Donness Nursing Home Limited

Donness Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 8 and 14 March 2017 and was unannounced on the first day. The service is registered to provide care and support for people who may have nursing needs. The service is registered for 34 people; during the inspection there were 17 people living at the home.

We last inspected the service on 14, 15 and 23 June 2016 when it was rated as Requires Improvement overall. At that inspection, we found three breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the running of the home, supporting staff and notifying CQC about incidents that affected the running of the service. The provider had produced an action plan to ensure improvements were made and sustained. Following the last inspection, the provider worked with local health and social care professionals and with the local authority quality monitoring team to improve the service as part of a whole home safeguarding process; this process is now closed because of the improvements that had been made to reduce risk to people's safety and well-being.

At this inspection, we found that improvements had been made and the breaches were met. We made two recommendations linked to staffing and the environment.

People said they felt safe and secure living at the home. People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding adults training and understood their responsibility to reports concerns immediately.

Since the time of the last inspection, a second registered manager had been appointed. We have referred to them as the day to day manager in the report. They were present on both days of the inspection. 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.

The service had two registered managers; one was in day to day charge of the running of the home and had been in post for approximately six months. They said they had worked closely with the provider in the running of the home. The second registered manager was also the provider. They visited the home two to three times a week and provided support for policies, procedures and managed the budget. Neither of the registered managers were practising nurses, although one had a nursing qualification. The service had a designated 'clinical lead' nurse to oversee and advise on clinical decisions at the home. There was also a deputy manager.

The registered manager who was in day to day charge of running the home was leaving at the end of March 2017. In preparation for their departure, they were developing the deputy manager to take on increased responsibilities. They had delegated some duties to them, for example auditing care records. The provider said they were considering what changes they would make to the management team following the

registered manager's departure.

People described their relationships with the staff as positive. For example, speaking about a staff member, one person said, "She is a lovely girl", another person described staff as "kind and gentle" and a third person said staff were "very good." People looked relaxed with staff. This included staff who worked as part of the housekeeping, activities and catering team. Care staff were able to describe their practice to ensure they respected people's dignity, for example when supporting people with personal care.

People's safety and wellbeing was promoted because there was sufficient staff to keep people safe and meet their needs at a time and pace convenient for them. The atmosphere in the home was not rushed and organised; staff worked in an unhurried way and were able to spend time with people. However, we have made two recommendations to the provider to look at deploying staff consistently and improving the information on the rotas, to include when the management team were on duty.

People had individual risk assessments and care plans to minimise risks identified. For example, people at risk of choking. Staff preparing food understood the risks for people of choking and had clear information about how their food should be prepared. Accidents and incidents were reported and reviewed to identify ways to further reduce risks and highlight trends or increased risks for individuals. For example, analysing falls in detail to see if further measures could be introduced to reduce the risk of reoccurrence. People received their medicines safely and on time. People were cared for in a clean, hygienic environment.

The day to day registered manager had introduced a robust system for health and safety monitoring around the home. Staff received regular fire, health and safety, safeguarding and infection control training. A maintenance team undertook an ongoing programme of repairs, maintenance and redecoration to maintain the environment of the home. The home's environment was maintained to high standard.

The day to day practice of staff and feedback from people living at the home showed staff had an understanding of the principles of the Mental Capacity Act. Throughout our inspection, staff took time to check with people that they understood their wishes and gained their permission to help them. Staff changed their approach to meet the individual needs of people, for example rephrasing their questions if the person seemed unclear what they were being asked. Staff did not rush people and gave people eye contact. Mental capacity assessments were undertaken to assess people's capacity to give their consent to live at the home to receive care and treatment.

Formal observations of staff practice and competence had been established as part of the supervision process for staff. The day to day registered manager said this offered a valuable opportunity to give individual staff feedback on their practice and interactions with people and helped identify any specific training needs. Staff said they felt supported and were positive about the purpose of having their practice observed. Training records showed staff received training on a range of subjects.

Staff members commented there was good communication between shifts to ensure people's changing needs were shared when staff came on duty. They also said staff worked well as a team. Staff were provided with equipment and information to meet people's health needs and to recognise changes in people's health.

Adaptations were made to the home to meet the individual needs of people with physical disabilities. There were two passenger lifts to help people access the upper and lower floors. However, further work was needed to consider the needs of people living with dementia. Some people chose to regularly walk around communal areas of the home, staff chatted with them as they walked alongside them. There were few

pictures and objects around these routes for people to talk about with staff to stimulate their memories or interests.

