The Beeches Worthing Limited

The Beeches Nursing Home

Inspection report

45 Wordsworth Road
Worthing
West Sussex
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Date of inspection visit:
04 December 2017
07 December 2017

Date of publication:
01 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out a comprehensive inspection of The Beeches on 4 and 7 December 2017. The inspection was unannounced.

The Beeches Nursing Home is a care home with nursing care. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The Beeches Nursing Home is registered to provide accommodation for up to 40 older people and people with physical disabilities who require nursing or personal care. At the time of the inspection there were 35 people living at The Beeches.

There were two registered managers permanently in post who shared joint responsibility for managing the regulated activities at the service. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection of The Beeches Nursing Home since a change to the provider's legal entity in August 2015.

People told using the service said they felt safe. There were systems in place for ordering, transporting, storing, disposing and administrating medicines safely and securely. However, these systems were not always effective, which left people at risk of possible harm.

The service had quality assurance and information governance systems in place to monitor the quality and safety of the service. However, it was not always evident the service had taken effective action to rectify identified issues.

The service provided training and support for staff to meet people's needs. Some people had courses that required updating. The service had a plan in place to address this.

People's care plans identified the support people required to meet their individual needs. Staff knew people well. However, care plans sometimes lacked details about people's individual preferences and aspirations. The service was aware of this and management were in the process of reviewing and updating care plans.

The service was committed to upholding the principles of the Accessible Information Standard (AIS) and took steps to do so. The service was currently developing different care plan formats to ensure better

accessibility of information for people with a disability, or sensory loss related communication needs.

People had appropriate support with any dietary or health related food and drink needs. Some people complained about the choice and quality of the food. The service was aware of people's feedback and was taking action to improve these issues.

There were risk assessments in place for people to provide the right support to keep people safe. People were involved in this process and restrictions on their independence were minimised.
There were enough staff with the right skills and experience to meet people's needs. Safe recruitment practices were followed. Staff knew the correct systems and processes to follow if they suspected abuse. People and staff were protected from discrimination which might amount to abuse or psychological harm.

Accident and incidents were recorded and actions were promptly taken to keep people safe in response. Management reviewed and communicated learning with staff following safety incidents and worked with relevant partnership agencies to agree any necessary actions needed in order to keep people safe.

Risks of infection to people were effectively prevented and controlled and the premises were clean and hygienic. Staff had received food hygiene training and the correct procedures were followed when preparing and storing food.

The service had control measures in place to keep people safe in the event of a fire. People had a personal emergency evacuation plan (PEEP) and checks on fire alarm systems and evacuation drills occurred regularly.

People, or people acting in their best interests, had consented to their care and support in line with the principles of the Mental Capacity Act 2005 (MCA).The registered manager was aware of their responsibilities for assessing and submitting applications for Deprivation of Liberty Safeguards (DoLS) for people who might require this.

People had support to access and receive appropriate health care support and services. People were involved in any changes to their healthcare and treatment. Staff liaised with appropriate people, used appropriate equipment and followed relevant professional guidance when assessing people's needs, to ensure the right support was put in place.

When people had a support need, or made a particular decision, related to any protected characteristics under the Equality Act 2010 this was respected. Staff treated people with kindness and compassion. People's privacy, dignity and independence were respected. People's personal information was treated confidentially and in compliance with the Data Protection Act.

The service provided a range of activities both at the service and in the wider community. People had an active input in requesting activities that were socially and culturally relevant to them. People were aware of how to raise a complaint and felt confident to do so. Complaints were responded to appropriately and used as a way to learn and improve people's support.

People's wishes and preferences for their end of life care was respected, including any relevant spiritual and cultural needs. People, their relatives and staff had sensitive support during the end of life process. The service provided the right support, equipment or medicines if someone's end of life condition was changing rapidly.

The registered managers had a clear vision for the service and were committed to creating a culture of delivering high quality care. There were effective management processes to outline expectations for staff responsibility and accountability. Staff, people and their relatives were involved in developing the service.

The service was committed to protecting the rights and well-being of its staff, including any protection from any form of work related discrimination. Staff told us they felt there was an open and positive team culture that protected their rights and well-being. The registered managers had shared information and worked in partnership with outside agencies in an open and honest way.

During this inspection we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

People had risk assessments and systems were in place to keep people safe from abuse.

The service had enough staff to meet people's needs and followed safe recruitment practices.

