HC-One Limited

Knowsley Manor 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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Knowsley Manor Nursing Home is a 'care home' that provides nursing care for a maximum of 50 people. At the time of the inspection there were 36 people living at the service. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There is no registered manager working at the service. There was however a manager in post who was responsible for the day-to-day running of the service. The manager had applied to CQC to become the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We carried out this inspection on 10, 15 and 18 May 2018. The first day of the inspection was unannounced and the other two days were announced.

At the last inspection, in June 2016, the service was rated Good. At this inspection we found improvements were required in relation to safe and effective care for people.

Medication was managed safely overall. However, on the first day of inspection thickening powder prescribed to people to modify their fluids was left unattended in a dining room which was occupied by people. If ingested thickening powder can cause a person to choke. The powder was stored away safely on the other two days of inspection. All other medication was safely stored and administered to people and there were safe systems in place for the receipt, disposal and returning of medication to the supplying pharmacist. People were administered their medication on time by suitably trained staff.

Call alarm bells were in place around most part of the service, however there were two toilets and two bathrooms without one. This meant that there was no means for people to alert staff should they need to when using those rooms independently. The manager immediately contacted the relevant department within the organisation to arrange for call alarm bells to be fitted and this done by the end of our inspection. Cleaning schedules were in place and being followed. The environment was clean and hygienic and smelt pleasant throughout. Staff followed good infection prevention and control practices to minimise the risk of the spread of infection.

Care plans were in place for people's assessed needs and they included directions for staff on how to meet them. This included the completion of charts to record the care given. Some people's charts did not include information about their care needs and others did not reflect the care given. Staff assured us that people had received the right care and we did not evidence any impact on people. However, there was no guarantee that people had received the right care and support in line with their care plan.

People were offered a choice of food and drink which was prepared in line with their dietary needs which were well documented. However, meals were not always well presented. Each element of a pureed meal for one person was mixed together in a bowl making the meal look bland and unappetising. Bread was placed on the edge of soup bowls rather than people being provided with a side plate. In one instance the bread fell into a person's soup and they struggled to eat it.

The quality and safety of the service was assessed and monitored. The required checks had been carried out and improvements made in line with the registered providers quality assurance framework. However more regular checks were required to ensure records about people's needs and the care given were accurately completed and maintained. More robust checks to ensure people's safety were also required in relation to the storage of thickener, presentation of meals and accessibility to call bell alarms. The manager quickly addressed these issues, however consistent good practice is needed over time to ensure people always receive safe and effective care.

People, staff, family members and other visiting professionals reported positively about the manager and their management style.

The environment had undergone some refurbishment since the last inspection making it more attractive and comfortable for people. At the time of the inspection further improvements were underway. Although there was some signage around the service to help orientate people and items of stimulation for people living with dementia, further improvements were needed. The manager recognised this and prior to the inspection had put plans in place for the development of communal areas.

People were protected from abuse and harm because staff understood how to recognise and report safeguarding concerns. Staff knew about the registered providers whistleblowing procedure and were confident about using it should they need to. Risks to people's safety were assessed and mitigated, this included risks associated with aspects of people's care and the environment.

Staff were recruited safely. Applicants were subject to a range of pre- employment checks prior to an offer of employment being made. This included a check on their criminal background, previous work history, skills and qualifications. Sufficient numbers of appropriately skilled staff were available to meet the needs of people and keep them safe.

Staff received training and support for their role. New staff completed induction training which included learning about the expectations of their role and emergency procedures. New staff were enrolled onto the Care Certificate and all staff were provided with ongoing training relevant to their role and responsibilities and people's needs. Staff told us they received a good level of support from the manager and other senior staff. Since being appointed the manager had met with each member of staff on a one to one basis as a way of getting to know them and their training and development needs.

The manager and staff had a good understanding of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). Staff provided care and support to people in line with the principles of the MCA. The manager worked alongside family members and relevant health and social care professionals to ensure decisions were made in people's best interests when this was required. Applications for DoLS authorisations had been made to the local authority appropriately. Expiry dates of DoLS were monitored to ensure they remained effective.