Care records were well laid out and easy to navigate. People's records had person centred details about each person, their likes and dislikes, information about their life before they came to live at the home and their medical history. Staff used the knowledge of people's previous interests and employment to engage with them. People responded well to this approach, for example a person became animated and spoke enthusiastically about their life to staff.

Improvements had been made and were continuing regarding the provision of activities for everyone living at the home. People told us about the activities which they preferred and they chose to participate in, which records confirmed. Photos showed people participating in a variety of events including flower arranging. Staff involved in activities knew people's individual preferences and records showed how they catered for this through group work and one to one sessions.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the management team and were confident it would be dealt with straightaway.

The day to day registered manager said the morale of the staff team was good. They were pleased with the improvements to the service but acknowledged this was "work in progress" with more time needed to embed the changes/improvements in practice. Staff praised the impact of the day to day registered manager on the culture of the home and the improvements that had been achieved. They said the day to day registered manager was approachable and listened to their ideas.

Following the last CQC inspection the provider had met with people and families to outline the findings and steps being taken to improve. The day to day registered manager said people and relatives said they were happy with their care. A newsletter had recently been produced to keep people, relatives and staff updated about the changes and improvements at the home. The January 2017 newsletter encouraged people and families to provide feedback on things that mattered to them about the running of the home in person or via e mail.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

Most aspects of the service were safe.

Staffing levels were sufficient on most shifts to help ensure people were safe and their care and social needs met. However, there were areas for improvement linked to staff deployment and information on staff rotas.

Staff recognised their responsibility to report safeguarding concerns or poor practice in a timely manner.

Risks to people's physical health were monitored and equipment was in place to reduce risks to people. The home was well maintained.

The recruitment procedure was effective to ensure the suitability of new staff. Medicines were well managed.

Is the service effective?

Good

The service was effective.

People's legal rights were protected under the Mental Capacity Act.

Systems were in place to supervise and train staff.

Staff ensured people had access to health care professionals and monitored people's health.

Is the service caring?

Good

The service was caring.

Staff practice supported people's dignity.

Staff demonstrated good care, showing affection and respect towards people. There was a commitment to providing end of life care for people.

Is the service responsive?

Good

The service is responsive.

On-going improvements were being made to the range of activities on offer.

Care plans were clear and easy to read with person centred information, with guidance to staff which they followed.

There had been no complaints since the last inspection and people felt confident their concerns would be addressed.

Is the service well-led?

Good

The service was well led.

A number of improvements had been made to the way the home was run. Changes in the management team were imminent following the departure of one of the registered managers. New quality assurance systems had been introduced which required maintenance to ensure they remained effective and embedded in the culture of the home.

Donness 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 inspection took place on 8 and 14 March 2017 and was unannounced on the first day. The inspection team comprised of two adult social care inspectors on the first day and one adult social inspector on the second day. We reviewed the information we held about the home, such as the provider's action plan, feedback we received from health and social care professionals.

We met with all 17 people using the service, and spoke with 4 relatives and a visitor. We looked at five people's care records and at people's daily records in their room. A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not comment directly on their experience.

We spoke with eight staff and the two registered managers. We looked at systems for assessing staffing levels, for monitoring staff training and supervision, staff rotas, and staff files, which included recruitment records for new staff. We also looked at quality monitoring systems the provider used such as audits and provider visit reports. We sought feedback from commissioners, and health and social care professionals who regularly visited the home and received a response from two of them. Neither of them had information of concern about the service.

Good

Is the service safe?

Our findings

People said they felt safe and secure living at the home. A visitor commented they were reassured by the comfort checks staff carried out to check on their relative's well-being. Another visitor said the atmosphere was calm and staff had an awareness of where people were in the building which helped keep them safe.

People were protected from potential abuse and avoidable harm. Staff had undertaken safeguarding adults training and understood their responsibility to reports concerns immediately. The provider had safeguarding and whistle blowing policies in place and information about what action staff should take if they suspected abuse. Contact numbers for the local authority safeguarding team were also on display in staff areas around the home. This meant staff knew who to contact and what to do if they suspected or witnessed abuse or poor practice.

People's safety and wellbeing was promoted because there was sufficient staff to keep people safe and meet their needs at a time and pace convenient for them. The atmosphere in the home was calm and organised; staff worked in an unhurried way and were able to spend time with people. People were offered support with personal care regularly throughout the day.

