Firgrove Care Home Limited

Firgrove Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 21 September 2017 and was unannounced. Firgrove Nursing Home is a privately owned care home that provides nursing care and support for up to 35 people. At the time of our inspection, there were 22 people living at the home. Firgrove Nursing Home supports people with a range of needs such as physical frailty, Parkinson's disease, stroke and people living with dementia. The home is situated in a residential area of Burgess Hill and is a large two storey building, with accessible gardens to the rear of the premises.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Both the registered manager and the provider were present during the inspection.

At the last inspection undertaken on the 24 and 26 March 2015 we had no concerns and rated the service as 'Good' overall. At this inspection we found three breaches of regulations and further areas of practice that needed to improve.

Staff did not demonstrate a clear understanding of the requirements of the Mental Capacity Act 2005 and their responsibility to seek consent for care and treatment. Some people lacked capacity to make specific decisions, including consent for the use of certain equipment that restricted their movement. Decisions that had been made in their best interest had not been documented and reviewed in line with legislation and guidance. This was a breach of the regulations.

People's social needs were not being met and this meant that some people were at risk of social isolation. Some organised events were arranged with external performers but these were on an occasional basis. People did not have things to do throughout the day that were suitable for their needs, and relevant to their personal interests. This was a breach of the regulations.

Some management systems had not been effective in providing oversight of shortfalls in practice. This was identified as a breach of the regulations.

People were receiving their medicines safely. However during the administration process medicines were not always stored safely and this was identified as an area of practice that needed to improve.

Some people needed help to move around and staff were using equipment to support them. However, staff were not always using equipment in line with current good practice. This is an area of practice that needs to improve.

People told us they were happy with the food provided at the home. They received the support they needed

to have enough to eat and drink and any nutritional needs were assessed and monitored. One person told us, "The food is good here." People were given a choice at supper time but not for the main meal at lunchtime. Staff said that people were offered alternatives if they did not like the main meal. One person was asleep when their lunchtime meal was brought to them but staff did not offer to reheat the food even though half an hour had passed. This was identified as an area of practice that needs to improve.

People and their relatives told us they felt safe and happy living at Firgrove Nursing Home. One person said, "I feel safe, if not I would tell my family." A relative said, "The care is very good." There were enough staff on duty and people did not usually have to wait to have their care needs met. Risks to people had been identified and assessed and care plans were in place detailing how care should be provided. Staff had a clear understanding of their responsibilities to keep people safe and knew how to recognise abuse and what actions to take.

People and their relatives had confidence in the skills of the staff. One person said, "I am very happy with them and trust them completely." A relative said, "I've been very impressed by the care." Staff had received the support and training they needed to provide care to people safely. They were proactive in supporting people to access the health care services they needed. A visiting health care professional told us that they had confidence in the staff, describing them as "Knowledgeable about people's needs," and confirming that they always received appropriate referrals.

People were supported by staff who knew them well and understood their needs. People told us that staff were kind and caring. One person told us, "The carers are wonderful." Staff spoke to people respectfully and were careful to protect people's privacy and dignity. One relative told us, "I love the way staff speak to my (relation), they are always refer to people here as Mr or Mrs and I think that makes them more respectful." People, and where appropriate their relatives, had been included in developing care plans that were person-centred and covered all aspects of their life. Staff were responsive to changes in people's needs and care plans were amended to reflect this. A relative said, "As things have progressed they have made adjustments to make sure my (relation) remains comfortable."

There was a visible complaints process and people and their relatives told us they would feel comfortable to raise concerns. The registered manager documented all complaints and actions taken to address the complaint. Quality assurance systems were in place to monitor the standard of care. The registered manager analysed incidents and accidents to look for trends and patterns and used this information together with feedback on the service to drive improvements.

There was clear management and leadership and the values and ethos of the service were embedded within staff practice. The registered manager had good knowledge of the needs of all the people living at the home and worked alongside staff on a regular basis. People and staff spoke highly of the management of the home saying that the manager was easy to talk to and the service was well run. A relative told us, "The communication is good, I would always approach the managers with any issues."

We found three breaches of the regulations. You can see what action we have told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were receiving their medicines safely but medicines were not stored safely during the administration process.

There were robust recruitment procedures in place and there were enough staff on duty to care for people safely. Staff understood their responsibilities with regard to safeguarding people.