People's healthcare needs were well documented. People received the care and support they needed with their healthcare and appropriate referrals were made when required to external healthcare professions.

Family members were kept informed of any changes to their relative's health and of any healthcare appointments made.

Staff were kind caring and respectful towards people and saw many examples of this. Staff were patient and sensitive in their approach, they comforted and reassured people with good outcomes for them. Where people were unable to tell us about their experiences we observed they were comfortable, relaxed and at ease with staff.

People were provided with opportunities to take part in group and one to one activities. A profile was put together based on information shared about people's life history, important relationships, hobbies and interests. This enabled staff to plan meaningful activities for people and engage people in conversations of interest.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medication was safely managed overall; however thickening powder was not always safely stored.

Some toilets and a bathroom did not have a call alarm bell for people to alert staff when they needed them.

People were safeguarded from abuse and other potential harm.

Is the service effective?

Requires Improvement

The service was not always effective.

Records did not always reflect the care people needed and were given.

People were offered a choice of food and drink in line with their care plan, however meals were not always well presented.

Staff received the training and support they needed for their role.

Decisions for people who lacked capacity were made in accordance to legal requirements.

Is the service caring?

Good

The service was caring.

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

Staff knew people well and they were patient and caring in their approach.

Staff showed compassion towards people. They comforted and reassured people who were anxious and upset.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and planned for with the involvement of the person and relevant others.

People and family members were provided with information about how to make complaint and they were confident about complaining. Complaints were listened to and acted upon.

People's life history and interests were known and they were offered activities which were planned around them.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality and safety of the service was checked, however further checks were required to ensure people always received safe and effective care.

The manager and other staff worked in partnership with others including external health and social care professionals and family members.

The culture of the service was positive and staff reported feeling valued.

Knowsley Manor 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 10, 15 and 18 May 2018. The first day of the inspection was unannounced and the second and third days were announced. One adult social care inspector carried out the inspection.

Before the inspection we reviewed information, we held about the service and notifications we had received. A notification is information about important events which the registered provider is required to send us by law. This enabled us to decide if we needed to respond to potential areas of concern. We also reviewed the Provider Information Return (PIR). The PIR provides key information about the service, what the service does well and the improvements the registered provider plan to make.

During the inspection we spoke with two people who could express their views of living at the service. Not everyone was able to verbally communicate with us due to their health care needs.
We used the Short Observational Framework for Inspection (SOFI) at different intervals throughout the inspection visit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nine family members and two visiting healthcare professionals. We spoke with the manager, an area director, two nurses, unit manager, a nursing assistant and ten other staff who held various roles including care staff and ancillary staff. We looked at records relating to the care of six people, four staff recruitment files, staff rotas, staff training records and records relating to the running of the service.

Requires Improvement

Is the service safe?

Our findings

Medication was safely managed overall. However, on the first day of inspection thickening powder prescribed for one person was left on a trolley in a dining room and no staff were present. Thickening powder is prescribed for people who require their food and drink modifying and if ingested can cause choking. We raised this with staff at the time and they stored it away safely. When we raised it with the manager they reminded relevant staff of their responsibilities for ensuring the safe use and storage of thickening powder. On the second and third days of inspection thickening powder was appropriately supervised and stored away safely after use.

All other items of medication were kept secure in dedicated rooms which were only accessed by nominated staff with responsibilities for managing medication. Those staff had undertaken regular medication training and competency checks. They also had access to good practice guidance, advice leaflets and policies and procedures for the safe management of medication. The temperature of medication rooms and fridges were monitored and recorded daily. This helped to ensure that they were within the range required so that medicines remained effective. Items of medication which on opening had an expiry date were labelled with the date when they were first used, all opened items were within their use by date. There were safe systems for the administration, ordering, storage and disposal of medicines. Records were maintained of all medicines received into the service, disposed of and returned to the supplying pharmacist.