The service took steps to prevent and control the risk of infection.

Is the service effective?

Good

The service was effective.

Staff were skilled and knowledgeable. The service assessed and met people's needs and choices.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People had support to access healthcare services and received health care support.

People had enough to eat and drink and support with any dietary needs.

Is the service caring?

Good

The service was caring.

Staff were kind and considerate to people.

People were given choices and involved in decisions about their care.

The service respected people's privacy, dignity and

independence.

People's personal information was treated confidentially.

Is the service responsive?

Good

The service was responsive.

People contributed to the planning of their care and support and had care plans that reflected their needs and wishes.

People knew how to make a complaint and were comfortable to do so. The service listened to and acted on concerns.

People had access to a range of social activities in the home and the wider community.

The service provided appropriate end of life care to people.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had not always identified or acted on issues affecting the quality and safety of the service.

There was clear vision for the service and a commitment to creating a culture of delivering high quality care.

Staff, people and their relatives were involved in developing the service.

The service shared information and worked in partnership with outside agencies in an open and honest way.

The Beeches 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 4 and 7 December 2017 and was unannounced. The inspection team for the visit on 4 December consisted of one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience with older people who used services and their family carers. For the visit on 7 December, the inspection team consisted of one inspector.

Due to the provider being unable to provide access to staff recruitment documents during the first two days of the inspection, an inspector briefly returned to the service on 14 December to view these documents.

The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. However, due to technical problems we were unable to access the PIR prior to the inspection. Although we did not see the PIR before the inspection, we took the fact this had been completed into account when we inspected the service and made the judgements in this report.

We reviewed other information we held about the service. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events the provider is required to tell us about by law.

During the inspection, we met with people living at the service. We spoke with eight people at the service, five relatives, three staff members, including the chef. We spoke with four staff members, both registered managers and the registered provider, two relatives and an independent physiotherapist working with people at the service.

We reviewed care records for six people and 'pathway tracked' four of them to understand how their care was being delivered in line with this.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed the support that people received in the communal areas including lounges and dining areas of the service.

We reviewed four staff training and supervision records, nine staff recruitment records, medicines records, six care plans and risk assessments, and accidents and incident records. We also reviewed complaints and compliments documents, quality audits, policies and procedures, staff rotas, information about activities and other records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person told us, "I feel safe all the time; I didn't feel safe at home". Another person told us, "I feel safe because there are people around". People's relatives we spoke with told us they also felt the service was safe. Despite this positive feedback, we found improvements were needed to ensure the safe and proper use of medicines.

There were systems in place for ordering, transporting, storing, disposing and administrating medicines safely and securely. However, these systems were not always effective which left people at risk of possible harm.

Staff did not always record quantities of medicines received into the service and did not always check stocks of medicines against current lists of prescribed medicines. We saw expired medication for a person who had passed away stored alongside other people's current medication. The medicine had not been disposed of appropriately. This meant staff would not know if this medicine had gone missing or if this medicine had been given to another person in error.
We asked the clinical lead nurse, who was responsible for medication, about this. They told us, "It depends which staff member checks the medication in, they don't always do it. We need to address it. It is an old habit that carries on". We saw people's medicines that had expired being stored alongside their current medication. Staff had not always recorded dates of when liquid medicines were opened, in order to ensure the medicines remained effective. This meant people were at risk of receiving medicines that were not safe to use.

Some people were prescribed medicines on a 'when required' (PRN) basis if they needed them. Most people did not have PRN guidance in place describing the requirements for staff to offer and administer PRN medicines for people. This meant staff may not always know when to give PRN medicines or what signs a person might display if they needed them.
We asked the clinical lead nurse about this who told us some people were able to communicate when they needed their PRN medicine. We were told the staff nurses relied on "clinical judgement" to decide when to give PRN medicines to people who could not communicate this need. However, when staff administered PRN medicine they did not always record the reason for doing so, although there was a system in place to do so. People's Medicine Administration Records (MAR) showed people receiving PRN medicine across several weeks but the corresponding reason for why this was appropriate was not always recorded. This meant staff could not be sure people were receiving their medicines as intended.

Medicines were stored and transported securely. However, staff did not record temperatures for medicines stored in a trolley secured in the first floor office. Heat reduces the effectiveness of medicines. There were systems in place to record storage temperatures for medicines stored in fridges, other trolleys, storage rooms and in peoples' cupboards. However, staff were not consistently doing this. This meant staff did not know if temperatures had remained in a safe range consistently and medicines were safe to use.