The day to day registered manager used a dependency tool to assess and monitor the support each person needed and amended staffing levels accordingly. The dependency assessment tool calculated staffing levels using a scoring tool based on a risk assessment of each person's care needs. The day to day registered manager said this showed current staffing numbers were safe. We looked at staff rotas over a period of five weeks, which included a week planned in advance. After a discussion with the day to day registered manager and reviewing each rota, we were reassured that staffing levels were kept under review and changed to cover sickness. Rotas showed one nurse worked on every shift and some shifts were covered by the clinical lead as well. At nights, staffing levels were assessed as two care workers, plus a nurse. The day to day registered manager explained how shortfalls had been addressed by using bank staff to provide cover where possible for annual leave.

Based on the dependency tool, the registered managers had assessed the minimum number of care staff should be three in the morning but ideally should be four care staff. There were three care staff on duty for ten morning shifts out of 28 shifts. However, five shifts ran with five staff in the morning and the remaining shifts with four care staff in the morning.

The rotas did not show when the registered managers and the deputy manager were working at the home. This meant they could not demonstrate the level of support they gave to staff by being available and the level of oversight they had in running the home. It would also enable staff to inform people living at the home and visitors when managers would be available to meet with them.

Afternoon shifts had been assessed as two care staff from 2pm being the minimum level, plus one nurse. This meant staff could support people were living with dementia who can become more restless and anxious later in the day and need more support and reassurance from staff. On the second day of the

inspection, one person living with dementia was on their own in a lounge for 30 minutes without staff being present or interacting with them. A visitor for another person had to call a staff member away from an activity session to reassure the person and on one occasion we asked the nurse who was working in the office to reassure them. There was the assessed number of staff on shift but they were supporting people in another part of the building.

We recommend that the service review staff deployment as currently there is not an equal distribution of care staff on each shift and the availability of the management team is not shown on the rota. We recommended that the service improve communication between staff to ensure communal areas are supervised by a staff member if other staff are supporting people in their bedrooms.

There were five nurses working at the home, and agency nursing staff were used to cover sickness and other absences. Both registered managers recognised an additional nurse would benefit the team and a potential employee was undergoing recruitment checks. Nursing staff worked flexibly to cover day and night duties.

There was a core group of experienced care staff working at the home who provided stability and consistency for people living at the home. Visitors commented on the stable care staff team. There were two care staff vacancies which the service were actively trying to recruit to. The day to day registered manager emphasised the importance of getting the right calibre of staff to fill these vacancies. Staffing levels had also improved because the day to day registered manager had been working with staff to address high levels of sickness amongst the staff team, which had significantly reduced over recent months. Where shifts needed covering because of annual leave, mostly these were done by existing staff working extra hours. This had meant the use of agency staff had dramatically reduced at the service.

We identified in one person's employment file two areas for improvement to explain a gap in a person's employment history and to ensure they contacted the most appropriate person for a reference. These were addressed by the day to day registered manager during the inspection. Other recruitment files contained the correct information and provided a clear audit trail of the steps taken to ensure the suitability of new staff members. This included disclosure and barring Service (DBS) checks and ensuring nurses were registered with the Nursing and Midwifery Council. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

A new call bell system had been installed but further equipment was needed before it could be introduced. In the meantime, the usual call system was still in place and enabled people to call for assistance from staff. The day to day registered manager said the new system would provide information about call bell response times and how long staff spent with each person. They explained this data would help assess staffing levels so they were based on people's individual needs.

People had individual risk assessments and care plans to minimise risks identified. For example, people at risk of malnutrition, dehydration, with choking/swallowing risks, of falling and developing pressure ulcers. Staff demonstrated awareness of each person's safety and how to minimise risks for them. For example, they reminded people to use their mobility aids when they were moving around the home to increase their safety and independence. Where people had bed rails fitted for their safety, these had been risk assessed. Staff preparing food understood the risks for some people of choking and had clear information about how their food should be prepared.

Accidents and incidents were reported and reviewed to identify ways to further reduce risks and highlighted trends or increased risks for individuals. For example, analysing any falls in detail to see if further measures could be introduced to reduce the risk of reoccurrence. Where a person was at high risk of falling or they

were confined to bed for health reasons, staff did regular 'comfort rounds.' This was to help the person reposition, offer them drinks and snacks, prevent isolation and check if they needed anything. Other measures used to reduce the risk of falls included close observation by staff when the person mobilised to support the person and keep them safe. We saw staff encouraging people to take their time as they mobilised; they provided clear and calm information when people chose to move independently. Anticipating people's needs helps avoid slips, trips and falls and is in accordance with NICE guidelines.