Each person had a medication administration record (MAR) detailing their prescribed medication and instructions for use. This information was printed onto MARs by the supplying pharmacist. However, there were occasions when staff were required to handwrite information on to MARs, such as for medication which was prescribed for short term use. Handwritten entries were clear and signed by a second member of staff to ensure the accuracy of the information, thus reducing the risk of potential errors. MARs were signed when medication had been administered to people and marked with specified codes in other circumstances such as when a person had refused medication or if they were in hospital. Staff followed guidance about when to contact a GP if a person continually refused to take their medicines. Medication profiles which accompanied MARs displayed a recent photograph of the person, details of medicines they shouldn't take due to allergies or intolerances and any special instructions or preferences for taking medication. Some people were prescribed PRN medication, to be given only when required such as for pain relief, clear protocols were in place instructing staff on the use of PRN medication.

Overall the environment was safe, clean and hygienic. A nurse call system was in operation at the service to enable people to alert staff should they need help or assistance. Accessible call bells were available in each person's bedroom and in most communal areas. However, two toilets and a bathroom which were located close to people's bedrooms were not fitted with a call bell. This meant that people using those facilities independently did not have the means to alert staff should they need to. We raised this with the manager and they immediately contacted the relevant department to organise the installation of call bells. Call bells were fitted to the toilets and bathroom by the third day of inspection.

Systems were in place to ensure utilities and equipment was regularly checked, serviced and repaired so

that it was safe to use. This included checks on gas and electricity systems, portable appliances, water quality, fire systems and equipment people used such as hoists and wheelchairs. Safety checks and tests had been completed by an appropriately qualified person and certificates of safety were issued by them confirming the equipment was in good working order and safe for use.

Good infection control procedures were followed to minimise the spread of infection. Staff had access to information and guidance informing them about the prevention and control of infection, and they had completed training in the subject. Cleaning schedules were in place and being followed for all parts of the environment and equipment people used. Clinical and none clinical waste was disposed of in appropriate bins which were located around the service. Staff had access to a good supply of personal protective equipment (PPE) including disposable gloves and aprons, and they used them appropriately thus minimising the risk of the spread of infection.

People were protected from abuse and harm. Staff had completed safeguarding training and were provided with information and guidance on how to recognise and report any abuse they were told about, witnessed or suspected. Staff knew the different types and indicators of abuse and how to report any safeguarding concerns. Allegations of abuse had been promptly referred to the relevant agency including the local authority and CQC. The registered provider had a whistle-blowing policy and procedure which guided staff on how to report any concerns in confidence without any reprisals. Staff told us that they were familiar with the whistleblowing procedure and were confident about using it to report any concerns.

People told us they felt safe living at the service. Their comments included, "Yes I feel safe here and they [staff] treat me well" and "They [staff keep me safe." Family members told us they were confident that their relative was safe living at the service. Their comments included, "I go home knowing [relative] is safe and well cared for" and "No worries about their [relative] safety."

Risks to people were assessed and mitigated. Risks associated with the environment and people's individual care and support needs were assessed and measures were put in place to reduce the risk of harm to people and others. Guidance was available for staff to follow on how to support people appropriately to minimise the risk of harm. Risks to people and others were kept under review and updated to take account of any changes in people's needs and the environment.

Accidents and incidents which occurred at the service were recorded and reported in line with the registered provider's procedures. A record of these events was held in people's care files and recorded onto the registered providers electronic system. Such events were audited by the manager as a way of identifying any patterns or trends and ways to reduce any further occurrences. Records showed actions were taken to help reduce any identified risk in the future.

There were sufficient numbers of suitably skilled and experienced staff to meet people's needs and keep them safe. Prior to the inspection we had received concerns that there were insufficient suitably qualified staff to safely meet people's needs. Following discussions with the manager and on checking the staffing rotas we evidenced sufficient numbers of suitably skilled staff deployed across the service. The manager did however advise us that there had recently been a shortage of permanent nurses which meant they had called upon agency nurses to maintain safe staffing levels and skill mix. The manager confirmed and records showed that where possible agency nurses who had previous experience of working at the service were called up. The manager advised that following a recent recruitment drive for permanent nurses, offers of employment were made, accepted and were subject to satisfactory pre- employment checks. Staff from all departments had completed training in topics of health and safety and they knew their responsibilities for working as a team when required to keep people safe.