Risks were assessed and managed effectively.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not understand their responsibilities with regard to MCA and Deprivation of Liberty Safeguards (DoLS).

People were receiving enough to eat and drink and they were supported to have access to the health care services they needed.

Staff were receiving the training and support they needed.

Is the service caring?

Good

Staff were caring.

People had developed positive relationships with staff who knew them well and understood their needs.

People were treated with dignity and respect and their privacy was maintained.

People were supported to express their views about their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's social needs were not being met due to lack of opportunity for activities and lack of meaningful occupation.

People's care plans were personalised and reflected the care that people were receiving.

Complaints were used to improve the quality of the service.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Some management tools for monitoring quality were not effective in identifying shortfalls.

There was clear leadership and good communication between staff.

The ethos and values of the service were embedded within staff practice and there was a positive, open culture in the home.

Firgrove Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 September 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the service including any notifications, (a notification is information about important events which the service is required to send to us by law) and any complaints that we had received. The provider had submitted a Provider Information Return (PIR) before the inspection. A PIR asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. This enabled us to ensure that we were addressing any potential areas of concern at the inspection.

During the inspection we spoke to 12 people who used the service and four relatives. We interviewed five members of staff and spoke with the registered manager and the provider. We looked at a range of documents including policies and procedures, care records for five people and other documents such as safeguarding, incident and accident records, medication records and quality assurance information. We reviewed staff information including recruitment, supervision and training information as well as team meeting minutes and we looked at the provider's information systems.

The last inspection on the 24 and 26 March 2015 identified no concerns.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Firgrove Nursing Home. One person said, "I feel safe, if not I would tell my family." Another person said they felt safe because they could use their call bell to summon help, They said, "They (staff) are good at answering the bell." A relative told us, "The care is very good and I have never felt this (care) isn't right." However, despite these positive comments we found some aspects of care that needed to improve.

People were being supported to have the medicines they needed. The provider had a medicine's management policy to guide staff. Those staff members who administered medicines had received training and were assessed as being competent. We observed people receiving their medicines. The administration of medicines did not always follow guidance from the Royal Pharmaceutical Society. We noted on three occasions that the staff member left medicines on top of the trolley unsupervised. On the third occasion, the staff member left the room altogether. This meant that medicines were not always stored safely during the administration process. This is an area of practice that needs to improve.

Medication Administration Records (MAR) charts were completed accurately. Some people were receiving medicines 'as required' (PRN), and appropriate protocols were in place to guide staff on how to manage these medicine safely. One person told us, "The staff give me my pain killers if I want them." A relative told us that staff were knowledgeable about their relation's medicines, saying "I'm always told about any changes in medicines."

Medicines requiring refrigeration were stored in a lockable fridge which was not used for any other purpose. The temperature of the fridge and the room in which it was housed was monitored regularly to ensure that medicines were stored at the correct temperature. One person received medicines covertly, that is without their knowledge or consent. We noted that a mental capacity assessment and best interest decision had been recorded to comply with the Mental Capacity Act 2005.

Risks associated with the environment were identified and assessed. A fire risk assessment was in place, along with individual Personal Emergency Evacuation Plans (PEEPS). Risks to people's safety were assessed and robust care plans were in place to guide staff on how to provide care safely. The provider used a range of tools to assess specific risks to people, for example, a validated scale, called a Waterlow score, was used to support clinical judgement when assessing risks of pressure damage and a Malnutrition Universal Screening Tool (MUST) was used to assess nutritional risks. Care plans provided guidance for staff in how to mitigate risks and provide safe care.

Some people needed support to move around and manual movement risk assessments and care plans were in place to guide staff in how to support them safely. Staff were using equipment including handling belts, to support people with the process of transferring between a chair and a wheelchair. Our observations were that staff were not always using the handling belt in line with current good practice. This meant that there was a risk that people or staff could be injured when assisting people to move with this equipment. We identified this as an area of practice that needs to improve. The registered manager told us that further

manual movement training had been arranged for staff.

We observed two staff members assisting people to move with the aid of an electronic hoist. They explained to the person what would happen and asked their permission before supporting them to move. Staff were reassuring and confident when using the equipment and supported people to move safely. One person told us, "They are very good." A relative told us, "I have seen them hoisting my (relation) and they know what to do. There are always two staff helping with the hoist." Care plans detailed that some people needed support to be repositioned when in bed. We saw that staff had appropriate equipment such a slide-sheets to assist with this process. One staff member told us the equipment was always available and staff knew how to use it safely.