The day to day registered manager had introduced a robust system for health and safety monitoring around the home. For example, first aid boxes had been installed all around the building. A maintenance team undertook an ongoing programme of repairs, maintenance and redecoration to improve the environment of the home. Hot water temperatures were controlled in areas people accessed independently and were within the health and safety recommended limit of 44 degrees. Records showed bath temperatures were also checked before the person was immersed. Gas and electrical appliances and equipment were regularly serviced and tested as was all equipment used at the home such as hoists, slings and pressure relieving equipment. Contingency plans were in place to support staff out of hours with any emergencies related to people's care or related to services at the home such as electricity, gas and water supplies.

Staff received regular fire, health and safety, safeguarding and infection control training. An up to date fire risk assessment was in place, regular checks of firefighting equipment, emergency lighting was recorded in fire log books and staff participated in regular fire drills, with the most recent on 27 January 2017. Each person had a personal emergency evacuation plan showing what support they needed to evacuate the building in the event of an emergency. Since the last inspection, the day to day registered manager had undertaken detailed environmental risk assessments and showed measures taken to reduce risks. For example, installing window restrictors to several bathroom and bedrooms areas. These reduced the risk of people falling from a height from the upper floor.

People received their medicines safely and on time. Since we last visited, the day to day registered manager had revised the medicines management policy which more comprehensive to reflect NICE guidelines. They had discussed the changes in detail with the nurses at the February 2017 nurses' meeting. The registered nurses undertook regular medicines training and twice yearly competency assessments, including medicines calculations. This ensured they had the required skills and knowledge to administer medicines safely.

Medicines were stored safely within a secure treatment room. Medicines, which need additional security because of their potential for abuse, were stored securely and records showed they were looked after safely. A medicines refrigerator was available and staff recorded the fridge temperature daily to check it was in the safe range for storing medicines. Medicines administered were well documented in people's Medicine Administration Records (MAR), as were prescribed creams. Medicines were checked and MAR sheets audited with actions taken to follow up any discrepancies or gaps in documentation identified.

People were cared for in a clean, hygienic environment, although one room had an underlying unpleasant odour which we asked the provider to investigate. A deep clean took place the following day which addressed the issue. Housekeeping staff used suitable cleaning materials and followed cleaning schedules and infection control procedures in accordance with Department of Health infection control guidance. Staff used hand washing gels, paper towels, and protective equipment such as gloves and aprons to reduce cross infection risks. Regular infection control audits were carried out with steps taken to address any concerns identified. For example, installing more hand towel dispensers for staff hand washing.

Good

Is the service effective?

Our findings

At our last comprehensive inspection in June 2016, there were two breaches of regulation which included records relating to decision making and a second relating to how staff were supported and supervised. There had been improvements made and the breaches had been met.

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.

We checked whether the service was working within the principles of the MCA. Mental capacity assessments were undertaken using the local authority assessment tool. When these demonstrated the person lacked capacity to consent to live at the home records demonstrated decisions had been made in their best interests involving families and health and social care professionals. This showed people's capacity to give their consent to live at the home to receive care and treatment had been assessed and captured decisions made about this in the person's best interest. Further work was needed to ensure there was a consistent approach for people who lacked mental capacity or had fluctuating capacity. There were no records of specific 'best interest' decisions being made for the use of motion sensors to help keep the person safe, which staff confirmed. The management team agreed this was an area for improvement and would be addressed. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided.

Where people are deemed to not have capacity to make a decision about a particular issue, it may be necessary to consider whether they are being deprived of their liberty in relation to the issue. If this is found to be the case, an application for a Deprivations of Liberty Safeguards (DoLS) authorisation must be made. In these circumstances the provider must do all they can to find the least restrictive ways to meet the person's needs. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests. Applications for a DoLS had been made for people living at the home and staff had received training to understand their responsibilities.

Adaptations were made to the home to meet the individual needs of people with physical disabilities. There were two passenger lifts to help people access the upper and lower floors. Electric beds were available to assist people to get in and out of bed and to sit up in bed. Pressure relieving mattresses were available for people at risk of pressure damage and were serviced and maintained regularly. We checked and they were at the correct setting for the person's weight. Pressure mattress setting were also audited regularly. The service had also purchased equipment such as beds, chairs and hoists suitable for caring for people, with higher body weights.

However, further work was needed to consider the needs of people living with dementia. Some people chose to regularly walk around communal areas of the home, staff chatted with them as they walked alongside them. There were few pictures and objects around these routes for people to talk about with staff to stimulate their memories or interests.