Recruitment of new staff was safe. Records showed that the suitability of staff was thoroughly assessed prior to an offer of employment. All staff employed had completed an application form which included details of their previous work history, qualifications skills and experience. In addition, a series of pre- employment checks were carried out with their most recent employer/s and with the Disclosure and Barring Scheme (DBS). Staff told us that they thought the recruitment process was thorough and confirmed their employment commenced on the receipt of satisfactory checks. There was a system in place for checking that nurse's registrations were valid and updated as required.

Requires Improvement

Is the service effective?

Our findings

A care plan had been developed for people's assessed needs. The plans were titled with the identified area of need, the intended outcome for the person and instructions for staff on how this was to be achieved. Some people required certain aspects of their care monitoring throughout the day and night, for example food and fluid intake and air flow mattress settings. A chart was put in place for staff to record the care given, when it was given and the outcome for the person. These records are an important way of evaluating and planning people's care.

Care plans directed staff on the use of monitoring charts where this was required. Monitoring charts were in place, however on the first day of inspection some did not include directions for staff regarding the care to be given. In addition, some had gaps where staff had failed to record the care given and outcomes for the person. For example, some people required an air flow mattress to reduce the risk of them developing pressure ulcers. Staff were required to carry out checks and record the outcome to ensure mattresses were correctly set for them to provide effective relief for the person. However, charts for four people did not record what the setting should be. Although checks were recorded to show they had taken place there was no guarantee mattresses were correctly set because the charts did not provide this information.

Some people required their food and fluid intake monitoring because they were at risk of malnutrition and or dehydration. Charts were in place for recording people's intake, however there were gaps on three people's charts were staff had failed to complete them. Charts should have recorded the amount of fluid a person needed to consume over a 24-hour period to remain hydrated and the total consumed at the end of the period. However, some people's charts had not been completed to reflect this information. Staff assured us that people had received the appropriate care and we did not evidence any impact on them. However, the failure to maintain accurate and up to date records about people's care meant there was no guarantee that people had received effective care in line with their care plan. We raised this with the manager who reminded staff of their responsibilities for ensuring records for monitoring people's care were appropriately maintained. Records were completed as required on the second and third days of inspection.

People's nutritional and hydration need were assessed and planned for using a nationally recognised tool. People were offered a choice of food and drink in line with their care plan. Staff modified food and fluids for people who were at risk of choking. They used thickening powder in line with the prescriber's instructions and texturized and fortified meals in line with guidance provided by speech and language therapists (SALT) and dieticians. A family member commented that meals were not always attractively presented and we evidenced this on the first day of inspection. For example, we observed one person being assisted to eat a cooked breakfast which was pureed. It was difficult to establish what the meal consisted of as it was mixed together in a bowl rather than each element being served separately on a plate. Serving each item of a pureed meal separately helps to retain colour and promote taste of each element and makes a meal more appetising. Some people were served soup for their lunch and were offered slices of bread to accompany it. Staff did not provide people with a side plate for their bread, they placed it on the side of soup bowls. We saw an example where a person struggled to eat their soup after the bread fell into it. We raised this with the manager and they ensured people were provided with a side plate at meal times.

Each person had a diet notification form which included their dietary needs and preferences. For example, likes and dislikes, food allergies or intolerances, low or high sugar content, consistency of meals and any cultural or religious requirements. This information was available in the kitchen so that the chef and other staff preparing meals and drinks knew the correct way to prepare them for each person.

One person told us "Oh yes the food is lovely and I get plenty to eat" and another person said, "Yes I get a choice and it's usually quite tasty." A family member however told us they had in the past complained about a lack of food choices and that they had noted some improvements. Other family members said, "[Relative] has not complained so they must be happy with the meals" and "What I've seen looks good."