Incidents and accidents were recorded and the registered manager told us risk assessments and care plans were reviewed following any such incidents. Records confirmed this, for example when a person had a fall the registered manager arranged a referral to the falls prevention team for advice about their care plan.

Most people we spoke with and their relatives told us that there were enough staff on duty. One person said, "I think there are usually enough staff." Another person told us, "They are good at answering the call bell." A third person said, "If I push the bell they come quickly." A relative told us, "There always seems to be a good number of staff." Another relative said, "I have got to know the staff, they are very good and hard-working but they still have time to be attentive to my (relative). They always arrive quickly if I press the call bell." Our observations throughout the day were that staff were busy but people did not have to wait for their care needs to be met.

The provider used a dependency tool to determine the number of staff they required to meet the needs of people safely. This was reflected consistently in the staff rota. Staff told us that only regular agency staff were used and any vacant shifts were covered by the existing staff team. Records confirmed that staffing levels were consistently maintained.

There was an effective recruitment system in place, this ensured that people were cared for by staff who had been checked and found to be safe to work in the health and care sector. Prior to their employment commencing, employment history and references from previous employers were gained. Appropriate checks with the Disclosure and Barring Service (DBS) were also undertaken. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people. This ensured that people were protected against the risk of unsuitable staff being recruited.

Staff had received training in how to safeguard people from abuse or avoidable harm. They were able to describe how they would recognise abuse and understood their responsibilities to report any concerns including procedures to follow in line with the provider's policy. One staff member told us, "I would make sure the person was safe and then I would let the manager know". Another staff member told us, "I would let the CQC know if the manager didn't listen to me".

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us that they had confidence in the staff. One person said, "I am very happy with them and trust them completely." A relative said, "I've been very impressed by the care." Another relative said, "The staff know how to look after my (relation), I am more than happy with the care here." Despite these positive comments were found some areas of practice that required improvement.

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 this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met.

Staff had undertaken training about the Mental Capacity Act 2005 however learning for this had not been consolidated and embedded within their practice. Our observations were that staff sought consent from people before providing care and one person confirmed that this was the case. They told us, "They always ask consent before washing and showering me." However, staff were not able to demonstrate a clear and consistent understanding of their responsibilities with regard to people's rights to make decisions. For example, we asked staff if someone who had capacity could make an unwise decision. Some staff felt that they would not be allowed to do so, this demonstrated that they lacked a basic understanding of the legislation.

Some people were living with dementia and lacked capacity to make specific decisions. Our observations identified that some people had bed rails, lap belts and foot straps in place. These items were being used to ensure people's safety but they could also restrict people's movements. Whilst care records indicated that some people had been assessed as lacking capacity to consent to their use there was no documentation to explain what other options had been explored, that this was the least restrictive option and who had agreed that it was in the person's best interest. We discussed with the registered manager how the care plans advised that people lacked capacity, but we identified that this needs to be underpinned with a specific mental capacity assessment and best interest decision to demonstrate why it is in the person's best interest, for a bed rail or other restrictive equipment to be used.

The registered manager had submitted DoLS applications for some people but staff we spoke with did not have an understanding of DoLS. They were not able to tell us which people were subject to DoLS authorisations and were not aware of any conditions attached to DoLS authorisations. Whilst we did not identify that any person was being deprived of their liberty without lawful authority, the lack of staff understanding meant that the registered manager could not be sure that staff were compliant with all conditions. Staff lacked understanding of the MCA and DoLS and there were failures in documenting best

interest decisions for people who lacked capacity. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were being supported to have enough to eat and drink. They told us that they enjoyed the food on offer. One person said, "I mostly like the food here, especially anything with custard." Another person said, "I like the choice of food here and I like (the chef)." A third person told us, "The food is good here, they ask me what I want for supper." Staff told us that if people didn't want the meal on offer they would offer an alternative. People told us that they were given a choice of meals at supper time but not for the main meal at lunchtime. A relative told us that their relation could choose an alternative if they wanted to, saying, "I know they will make a sandwich or an omelette or something if they doesn't want the main meal, but they usually enjoy it."