Medicine Administration Records (MAR) were in place and signed by staff to show people had received their medicines on time and as intended. MAR were provided by the pharmacy supplying people's medicines and included information such as the name and date of birth of the person, names, strength and amount of medicine to be taken. MAR also included details about how the medication should be taken or used and how often.

Staff did not sign the MAR when administering prescribed creams and medicine gels, this was recorded on a different record that was stored separately from the MAR. This record did not contain the same level of detail as the MAR, showing only a signature and time of when a cream had been applied. Staff did not make a note on the MAR to confirm whether the prescribed creams or gels had been administered as prescribed and recorded on a different record. This increases the risk of recording errors and people not getting their medicines as intended or at the right time. We saw staff meeting minutes that showed prescribed creams for people were being stored in other people's rooms and documentation of cream administration was not up to date. T

We found the failures to ensure medicines were managed, recorded, stored, disposed of and administered safely is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We observed staff handling and administering medicines in a hygienic and caring manner. Registered nurses were mainly responsible for administering medicines and had received medicine training. Support workers administered prescribed non-medicated topical creams and gels to people, and had received training about how to do this safely. There were body maps in place to indicate where to apply topical creams for people who required this. Records showed staff had engaged with healthcare professionals to review people's medicines at appropriate intervals. Staff had assessed risks to people who wished to self-administer medication appropriately. There was a policy in place to for staff to follow if covertly administering medicine in line with the Mental Capacity Act 2005.

We discussed the issues found with medicine management with the registered managers at the end of the first day of the inspection. When we returned for the second day of the inspection they had reviewed National Institute of Clinical Excellence (NICE) guidelines and other sources of best practice advice and re-audited their medicine management system and processes, with a view to taking remedial actions.

People had risk assessments that identified potential hazards to their safety and well-being. Staff used the information from the risk assessments to provide the right support to keep people safe. The service ensured that people were involved in this process and restrictions on their independence were minimised. For example, one person assessed as being at risk of falling had been supported to use walking aids to allow them to move around without having to rely on waiting for staff support.

We found some risk assessments lacked detail and guidance about how to manage identified risks safely. For example, there was no accompanying detail about the correct setting for pressure care mattresses in use for people. People who had been assessed as needing cognitive activity support to offset probable dementia did not have information about what these activities were or how often and when the person should be supported to undertake them.
The registered manager told us they were currently adding more detail to risk assessments. Staff told us they kept up to date with all relevant information about managing risks to people via other methods such as regular handovers, meetings and review of daily notes with peers, seniors and management. The service also regularly liaised with healthcare professionals and relatives regarding any possible risks to people, sharing this information amongst the team in a timely manner.

We received mixed feedback from people we spoke with about staffing levels and whether staff could meet their needs in a timely manner. One person said, "I can ring the bell, they answer quickly". Other people told us sometimes they had to wait for long periods before staff answered call bells. One person said, "I waited for 30 minutes".

Staff told us they aimed to answer calls within 4-5 minutes, but it could be longer sometimes if it was very busy. Staff carried pagers that alerted them to a call bell being rung and indicated the level of need the call represented. Staff told us they used this system to help prioritise calls during busy times. One staff member said, "Shifts are busy, but we work together". Another staff member told us, "Nurses help to answer calls if we are really busy or if there is an emergency".

We observed people requested support frequently but there were enough staff to respond to calls without an undue delay. The registered managers used a dependency level tool to ensure the service had enough staff. For the purposes of deploying staff, The Beeches was divided into four sections, with up to 10 people living in each section. In each section there were two support workers and one nurse on duty. There was further support available from senior support staff and nurses and the registered managers if needed. We sampled rotas showing the allocation of staff in line with the Dependency Level Tool recommendations. Senior staff helped deploy staff during each shift with the right skills, experience and competencies for the people needing support.

All staff underwent a satisfactory Disclosure and Barring Service (DBS) check before they commenced employment. DBS checks help employers make safe recruitment decisions and help prevent unsuitable staff from working in a care setting. The Nursing and Midwifery Council (NMC) had been contacted to confirm nurses' registration PIN numbers as valid. Prior to this, all staff had to submit an application form, supply two references, a full employment history and complete a successful competency based interview. We sampled nine staff recruitment files and found evidence that across a variety of roles, the service had taken these steps before considering any offer of employment.