Since the last inspection improvement had been made to the environment to make it more comfortable, brighter and attractive for people. This included the refurbishment and redecoration of communal areas and some bedrooms. At the time of the inspection other bedrooms were undergoing re decoration. There were some parts of the environment which offered stimulation and promoted independence for people living with dementia. This included a lounge and kitchen area furnished with items from the past. However other parts of the environment lacked items of stimulation and signage. Bathrooms and toilets along corridors were painted in a different colour to bedrooms however they did not display any signage to help people recognise them. The manager acknowledged that further work was required to make the environment more dementia friendly and confirmed plans they had put forward to achieve this. The manager demonstrated a good understanding about the importance of ensuring the environment was suitable for people living with dementia and they were keen to progress with the plans.

People received appropriate healthcare to meet their needs. People's clinical and general healthcare needs were assessed and reviewed on a regular basis. Appropriate referrals were made to external healthcare professionals where this was required for people. This included referrals to GPs, speech and language therapists (SALT), occupational therapists (OTs) and specialist nurses such as community mental health and tissue viability nurses. People were also supported to attend routine appointments with primary healthcare services including dentists, opticians and chiropodists. A record was maintained for each person detailing all contact that had with other health and social care professionals. This included details of any intervention, the outcome and any aftercare staff were to provide.

One person told us, "If I feel unwell they [staff] call for my doctor" and another person said, "They [staff] look after my health." Family members told us they were kept well informed about their relative's appointments and outcomes. During the inspection we spoke with two visiting healthcare professionals who commented that they had noted improvements at the service since the appointment of the manager. They told us the lines of communication regarding people's healthcare had got better and that staff were good at following any advice and guidance they gave following appointments.

The Mental Capacity Act (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 had their capacity assessed appropriately. Information was held about those who had appointed lasting powers of attorney (LPA) for either finances or health and welfare, and these people were asked to consent on behalf of the person if they lacked the capacity to do this for themselves.

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 and hospitals 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 on authorisations to deprive a person of their liberty were being met. Applications had been appropriately made for people to have a DoLS authorisation, for example as the person lived in a secure environment and was therefore not free to leave the service at any time. Expiry dates of DoLS were monitored to ensure they remained current. There were records of 'best interest' decisions were made on behalf of people, for example the use of bedrails to minimise the risk of people falling out of bed. The records showed that relevant others were involved in reaching the best interest decision.

People were supported to have as much choice and control as possible of their lives and staff supported them in the least restrictive way possible. The registered providers policies and systems in place at the service supported this practice. We observed throughout the inspection that staff obtained people's consent before assisting them with any care or support.

Staff completed training relevant to their roles and responsibilities and people's needs. All new staff including the manager completed an induction programme when they first started work at the service. Every new member of staff was assigned a mentor to provide guidance and support throughout their induction. During the initial part of their induction staff learnt about their role and the expectations of the organisation. They were provided with an orientation of the environment and made familiar with emergency evacuation procedures. Before being included on the core rota new staff spent a period of time working alongside more experienced staff. This gave them the opportunity to meet with people who used the service and become familiar with their needs. The training needs of new staff were assessed on appointment and those who had not completed the care certificate commenced it as part of their induction. The Care Certificate is an identified set of national standards that health and social care workers should follow when starting work in care. Staff told us they thought their induction had been thorough and that they learnt a lot from it. Training was provided to all staff on an ongoing basis, this included training updates in topics such as fire awareness, emergency first aid, safeguarding and moving and handling. Staff also completed training in topics specific to people's needs such as dementia awareness and care of people living with conditions such as diabetes. Practical training such as moving and handling was delivered to staff in a classroom environment and other training was completed on line (on a computer). Staff had their own unique password which enabled them to access and complete online training flexibly either in the workplace or at home. Staff were required to complete a knowledge check following each training session as a way of assessing their understanding of the topic. If they failed to achieve the minimum score they were required repeat the training. The manager had access to data which enabled them to monitor the completion of training and staff progress.

Staff were supported to gain further qualifications including a National Vocational Qualification (NVQ) in care and Diploma in Health and Social Care. Nurses completed training relevant to their clinical role such as wound care, end of life care and catheter care. Further training was planned for nurses.