We observed the lunch time meal. The menu was displayed on a board in the dining area but not everyone could see it. One person said, "I never know what I am getting, I think they do tell me but I can't remember." We observed staff bringing food to people and explaining what was on the plate. Staff members were supporting people who needed help to eat and we observed them encouraging people and offering them second helpings and drinks throughout the meal time. Some people had chosen to eat in their bedroom and we noted that one person was asleep when their food was set in front of them. No staff attempted to wake the person and assist them with their food until 30 minutes later, by which time the food was cold. The staff member did not check or offer to reheat the meal. We brought this to the attention of the registered manager and identified this as an area of practice that needs to improve.

Risks and nutritional needs were identified and assessed. For example, one person had been identified as being at risk of malnutrition. A nutritional care plan was in place and this identified that they had a small appetite and needed encouragement to eat and drink. We observed one staff member supporting this person, saying, "Try and eat some, would you like any help?" Other people were also receiving help to eat and drink and staff were seen to be patient and encouraging when supporting people. Staff monitored people's food and fluid intake and kept records when necessary, for example if someone had been identified as having lost weight. We observed staff discussing people's food and fluid intake during a meeting and staff noted that someone had been observed to be not drinking or eating well that morning. Staff were informed to increase opportunities for them to have food and fluids. We later observed this was happening.

The chef was knowledgeable about people's preferences and was able to tell us about their nutritional needs. For example they were providing vegetarian meals for one person, a number of people needed soft, mash-able food and some needed pureed meals. The chef was following current good practice for example, fortifying food when people were losing weight and told us that there were always milkshakes and snacks available for people between meals. We observed the chef chatting with people about the meal and asking if they had enjoyed the food. People were engaging in the conversation and we heard one person discussing their preferences for the supper time meal. The chef was heard saying, "There's some cake coming in a bit, I made it this morning for you."

Staff told us they received the training and support they needed to be effective in their roles. A training plan demonstrated that staff had undertaken training that was relevant to the needs of people they were caring for including, dementia awareness. The registered manager kept records to identify when staff needed to refresh their training. This included training for registered nurses in pressure care management, diabetes, venepuncture and end of life care. One staff member said, "The training is good and very regular. We are expected to keep ourselves up to date." Staff told us about their experiences of induction to the home when first coming to work for the provider. One staff member told us, "I was not new (to care) but when I started, I

worked with other staff until I was happy. I did training too."

Staff told us they received regular supervision and they felt well supported in their roles. Supervision is a mechanism for supporting and managing workers. It can be formal or informal but usually involves a meeting where training and support needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues. The staff we spoke with were satisfied with the process. They felt it was open and honest and that they had the opportunity to address issues both in the supervision process and day to day. Nursing staff were receiving clinical supervision from the registered manager.

People were supported to access the health care services that they needed. One person said, "I am able to see the doctor when I need to." Another person said, "If I was unwell I would tell the staff and they would get the doctor to have a look at me." A third person said, "I am just waiting to see the doctor." The registered manager told us that they had a good relationship with a local GP who visited the home regularly. We spoke to the GP who visited during the inspection and they told us that they were happy with the standard of care provided to their patients. They told us, "I have never received an inappropriate referral from staff here, they are always able to provide relevant information such as people's blood pressure and temperature. I have 100% trust in the staff here, they know people very well."

Records confirmed that people were receiving support to maintain their health. For example, one person was living with diabetes and their care records showed good day to day care, such as referrals to podiatry for foot care and regular eye checks to maintain health. The person had blood glucose levels taken and recorded appropriately. People were supported with appointments from a range of health care professionals including, physiotherapists, occupational therapists, dieticians and speech and language therapists and nurse specialists. A relative told us "They are very much on the ball when it comes to people's health, the doctor is often here, I have no worries about that."

Good

Is the service caring?

Our findings

People and their relatives told us that staff were kind and caring. One person said, "The staff are very nice," another said, "The carers are wonderful." A third person said, "I don't mind if I have a male or female carer, they are all so nice it doesn't matter." One relative told us, "They look after me too, they are lovely people." Another relative said, "I've got to know the staff well and they are all very good. I can't criticise them at all."