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We recommend the provider consult guidance on the design of environments for people living with dementia.

Throughout our inspection, staff took time to check with people that they understood their wishes and gained their permission to help them. Staff changed their approach to meet the individual needs of people, for example rephrasing their questions if the person seemed unclear what they were being asked. Staff did not rush people and gave people eye contact. For example, staff took time to explain the use of equipment and ensured people felt included as they assisted them. People were offered choice around day to day decisions, such as where they would like to spend their time, how they spent their time, what they would like to eat and drink. People moved around the home as they chose. Staff recognised some people chose to regularly walk around the home, which they supported them to do. Seats were strategically placed along corridors which people used to stop and rest on whilst they were moving around the home.

Staff had access to regular supervision and support. Observations of staff practice and competence had been established as part of the supervision process for staff. The day to day registered manager said this offered a valuable opportunity to give individual staff feedback on their practice and interactions with people and helped identify any specific training needs. Staff said they felt supported and were positive about the purpose of having their practice observed. Annual staff appraisals were in the process of being completed; staff appreciated the opportunity to discuss their development and understood the purpose of supervision.

Training records showed staff received training on a range of subjects. This included safeguarding vulnerable adults, fire safety and medicines administration. The day to day registered managers explained how they had worked in collaboration with accredited trainers at another care service who had no teaching space for training staff. This meant staff from both services were able to undertake their training at Donness Nursing Home and benefitted from mixing with each other to share practice ideas. At a recent nurses' meeting, updates for training on dementia, diabetes and Parkinson's (a medical condition that affects the nervous system) were planned. We saw staff had signed up for these training sessions; staff told us about their recent training. For example, their understanding of dementia awareness based on how they met people's individual and differing needs. A staff member commented "they are hot on training here" and another staff member said the appointment of the day to day registered manager had helped promote a commitment to training amongst the staff team.

Staff members commented there was good communication between shifts to ensure people's changing needs were shared when staff came on duty. Information was given verbally and there was a written record completed by the nurse on duty. They also said staff worked well as a team. Staff meetings took place and staff said they were able to share their views. Relatives told us they were kept up to date by staff and informed if there were any changes to their relative's health.

Staff were provided with equipment and information to meet people's health needs and to recognise changes in people's health. Following an audit of equipment, extra moving and handling slings had been purchased for the home. This ensured each person who needed one had their own sling and replacements were available when these needed laundering. Posters in the office also reminded staff about practice issues

such as the 'fingertip test' for checking circulation of people at increased risk of developing pressure ulcers.

Where a person was at risk of malnutrition and had lost weight, their nutritional care plan showed nutritional supplements had been commenced alongside regular meals and snack. This showed positive actions taken in response to weight loss. Catering staff knew who was at risk of weight loss and worked alongside care staff and nurses to monitor people's well-being. They told us how they adapted the person's diet and records were kept of people's weights, which showed people's health was regularly monitored. Advice was sought from dieticians. People were positive about the choice and quality of the food, although one person felt the taste was variable depending on who cooked the meal. People were offered a choice of food and drink; staff helped people to consider other options if the menu did not meet their preferences. Meals were not rushed and staff sat with people to encourage them to eat.

Where a person had mental health needs staff worked closely with the person's GP and mental health nurse to seek on-going advice and support. Care plans provided staff with advice to respond to people's experience of dementia. For example, how to respond if a person experienced hallucinations and to understand that these experiences 'are very real' to the person. Records showed staff were in contact with health professionals and staff made phone calls to health professionals during our inspection to update them on changes to people's well-being.

Good

Is the service caring?

Our findings

People described their relationships with the staff as positive. For example, speaking about a staff member, one person said, "She is a lovely girl", another person described staff as "kind and gentle" and a third person said staff were "very good." People looked relaxed with staff. This included staff who worked as part of the housekeeping, activities and catering teams. A staff member from this group told us it was an important part of their role as they cleaned people's rooms to engage with people and gain their trust. For example, we saw them chatting with a person as they cleaned. The person was unable to engage in a verbal conversation but the staff member spoke about objects in their room to relax them and showed they knew what was important to them, such as a soft toy. Written feedback from relatives included praise about the staff group's 'kindness and care' and how staff were 'all very kind and always talked to and of (person) in a kind and respectful way.'