Staff received the support they needed for their role. On appointment the manager identified that staff had not received the level of formal supervision in line with the registered provider requirements. However, since then all staff have met with the manager for a formal one to one supervision. The manager explained that this gave them an opportunity to meet with each member of staff in private to discuss their work and future training and development needs. Future arrangements were for each member of staff to be assigned a supervisor. For example, the manager would continue to provide supervision to clinical staff and they in turn would each provide supervision to a group of care staff. Other staff including housekeeping and kitchen staff would receive supervision from their heads of department. Staff told us that the manager was very fair, supportive, approachable and a good listener. They told us in the absence of the manager there was always a named person in charge who they could go to for advice or support. Staff meetings were held each month as a way of keeping staff up to date with any changes to the service or service delivery. The meetings also

gave staff and opportunity to come together as a group and share any ideas or ask questions.

Good

Is the service caring?

Our findings

Comments people made about the staff included, "All of them [staff] are ever so nice and they always say good morning, how are you" and "Yes they [staff] are respectful and kind."

People were treated with dignity and respect. Staff knocked on bedroom doors and on entering greeted people and enquired about their wellbeing and comfort. Prior to providing people with personal care staff made sure they had everything they needed at hand, for example, clean towels and the persons toiletries and clothing. All personal care was provided to people in the privacy of their own bedrooms or bathrooms and toilets with doors locked. This helped to minimise disruption to the person and protected their privacy and dignity. Staff carried out regular checks on people who were being nursed in bed to make sure they were clean, comfortable and had access to regular drinks. Care records identified people's preferred gender of carer to provide their personal care and this was respected.

We saw many examples where staff approached people and interacted with them in a caring and compassionate way. For example, a member of staff sat next to a person who was visibly upset, held the persons hand and offered them a cup of tea. The person's mood quickly changed to a positive one as they chatted and shared banter with the member of staff. Another example was when a staff member of staff bent down close to a person who they thought looked uncomfortable in a lounge chair. The member of staff asked the person if they were comfortable and offered to reposition them.

Staff spoke respectfully with people and about people. For example, staff referred to people by their preferred name and acknowledged people's strengths. Staff sat close to people when holding discussions with them and they maintained eye contact and listened to people with interest. Staff were knowledgeable about people's backgrounds, important relationships, likes, dislikes and personal choices. For example, staff knew not to send one person's clothing and other personal items to the laundry because the person preferred for a family member to take their belongings home for laundering. One person preferred to sit alone when eating in the dining room, staff ensured this and explained why it was important for the person. They explained that the person would become anxious if others invaded their space. Family members commented positively about the attitudes and approach of staff. Their comments included, "Staff are polite and respectful," "They [staff] are gentle and kind to the residents" and "They [staff] are very patient indeed."

Staff used their knowledge of people to engage them in conversations of interest and as a way of diverting people when they were anxious and upset. For example, on seeing a person upset a member of staff settled them after generating a conversation about a family member who was visiting later that day. A staff member invited another person to share memories of their past employment and the person was keen to talk about what they did and the different places they had worked. Throughout the three days of inspection there was much laughter and banter amongst people, staff and family members. One person told us they enjoyed the laughter and banter with staff, they said, "I have a good laugh with them [staff] which cheers me up." The body language of other people who were unable to verbally communicate indicated that they were comfortable and happy with the staff interactions.

Staff involved people and offered them with choices about their care and support. Before providing care and support staff explained to people what they were about to do and checked with people that they were comfortable and happy to proceed. Staff were patient when assisting people to eat and drink. They did not rush people and provided gentle prompting and encouragement to those people that needed it. Staff sat next to the person they were assisting, maintained eye contact and focused completely on the person throughout the meal time.

The views and experiences of people who used the service, their families and friends were obtained through care plan reviews, meetings and general discussions. This enabled people and relevant others to have a say about the care and support provided and the running and development of the service.

There registered provider had an equality and diversity policy and staff received training on equality and diversity. Staff were aware of their responsibilities in how to protect people from any type of discrimination. Staff told us they supported people in a way which ensured that they were not disadvantaged in any way due to their beliefs, abilities, wishes or choices.