Staff knew the people they were caring for well and spoke knowledgeably about them, their needs and their lives. One staff member said, "We all know people very well because we work closely with them." A relative told us, "There are not many staff changes and I think that's what makes the difference, because staff know people well." Our observations throughout the inspection showed that staff had developed positive, caring relationships with people and their relatives. For example, one person had fallen asleep in their chair but they were leaning over the chair arm. A staff member noticed this and gently placed a cushion to support their posture being careful not to wake the person. A staff member was heard reassuring someone who had become distressed, they sat with the person holding their hand, talking in a quiet soothing voice until they were calm. A third staff member was observed talking to someone about visitors that were expected later that day, reminding the person and talking about their relative with them. People were observed to be engaging with the staff, they appeared comfortable in their presence, making eye contact and smiling. When people were supported with a task we noted that staff approached people gently, explaining what they were about to do and giving the person time to understand the information before proceeding. One person was supported to be moved with the use of a standing aid, two staff members assisted with this process and they were gentle and reassuring throughout, giving clear guidance to the person without rushing them. The person appeared relaxed and thanked them for their help when the manoeuvre was completed.

People told us that they felt their dignity was respected. One person said, "The staff are very respectful." A relative told us, "I love the way staff speak to my (relation), they are always refer to people here as Mr or Mrs and I think that makes them more respectful." Staff told us that they used people's formal name unless they preferred to be called by their first name. We observed that this was happening consistently, including when staff were discussing people's care in a staff hand-over meeting.

Staff were careful to respect people's privacy. Records containing people's personal information were stored securely. We noted that staff members knocked on people's doors and waited for a response before entering their room. When people needed support with personal care staff approached people discreetly and supported them to their room to maintain their privacy. A relative told us, "When the staff are carrying out personal care I have noticed that they always pull the curtains because it's a ground floor room. They let me know what they are going to do and ask me to wait outside." Another relative told us, "My (relation) always looks well cared for, her hair is washed and brushed and her nails are short and clean. That would be very important to her."

People's differences were acknowledged and respected. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them. We noted that people were smartly dressed in clean clothes. One person

had spilt food on their clothes at lunchtime and a staff member noticed this and quietly offered support to change after lunch. This showed that people were being supported to maintain their dignity.

Some people told us that they were aware of their care plan and had been involved in its development. One person said, "I do have a care plan, I have been given one to read." Another person said, "The managers review the care plan with me fairly regularly." Some relatives also confirmed that they had been included in making decisions about their relation's care. One relative told us, "I always feel involved in my (relation's) care plan and any changes that are made." Another relative said, "I feel more involved in (relation's) care now than when they were at home." Records confirmed that where people had legal representatives or advocates they were consulted about changes to peoples' care plans. People told us that staff gave them choices and they were able to make decisions about their care. One person said, "I can decide when I want to get up, they will bring me breakfast in bed if I want it." Another person said, "You can choose how you spend your time here, they don't make you do things."

Relatives told us they were free to visit at any time and felt welcomed by the staff. One relative said, "No matter what time I arrive they always offer me a drink and know exactly what's going on with my (relation)."

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us that they were happy with the care they received. One person said, "The managers are very proactive and respond to issues quickly." A relative said, "As things have progressed they have made adjustments to make sure (relation) remains comfortable." Another relative said, "They notice little things that make a difference, such as making sure the position of the bed was right, I wouldn't have noticed but the staff do." However, despite these positive comments we found that the service was not always responsive to people's needs.

People were not always provided with meaningful occupation or activities that were suitable for their needs. The registered manager told us that they had recently recruited a new activities co-ordinator but they were not yet in post. Some organised group activities were arranged such as external entertainers and a church service, however there were no other activities planned. Our observations were that people were not being supported with meaningful occupations that were relevant to them. For example, during the morning of the inspection a number of people, some of whom were living with dementia, were sitting in the lounge with the television on but no sound. The television was sited high up on one wall and the sun was shining through onto the screen making it difficult to see. Nobody appeared to be taking any notice of the television although staff told us that one person was watching the programme. Some people were sleeping in their chairs, others appeared to be withdrawn. Some people were able to occupy themselves with a puzzle book or by reading a newspaper but most people had nothing to do. We noted that there were books and puzzles available on shelves in the lounge but people were not all able to access them and there were no materials within people's reach. Some people appeared to be bored and some who were living with dementia showed signs of agitation. One person was seen persistently wiping a table with her hand. Another person had unpicked a bandage on their hand and was trying to pull a dressing off. We brought this to the attention of a member of staff who asked the nurse to redress the wound. The person appeared calmer once this had happened.