The service had a safeguarding policy in place that outlined clearly all staff's responsibilities to prevent and keep people safe from abuse. Staff told us they had received safeguarding training and knew the systems and processes to follow if they suspected abuse. The service had whistleblowing policies and procedures in place. Staff confirmed they were aware of these, had access to them and would follow them if they thought someone was at risk of abuse.

There was an 'Equal Opportunities, Diversity and Anti-Oppressive Practice' policy in place, written in line the Equality and Human Rights Commission (EHRC) code of practice. Staff received equality and diversity training as part of their induction and showed a good understanding of the importance of ensuring there was no discrimination against people with protected characteristics under the Equality Act 2010. One staff member told us, "Discrimination is really frowned on here. Say if someone was gay we would not be allowed to discriminate against them because of that". Another staff member told us, "You treat everyone as an equal and don't judge people on their race or religion". The registered managers told us, "We respect everyone's differences". There was a multi-cultural staff team at the service. A registered manager told us they had taken action when people living at the home had historically made racist and homophobic comments towards staff. The action had resulted in an apology and acceptance of staff's differences from the people involved, and given a clear message there was zero tolerance towards discriminatory abuse.

Staff completed accident books and daily notes and knew to record all instances of concern regarding people's safety. The registered managers carried out audits of accident and incidents daily and analysed this information to put in place actions to keep people safe. The registered managers and senior staff

promptly reviewed and communicated learning with staff following safety incidents. The registered managers reported incidents and accidents onto other relevant partner agencies for review and to agree any necessary actions needed in order to keep people safe.

Staff received infection control training and the service employed separate domestic and housekeeping staff. We observed people's rooms and the entire premises were clean and hygienic.. Personal Protective Equipment (PPE) was available and staff used this when supporting people with personal care tasks. Suitable bags, containers and disposal equipment was available and in use for hazardous waste. Staff had received food hygiene training and there were dedicated kitchen staff that followed the correct procedures for minimising the risk of infection when preparing and storing food. The Food Standards Agency had inspected the service and awarded a five star rating for food hygiene standards in July 2017.

Staff and management carried out regular health and safety checks and audits of the physical environment. Any issues regarding the living environment were reported to the service maintenance staff, who took action to resolve them in a timely manner. Control measures were in place to keep people safe in the event of a fire. All people living at the home had a personal emergency evacuation plan (PEEP).Fire risk assessments for the entire property and checks on fire alarm systems and evacuation drills occurred regularly.

Good

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 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 to see if the service was operating within the principles of the MCA and found that it was.

Staff received MCA training and understood the relevant consent and decision-making requirements of this legislation. People had an assessment in their care plans of their mental capacity to be able to make decisions about different activities. We saw people or a relevant person acting in their best interests had signed a cover sheet in their support folders to say all individual plans had "been devised according to their preferences and wishes". People also had a separate signed 'Consent to Agree Care Plan' that evidenced people were involved in any review of their care and could see their care plans whenever they wanted.

People can only be deprived of their liberty so that they can receive care and treatment when this is in line with their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked to see whether any conditions on authorisations to deprive a person of their liberty were being met. Staff received DoLS training and the registered manager was aware of their responsibilities and the correct process for assessing and submitting applications for DoLS for people who might require this. The registered manager confirmed that currently there were no active authorisations or pending applications for DoLS for anyone at the service.

Staff had training to be able to have the right skills and knowledge to be able to meet people's assessed needs. Staff received an induction that met the Care Certificate standards. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. It sets out learning outcomes, competencies and standards of care that care workers are nationally expected to achieve. Staff received specific training to meet people's individual needs, such as diabetes and dementia.

We observed staff to be confident and competent when performing their roles. We sampled training records and saw some training required updating. We spoke with the service training co-ordinator who told us sometimes staff could not access the on-line training during normal working hours. The training co-ordinator had a plan in place to address the gaps in staff training, including paying staff additional wages to do the on-line training in their own time.

Alongside formal training, staff to kept up to date with their learning and development with supervisions, one to one meetings and appraisals. Staff confirmed these happened regularly and were useful to help them to understand their roles and responsibilities. The registered manager liaised with outside organisations

such as the local authority dementia care team. This made sure they kept their professional practice and knowledge updated in line with best practice and could cascade this knowledge to the staff team.