Personal information about people was treated in confidence. Paper records were locked away when unsupervised by staff and information held on the computer was password protected. Only authorised staff had access to people's personal information. Staff were careful not to be overheard when speaking with people about personal matters and when sharing information amongst other staff about people. Discussions about people were held in offices with doors closed. Staff understood their responsibilities for maintaining people's confidentiality. Staff also understood the importance of ensuring people's human rights, equality and diversity. Care plans captured information to ensure that the person received the care and support they needed in accordance with their wishes and lifestyle choices.

Good

Is the service responsive?

Our findings

People's needs were assessed in line with the registered providers assessment procedure. The assessment along with those carried out by other health and social care professionals were used to develop an initial care plan. Care plans were reviewed each month, or sooner, if a person experienced a change in their needs and a record of them was kept. Where possible people, and relevant others, such as family members contributed to assessments and the development and reviewing of care plans. Care plans covered areas of need including personal care, mobility, communication, nutrition and hydration, socialisation, and healthcare.

Communication systems helped ensure that people received care and support which was responsive to their needs. A staff handover meeting took place at each shift change to exchange relevant information about people. Daily records were also maintained for each person which summarised the care people received, any progress and significant observations which needed to be followed up. This enabled staff coming on duty to get a quick overview of any changes in people's needs and helped to ensure consistency of care. People's health was monitored and when staff noted a decline in a person's physical or mental health they reported it onto the nurse in charge. This helped ensure appropriate decisions were made in response to people's health and wellbeing.

People were provided with the equipment they needed to help with their comfort, safety and mobility. Nurse call bells were positioned close to people who occupied their bedrooms and sensor mats and bedrails were in place for people who were at risk of falls. Staff responded promptly to these throughout the inspection. Staff ensured that people who needed them wore their glasses and hearing aids and had easy access walking sticks and frames. Records showed this equipment was regularly monitored to ensure it was set according to people's individual needs.

Some information was made available to people in different formats, for example in large print and using pictures and symbols. The manager knew about the accessible information standard and explained that they were looking at other ways of producing information which could be shared with people in a format which they could easily access and understand. This included menus which at the time of inspection were only available to people in small print.

There was an activity co-ordinator employed at the service on a full-time basis. They had responsibilities for organising and facilitating both group and one to one activities with people. The activities co-ordinator worked flexibly both during the week and at weekends and showed a lot of passion for the work they did. They spent time with each person and family members building up a profile about people's hobbies and interests and their backgrounds such as their family, where they grew up and worked. An 'About me' document was put together based on the information shared and this helped staff get to know people and how they preferred to spend their time. This information also helped staff to generate conversations and discussions of interest with people. The activity co ordinator maintained a record for each person which detailed activities which they had been offered and taken part in. Activities included tea and coffee mornings, light exercises, and music sessions. People were given the choice to celebrate their birthday and

other seasonal events including, Christmas and Easter. Other celebrations which people had the opportunity to take part in included royal weddings and jubilees. At the time of the inspection arrangements were being made for a 'Royal wedding' party. The activities co-ordinator encouraged the use of an area of the service which was furnished to replicate the past and we were told this was well used. There were games, activities and tactile items specifically designed for people living with dementia. There was also a cinema with a large screen which was being used at the time of the inspection. People watched a movie and where offered ice cream.

There were processes in place to enable people to complain about the service and their complaints were listened to. The complaints procedure was on display near to the reception area and a copy was provided to people on admission to the service and their family members. The procedure clearly set out the steps people needed to take if they wished to make a complaint and it informed people about timescales for investigations and responses. The manager maintained a record of complaints which detailed when the complaint was made and who by, the nature of it, how and when it was investigated and the outcome. Family members told us they would not hesitate to complain if they needed to and they felt that their complaint would be listened to and dealt with in the right way. One family member said, "I'm definitely not worried about complaining. [X] (the manager) seems to take on board anything I raise and sort it out.