Staff told us that no activities were planned because there was no activities co-ordinator. We observed that staff spent little time interacting with people other than when undertaking a specific care task. People were not being supported with any type of stimulating occupation. This was also the case for people who were spending time in their bedrooms. People who were spending the day in their rooms were at risk of social isolation and people were not being supported to have meaningful and stimulating occupations during the day. Throughout the inspection we observed that people had nothing to occupy them and many people went to sleep or dozed throughout the day, only waking up when it was meal time. People told us they did not have enough to do and said that they did not have opportunities to go out in the local community unless with family members. One person said, "I only go out if my family takes me."

Some care plans included information about people's backgrounds, their interests and hobbies. For example, one care plan noted interests as 'enjoyed playing bridge and singing in a choir.' Another care plan described how the person enjoyed singing and watching television and stated 'enjoys the company of others during the day.' We noted that they had spent the day in their bedroom. We looked at records of previous activities but could find no evidence of how information about people's hobbies and interests was

used to effectively reduce risks of social isolation. This meant that there was a lack of evidence about how people's social needs were being met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their needs assessed before they moved to the home. Information had been sought from the person, their relatives and other professionals involved in their care. Information from the assessment had informed the care plans which were comprehensive and covered all aspects of people's lives. Where people had specific needs such as dementia, diabetes or epilepsy there were clear and detailed care plans describing the care and support people needed. For example, one care plan described signs and symptoms that would indicate that the person was unwell and gave clear instructions on actions to be taken. A dementia care plan was detailed and personalised. For example, staff had noticed the person became distressed when looking in the mirror as they believed it to be another person intruding into their room. Staff had removed the mirror and other reflective items and this was detailed within their care plan. This showed that staff understood the importance of person-centred care planning.

At the time of the inspection care staff did not always have access to people's care plans which were held on the computer system, this meant that there was a reliance on verbal information and staff knowledge. Since the inspection, the provider has confirmed that all care staff have access to people's care plans. Staff we spoke with demonstrated a clear understanding of people's needs. Handovers between staff at the start of each shift ensured that important information was shared, and that all staff were aware of any changes and could take appropriate actions when necessary. The nurse on duty told us, "The handover meeting is very important and detailed, we speak about every person and the care staff feed back to the nurses about what has been happening. Care plans are reviewed and updated on a monthly basis so they reflect the care. Staff have such good knowledge of the people here." The registered manager had confidence that staff could retain this information, stating that staff knew people and understood their needs very well. Throughout the inspection we found that staff demonstrated a good understanding of people's needs. Actions agreed in the handover meeting were followed through by staff and managers. Care provided was reflected in people's care plans, changes in need were recognised and care was adapted accordingly. For example, during the handover meeting staff spoke about one person who had complained of pain that morning and had received pain killing medicines. The nurse in charge advised staff to check them regularly and inform the nurse of any changes. Another person had been coughing and staff were advised to keep an eye on them and make sure they were having plenty of fluids. This showed that staff were responsive to changes in people's needs.

Relatives told us they had confidence that staff noticed changes and took appropriate actions to support people. One relative said, "The staff monitor people closely, if they suspect something is not right they report it to the nurse and if necessary the doctor." Another relative said, "They are very proactive and they keep me informed of any changes, they ring me to let me know." People were supported to maintain relationships that were important to them. A relative told us that staff had offered them the opportunity to stay at the home overnight if they wanted to. Another relative said that staff were always supportive to their relation and to them. They said, "The staff know how difficult it is for relatives when people have dementia, they are always supportive to me." This was reflected in the care plan for one person who was living with dementia and had difficulties with their memory. The care plan noted that the person may not recognise visitors and guided staff to talk to the person before their visitors arrived to help them recall who they were with photos. It also noted that visitors may also need support to understand why their relation might not recognise them and prompted staff to be mindful of this.

People told us that they would feel comfortable to raise any complaints or concerns with the staff. One person said, "I would talk to the manager." Another person said, "I can speak to any of the staff." Relatives

told us they knew about the provider's complaints process and would raise any concerns. We noted the complaints procedures was available for all to view in communal areas. It contained information about how and to whom people and representatives should make a formal complaint. There were also contact details for external agencies, such as the Local Government Ombudsman. The registered manager kept a log of all complaints and the actions that were taken to resolve the issues. They told us that they welcomed feedback and took complaints seriously.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the management of the home. One person said, "They are very supportive and I couldn't ask for better." A relative told us, "The communication is good, I would always approach the managers with any issues." A staff member said, "The managers are very easy to talk to." However, despite these positive comments we found some areas of practice that required improvement.

