go to church and have increased one to one time for reading. The activities staff had been asked to look into ways of providing this.

Staff meetings were also held and we saw that the agenda for the next meeting was; person centred planning and 'what can we do better'. Staff told us they were encouraged to question practice and make suggestions. They said they felt listened to and valued by the leadership team. One staff member said, "We can say to the manager if we think something will work better. We are all treated fairly; there is no favouritism or bullying. If we had concerns we would quite happily report it to the nurse or manager".

Staff told us that the manager and deputy manager both had a strong presence within the home and frequently walked around the home, observing care and giving staff feedback. One staff member said, "[The registered manager] is always out here walking around, she tells us that if there are any issues, we need to let her know".

Another staff member said that the manager and deputy were "Brilliant, they will roll up their sleeves". The registered manager was aware that staff supervisions had fallen behind, and explained that this had been due to a specific set of challenging circumstances that the service had needed to manage over the last year. They were aware that this was an area which needed to improve and plans were being put into place to ensure a robust schedule of supervisions was reinstated for all staff.

The provider's 'Philosophy of Care' set out the organisations aims, objectives and values. Central to the philosophy of care was the importance of providing people with a secure, relaxed and homely environment. Our observations and conversations with people indicated that they did feel safe and secure and felt the environment was one which was relaxed and comfortable. One person told us, "There is a friendly atmosphere, a homely feel, it's not clinical". A staff member said she was proud of how homely the service was. She said, "Its relaxed, chilled, you can really feel it". A health care professional told us, "The home feels a happy home". Throughout the inspection staff demonstrated that they worked in a manner that was consistent with the provider's values which included, privacy, independence, choice and respect. The registered manager told us she was proud of the home which she felt was forward thinking and professional. She said she was also proud of her whole staff team, who she felt did the very best possible for people. She said, "I care about the service passionately. First and foremost are the people here, its their home. We are guests in their home. I tell staff to treat people as if it was their parent, people have put their trust in us, they must be supported to feel safe". Staff felt that the culture within the service was as a direct result of the enthusiasm and person centred approach of the registered manager. A member of staff told us, "Each person is treated as an individual; we look at each person as a whole...what happens on the floor comes from the top".

There were some systems in place to monitor and improve the quality and safety within the service. A range of audits were undertaken by either the registered manager or the operations director. These were used to monitor the effectiveness of aspects of the service including care documentation, the catering, infection control and medicines management. Where areas requiring improvement were identified, a clear action plan had been drafted which included who would be responsible for

Good

Is the service well-led?

ensuring this was completed. We did note that some of the audits were only completed once or twice a year. A more frequent schedule of audits would make these more effective at identifying what the service was doing well and the areas it could improve on. For example, the audits had not identified the issues we found in relation to people's records. The registered manager undertook unannounced checks at night to help ensure that the support being provided to people was safe and effective. Detailed checks were also being undertaken of the fire and water safety within the service. We did note that some of the organisations policies could be more detailed. For example, the 'Whistle-blowing' policy did not include information about the specific protections available to staff who disclose concerns.

The registered manager worked in partnership with other organisations including the local authority and clinical commissioning groups to ensure that people received the best possible care and a joined-up service. A social care professional told us, "The manager is always in contact with the team should anything occur. A recent example was when a lift broke and the manager advised us of this and what residents it would affect and how it was being managed. Should there ever be any issues, the manager will always notify the team and work collaboratively with us.... I have every faith in the manager whom we have a good relationship with and whom will always share issues or concerns with the team".

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not done all that is reasonably practicable to mitigate risks to people including the risk of the spread of infections. Regulation 12 (2) (a) (h).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not have all of the training relevant to their role. Staff were not receiving regular supervision in line with the frequency as determined by the provider. Staff had not completed an induction programme that ensured they were suitably skilled and assessed as competent to carry out their roles.**