People were supported at the end of their lives to have a comfortable, dignified and pain free death. Where appropriate medicines were held at the service and used when necessary to keep people free from pain and comfortable. Where people chose to discuss their end of life plans an appropriate end of life care plan was developed outlining their preferences and choices for their end of life care. The service consulted with the person and, where appropriate, relevant others about the development and review of these plans. There were good links with GP's and specialist nursing services which helped to ensure people received the care they needed during this period of their life.

Requires Improvement

Is the service well-led?

Our findings

The service did not have manager registered with the Care Quality Commission (CQC). The previous registered manager left in November 2017. However, a new manager has been appointed and had applied to CQC to become the registered manager. The was a clear management structure in place at the service which people, family members and staff understood. The manager was responsible for the day to day running of the service and had the support a team of nurses and a unit manager. External support was provided by an area director and other senior managers with responsibilities for areas such as quality and compliance and human resources (HR).

There were systems and processes in place for assessing and monitoring the quality and safety of the service and making improvements. The registered provider had a comprehensive quality assurance framework in place. Guidance was provided on what areas of the service required auditing (checked) and the required frequency. Specified documents were in place for recording the findings of the checks and for the development of action plans for areas identified as requiring improvement. The manager was responsible for ensuring checks were carried out and for ensuring improvement plans were actioned. Checks took place at various intervals on things such as care plans and supplementary care records, accidents and incidents, medication, the environment, infection control and staffing. Records showed actions plans were developed and followed through for areas identified as requiring improvement. Although we found audits were completed at the required intervals we found improvements were required to ensure more regular checks were required on people's care records to make sure they accurately reflected people's needs and the care provided. We also found that the checks on the environment had not identified that there were no call alarm bells in two toilets and a bathroom. More regular observations were required to ensure thickening powder was safely stored and meals were better presented to people. Although these issues were addressed during the inspection consistent good practice is needed over time to ensure people always receive safe and effective care.

Information about falls, weight loss, pressure wounds, accidents and incidents was entered onto the registered providers electronic system. This information was collated and analysed each month or sooner to help identify any trends or patterns and as a way of putting in place the necessary measures to mitigate risk and reduce further occurrences. The manager held paper copies of the data giving them a quick overview of information about people's current needs. The area director and other senior managers within the organisation, who had responsibilities for monitoring quality and compliance on behalf of the registered provider, visited the service regularly. They carried out checks to ensure that the registered providers quality monitoring processes where being followed and provided managerial support to the manager.

Since their appointment the manager had established good working relationships with external health and social care professionals and was professional in their approach to staff and family members. This ensured that people received care and treatment they needed in a co-ordinated way. We received many positive comments about the manager and the way they managed the service. For example, staff told us they felt valued by the manager and that she operated an open-door policy. Other staff comments included, "[Manager] is very professional and cares about how we feel" and "She [manager] is excellent, really

supportive and approachable." Visiting professionals told us that the manager had made a lot of positive improvements and works well with them. Family members told us they found the manager approachable and easy to talk to. They said they always made themselves available if they needed to speak with them.

The manager had notified CQC of incidents which occurred within the service in accordance with our statutory notifications. Notifications were sent to us in a timely way and included an appropriate level of information to help us decide if there was any action we needed to take to ensure people were safe.

Changes to the service and service delivery were communicated to people, family members and staff either through direct communication with the manager, review meetings, newsletters and general meetings. Meeting dates and times were made available well in advance of them taking place. The manager encouraged people's involvement in the running and development of the service by encouraging them to put forward their views and ideas. People and family members were also given the opportunity to rate and comment on the service through the completion of a 'feedback survey'. In addition, there was a touch pad facility in reception which people could use to have their say about the service.

The registered provider had in place a set of policies and procedures relevant to the service and they were accessible to staff and relevant others. Policies and procedures support effective decision making and delegation because they provide guidelines on what people can and cannot do what decisions they can make and what activities are appropriate. The registered provider kept all policies and procedures under review and updated them as required to ensure they were in line with current legislation and best practice.

The rating following the last inspection was prominently displayed near to the entrance of the service making it accessible for all to see.