The registered manager had a number of systems and processes in place to monitor standards and quality of care at the home. This included a number of audits such as an infection control audit, medicines administration and a health and safety audit. However, not all of these systems were effective in identifying shortfalls and driving improvements. For example, a health and safety audit had been completed on 30-8-2017 but this had failed to identify omissions in records of weekly fire alarm checks that had not been completed since 30-7-2017. A fire log indicated that fire drills were due to take place on a six-monthly basis however there were no records of these having taken place. The registered manager said that they had undertaken fire drills with staff and people at the home but had not recorded when these happened. The health and safety audit had noted that a fire drill involving staff had not been carried out and identified that this should be completed by 15-9-2017 however there were no records to confirm that this had been done. Annual fire equipment tests were not recorded. This meant that the registered manager could not be assured that the premises were safe and compliant with fire standards and that staff would know how to evacuate the building in the event of a fire.

Care plans were being regularly reviewed and audited however this process had failed to identify that consent or best interest decisions were not documented for some practices that were restrictive, such as use of bed rails and lap belts. Care plans identified people's social needs, however, a lack of oversight meant that these needs were not being effectively met. Although the need for an activity co-ordinator had been recognised and recruitment was in progress no interim arrangements were in place to mitigate risks of social isolation and lack of stimulation.

Failures in some systems for monitoring standards and quality at the home had led to a lack of management oversight in some areas of practice. This meant that risks were not always effectively monitored to ensure the safety and welfare of people and to improve the quality of the service. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some management systems were effective in providing management oversight, including monitoring of incidents and accidents. This was documented on the provider's computer system and a report was available to help in analysing trends and patterns. The registered manager had used this report and others, including monitoring of training and supervisions to ensure that they had clear oversight of standards at the home. The registered manager attended staff handover meetings and worked alongside staff on a regular basis. They explained that this gave them a clear insight into people's needs and helped them to be assured that good standards of care were maintained. When discussing people's needs the registered manager was knowledgeable about all of the people living at the home.

The registered manager had a good awareness of the day to day culture within the home and staff told us they felt able to be open about any concerns that arose within the staff team. Staff told us that the registered manager was easy to talk to and confirmed that they had a good understanding of the needs of people they were supporting. We asked staff if they thought the home was well-led. One staff member told us, "Yes, I think so." Another staff member told us, "I think it's very good. We are a good team." There was a clear management structure with identified leadership roles. Staff had a clear understanding of their responsibilities and knew what was expected of them. There were clear policies and procedures to support staff in their roles. The provider's stated philosophy of care placed an emphasis on treating people with respect and maintaining their dignity and privacy. These values were understood by staff and embedded within their practice

Communication within the staff team was good and staff reported feeling well supported and motivated. One staff member said, "I've been here for years so something is going right!" We noted that staff meetings were held infrequently, the registered manager explained that they rarely needed to have staff meetings because they managed communication with the staff team in other ways including within handover meetings. They explained, "If we need to get staff together we do but on the whole communication happens on a daily basis and in supervision." There was a written communication book which enabled staff to leave messages about forth coming appointments and other important information that needed to be passed between staff. Staff told us that this was an effective tool and worked well. We saw that where information was relevant to changes in people's needs this was transferred to people's care records.

Quality assurance questionnaires were sent to people, their relatives and other relevant professionals to gather opinions on the standards of care at the home. One person told us, "I have had several questionnaires, things do get actioned." A recent questionnaire showed that responses rated satisfactions levels as 'very good' or 'excellent.' We asked the registered manager what changes had been made following receipt of feedback. They explained that in response to some concerns regarding manual handling practice all the staff had received refresher training and further external training was booked. This showed that the registered manager was using feedback to drive improvements at the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's social needs were not being met and people were at risk of becoming socially isolated.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent to care and treatment was not always sought and documented in line with legislation and guidance

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Failures in some systems for monitoring standards and quality at the home had led to a lack of management oversight in some areas of practice.