Staff were observant and picked up on people's moods. One person became anxious during the day and was restless. Staff recognised this and walked alongside them. The person responded well to signs of affection from staff; the day to day registered manager said to the person "you're like a magnet, we're drawn to you." The person smiled in response. Staff were also sensitive to the needs of the person's relative; one staff member in particular took time to sit with them and check they were not overly tired as they recognised the strain they were under. The relative told us they were always welcomed and staff were "helpful." Another visitor said the staff were "more caring" than the staff at another home their relative had lived in. They said staff treated their relative with respect. People looked well cared for, for example people's hair was brushed and their glasses clean, which visitors confirmed was the norm.

Staff knocked before they entered people's rooms, which people said was usually the case. There were working locks on toilet doors and the home was kept odour free which helped maintain people's dignity. Care staff were able to describe their practice to ensure they respected people's dignity, for example when supporting people with personal care. During the inspection, staff discreetly supported people to find the toilet or gently encouraged people to be assisted to the toilet.

Staff checked with people if they needed assistance with their meal before helping and subtlety prompted people to encourage them to eat. Staff were careful not to rush people when they helped them to move using equipment. They explained what they were doing and ensured the person understood; staff checked people's dignity was maintained by placing a rug over them and ensuring their clothing was correctly positioned once they were sat down. Staff recognised some people had the potential to become distressed when moved so made sure there was a cup of tea ready for them once they were comfortable.

People were asked about where and how they would like to be cared for when they reached the end of their life. Any specific wishes or advanced directives had been discussed with people and families and were documented in their care records. For example, the person's views about resuscitation in the event of unexpected collapse. The management team explained how people's final wishes were known by the staff team in the event of the emergency to ensure people's wishes could be respected.

The service provided end of life care for people, although no one was receiving this service when we visited. The deputy manager spoke passionately about the importance of this work and the importance of "a good death" for people and their families. When we asked about this they emphasised the importance of keeping the person comfortable, pain free and support them and their relatives. They described how they worked closely with other staff in the home, district nurses and hospice staff to support people receiving end of life care and their families. Written feedback from a relative said it was "comforting to know how well you looked after her right to the end." The deputy manager planned to undertake a training programme called 'The Six Steps End of Life Care' at the hospice in April 2017. This programme incorporates the five national priorities for care of the dying and covers end of life care of people with dementia. This will be used to improve existing care and keep staff up to date with best practice in end of life care.

Good

Is the service responsive?

Our findings

Care records were well laid out and easy to navigate. People's records had person centred details about each person, their likes and dislikes, information about their life before they came to live at the home and their medical history. Staff used the knowledge of people's previous interests and employment to engage with people living at the home. People responded well to this approach, for example a person became animated and spoke enthusiastically about their life to staff.

There were care plans about each person's communication needs, personal care, night time support, continence care, and health needs. There were also instructions for staff about how to support people with oral health, nutrition, and hydration and with their dietary requirements. In one person's care plan, there was a picture of their glasses to help staff identify them if they became mislaid. We saw the person wearing their glasses during the inspection. Other individualised care plans were available for people with medical conditions such as diabetes.

One person had been assessed as being at high risk of pressure damage to their skin; staff followed the care plan to encourage them to rest in bed on a specialist mattress in the afternoon. A chart was in place to ensure staff turned them regularly to reduce the risk of skin damage. In the morning, we met the person in the lounge where they were watching the television; staff had ensured they were sitting on a specialist pressure relieving cushion. Review dates showed care plans were reviewed and updated regularly.

Where people had swallowing difficulties or choking risks and needed their drinks thickened to help them drink safely, staff followed instructions in accordance with their care plan. Where concerns were raised about another person's weight loss, staff kept a food diary to record what they were eating. People were supported to maintain their independence and daily living skills. For example, one person's care plan instructed staff to encourage the person to participate in personal care by washing their own hands and face.

Improvements were continuing regarding the provision of activities for everyone living at the home. People told us about the activities which they preferred and they chose to participate in, which records confirmed. Photos showed people participating in a variety of events including flower arranging. Staff involved in activities knew people's individual preferences and records showed how they catered for this through group work and one to one sessions. This variety was needed as we saw one person living with dementia appeared bewildered by being asking questions during a quiz where there was a lot of background noise. The management team explained there was not usually so much activity in the room during these types of sessions and this would be monitored. There were plans to create memory boxes for people living with dementia to help staff initiate conversations with people. The day to day registered manager said the home was on the waiting list to have regular visits from the 'Pat a Dog' scheme. This is a volunteer scheme which provides people with comfort and companionship through regular visits by dog and their providers, who have been carefully vetted. They stated they had encouraged a larger variety of activities to meet the needs of people living with dementia.

A person told us how they were planning to return to their own home; staff showed us recommendations from a health care professional who was working with the person to help them develop new skills. The management team explained how staff were interpreting the recommendations into their practice which meant they were learning to encourage the person to become more independent whilst balancing these potential risks to maintain the person's safety. We saw staff adopting this approach and a health professional confirmed staff were working with them to assess the person's needs.

People and relatives said they had no concerns or complaints about the home. They said if they had any concerns, they would feel happy to raise it with the management team and were confident it would be dealt with straightaway. One person commented that the office manager listened calmly and would then correct things. The provider had a written complaints policy and procedure. Written information was given to people and was on display in the home about how to raise a complaint. No complaints had been raised about the home since we last visited. The day to day registered manager explained how they had addressed a concern about a staff member's attitude towards another staff member. They said they were working with the staff member to change their approach to ensure it was respectful to work colleagues, although they needed to record this approach.

Good

Is the service well-led?

Our findings

At our last comprehensive inspection in June 2016, there was a breach of regulation relating to good governance and one regarding notifying the Care Quality Commission (CQC) of incidents within the service. At this inspection we found there has been improvements and the breaches were met.

The service had two registered managers; one was in day to day charge of the running of the home and had been in post for approximately six months. They said they had worked closely with the provider in the running of the home. The second registered manager was also the provider. They visited the home two to three times a week and provided support for policies, procedures and managed the budget. Neither of the registered managers were practising nurses, although one had a nursing qualification. The service had a designated 'clinical lead' nurse to oversee and advise on clinical decisions at the home. There was also a deputy manager.

The registered manager who was in day to day charge of running the home was leaving at the end of March 2017. In preparation for their departure, they were developing the deputy manager to take on increased responsibilities and had delegated some duties to them, for example auditing care records. The provider said they were considering what changes they would make to the management team following the day to day registered manager's departure.

The day to day registered manager said the morale of the staff team was good. They were pleased with the improvements to the service but acknowledged this was "work in progress" with more time needed to embed the changes/improvements in practice. Staff praised the impact of the day to day registered manager on the culture of the home and the improvements that had been achieved. They said the day to day registered manager was approachable and listened to their ideas.

The management team worked alongside staff to role model the expected behaviours and standards of care using a coaching style of leadership. For example, the day to day registered manager had identified some moving and handling concerns and worked with staff to ensure all moving and handling met best practice standards. We asked the day to day registered manager how the management team had worked together. They said this had been a "learning curve," during which they had clarified roles and responsibilities for decision making.

The day to day registered manager described their leadership style as "firm but fair" with a willingness to tackle issues and take tough decisions. The management team met together regularly and minutes of a meeting on 6 February 2017 showed agreements had been made about their different responsibilities. For example, completing appraisals, plans for recruitment and to develop a newsletter.

The culture of the home had improved becoming more open, inclusive and friendly. The day to day registered manager spoke about how they were promoting the home's values of being person centred amongst the staff team. For example, encouraging staff to speak about people as individuals, rather than focusing on care tasks. The day to day registered manager had signed the service up to the Social Care

Commitment; staff were working towards meeting the requirements. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is made up of seven 'I will' statements, with associated tasks. Each commitment focuses on the minimum standards required when working in care. It aims to increase public confidence in the care sector and raise the quality of the workforce in adult social care.

The day to day registered manager explained how they had incorporated the commitments into staff appraisals and supervision to set expectations for staff about standards expected and help embed them in practice. At the time of the inspection they were focusing on the topic of professionalism. They had also identified the need for consistency of staff supervision and line management as a key way of setting expectations of staff and providing high support to achieve the expected standards of care for people. For example, they explained that they managed the care staff, the clinical lead managed the nursing team, and the deputy manager managed the catering and housekeeping team.

Staff were made aware of any recent changes to people's health and care needs when they came on duty through a staff handover meeting. This ensured that important information was shared, and acted upon. The handover meeting was held at two o clock although staff for the afternoon shift came on duty at midday. Some staff were concerned this could potentially mean they were not aware of important changes to people's health until later in the shift; the day to day registered manager had highlighted this arrangement as a routine to be changed. We shared this information with the provider for them to consider, although they said they were confident key information would be shared as soon as staff came on shift if needed.

A written handover sheet was also completed by nurses which highlighted what assistance people needed and any recent changes in health or care needs. A range of 'spot checks' had been introduced on each shift, for example, on people's personal care, cleanliness, medicines management, fire safety and the environment by the management team and team leaders. A whiteboard was used to follow up important messages about people's care and treatment. For example, when people's dressings were due to be changed and about prescription changes such as antibiotics or the commencement of eye drops.

The day to day registered manager had developed a comprehensive service improvement plan during their six months at the home which showed improvements underway, their progress and the timescale they were due to be completed. This showed a number of improvements had already been achieved. For example, in the documentation of mental capacity assessments and best interest decision making, Other improvements were ongoing, for example ensuring records were completed consistently such as signing and dating records.

Staff were consulted in decisions about people's care and the running of the home through regular bimonthly staff meetings. For example, at a staff meeting on 13 February 2017, a new format of care plan was discussed with staff with key changes highlighted. Feedback was given to staff about the findings of audits and areas identified for further improvement such as in relation to managing mealtimes better. This related to staff helping people back from the dining room so people were not waiting in wheelchairs in the lounge for staff to be available to assist them to transfer into their chair. This showed a commitment to consult and involve staff in the changes and improvements taking place. Staff said the day to day registered manager listened to them and where possible acted on their suggestions. The service had also worked with the local authority quality monitoring team to improve people's care records.

As several nursing staff were new, the day to day registered manager explained the nurses still needed to gain more experience of supervising other staff. Minutes of a nurses' meeting showed registered nurses'

roles and responsibilities in managing each shift were discussed and support offered by the clinical lead and the provider. For example, emphasising the importance of delegating duties appropriately to the staff team and monitoring practise, the quality of care being provided and the safety of the environment. Nursing staff were expected to work both day and night shifts to ensure consistency of nursing practice throughout the 24 hour period.

Where persistent issues about staff practice or capability were identified they were dealt with through additional supervision and training. Where individual staff were still not making the expected improvements, formal disciplinary and capability procedures were used. Where staff had their practice monitored by an external regulatory body, the provider had ensured they had written information so they were clear on any restrictions. This ensured any issues affecting the quality of people's care were addressed proactively. Staff fed back that relationships had improved at the home and that the current team was working really well together and they felt well supported by their work colleagues.

People's and relatives views were sought day to day, through the use of a suggestion box, surveys and through regular care reviews. Staff kept in regular contact with families by phone and email. For example, in response to feedback from people, the day to day registered manager had introduced printed menus so people could see the menu choices in advance. There were also plans to develop picture menus to assist people with memory problems to make food choices. This showed staff sought people's views and acted on them.

Following the last CQC inspection the provider had met with people and families to outline the findings and steps being taken to improve. The day to day registered manager said people and relatives said they were happy with their care. A newsletter had recently been produced to keep people, relatives and staff updated about the changes and improvements at the home. The January 2017 newsletter encouraged people and families to provide feedback on things that mattered to them about the running of the home in person or via e mail. It also highlighted the last CQC inspection report findings and the efforts being made to make improvements, including the installation of a new call bell system.

There was a range of quality monitoring systems to continually review and improve the service and identify areas for improvement. For example, daily, weekly, monthly and six monthly audits. These included audits of people's care records, medicine records, health and safety checks of the premises and equipment and infection control checks of cleanliness, laundry and waste management. The day to day registered manager took action to address areas where improvements were needed. For example, minutes of a nurses meeting on 17 February 2017 showed an audit of medicines management had highlighted missed doses and difficulty identifying when these occurred. In response, daily checks of prescription sheets were introduced to detect any issues, so action could be taken in response. This had been effective as no missed doses were identified in the medicine records we looked at. Other improvements following audits included introducing a new format for care records.

Other improvements included improving accident/incident reporting and recruitment systems.
The use of computers had also been introduced at the home, so documents and systems were more accessible, legible and could be updated as things changed. The deputy manager in particular praised this development which had enabled them to develop their computer skills. The service was also considering whether to introduce electronic care records and had started to research which system might best suit their needs.

The day to day registered manager kept up to date with evidence based practice through established networks with other health and social care providers. They demonstrated an up to date knowledge of

evidence based practice, for example, the National Institute for Health and Care Excellence (NICE) guidelines on managing falls and pressure area care. They also worked closely with the local quality monitoring team and with local professionals to implement evidence based practice tools to improve the quality monitoring systems and standards of care. The day to day registered manager said the tools provided to reduce people's risks of falling were particularly valuable. The service provided policies and procedures to guide staff in their practice. These included policies on safeguarding, Mental Capacity Act and DoLs, health and safety and infection control.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. The day to day registered manager had notified the CQC about significant events. We used this information to monitor the service and ensure they responded appropriately to keep people safe.