Staff referred people with complex eating and drinking needs to dieticians and Speech and Language Therapists (SaLT).Plans showed where people were at risk from choking and featured advice on foods to avoid due to people's allergies. There was a dedicated chef and catering staff. We spoke with the chef and they were aware of people's specialised dietary needs and had adjusted individual menus accordingly.

We observed lunch at the service. People had a choice of eating at the communal dining room or in their rooms. Lunch was a friendly social occasion with people chatting together. Staff offered and served a choice of drinks and two main courses and two puddings. One person who did not want what was on the menu was offered an omelette as an alternative, which they accepted. There were large portion sizes to ensure people ate in sufficient quantities.

We received mixed feedback about the menu choices and standards of the food. One person said, "They give you a good choice of menu". Another person said, "My fish was cold" when they had a meal delivered to their room. One person told us they did not like the food, saying, "I think it is bland and repetitive the menu is repeated every fortnight. My friend brings me tasty things in". We discussed this with the registered managers. They told us they were aware of this feedback and had been recently been actively encouraging feedback from people, to explore how they could improve the menu to reflect a wider variety of people's choices.

A Nurse Practitioner (NP) from a local GP surgery visited people once a week to review their medical and health care needs. If the NP identified any health related issues, they discussed these with a GP and the person on that day to agree any necessary treatment or further referrals. People were involved in any changes to their healthcare and treatment and give consent if their medication changed or they needed further medical treatment.

People's care plans showed that staff completed monthly records of people's weight, blood pressure, temperature, pulse and respiration to monitor people's health. People told us staff recognised and acted on any healthcare concerns. We saw staff kept records of all health care appointments and these showed evidence that people had support with referrals to other health services if needed.

The registered managers assessed people's needs to make sure they were able to meet their preferred support outcomes. All relevant people in the person's life – including family members and other health and social care professionals – were involved in assessing the person's support. This approach helped to build trust and share information so everyone involved could be confident people would get the support they wanted and needed. Relevant professional guidance was followed by the registered managers when assessing people's needs, to ensure the right support was put in place. For example, we saw a National Institute for Health and Care Excellence (NICE) recommended risk assessment scoring tool was used to assess people at risk of developing pressure ulcers and putting preventative measures in place.

Staff used necessary equipment to deliver the outcomes people needed. For example, by using fixed and mobile hoists, people who received their care in bed had their personal care needs met effectively and safely. The service supported people who needed help to move around to access walking aids to ensure they remained as independent as possible.

Staff respected and did not discriminate when people had a support need or made a particular decision related to their protected characteristics under the Equality Act 2010. For example, staff told us of when they

had provided particularly prepared food and specific clothing for a person who practiced a certain religion. The person received their care in bed and staff also supported them to move into position so they could pray at particular times.

The premises had wide doorways to allow people with walking aids and wheelchairs to pass through easily. There were lifts for people to travel between floors. There were large communal living areas where people could spend time together and take part in group activities if they wished. People's rooms were personalised to reflect their individual tastes and contained personal items, decorations and belongings. People had access to a large garden if they wished to be outside and there were benches for people to sit. The entrances and exits of the property were accessible, with slight ramps to allow for wheel chair users and people who might struggle to walk up steps.

Good

Is the service caring?

Our findings

Everyone told us The Beeches Nursing Home was a caring place to live. One person said, "They treat me with courtesy and respect". A physiotherapist who treated people at the service told us they thought the staff were, "friendly and kind, I'd put my mum here".

People told us they felt listened to and that staff talked to them appropriately. One person said, "They use my correct name and are interested in what I say". Staff told us they always looked to make people feel as if they mattered at all times. One staff member told us, "Some people cannot say much, but it doesn't matter. You still chat with people, you look for their facial reactions and expressions and let them know you understand their responses". We observed staff acknowledging and included people when they were supporting them by offering appropriate touches for reassurance, interacting with people at eye level and using sensitive and gentle tones of voice.

Staff took into account any protected and other characteristics under the Equality Act 2010 when considering how to communicate in the most accessible way for people. A whiteboard was used to have written conversations with a person who was hearing impaired. The menus were printed on large picture cards for people who were vision impaired and found written communications difficult to see.

Staff told us about how they thought it was important to know about people's life histories and backgrounds, so they could get to know people as individuals. One staff member said, "They are people who have had a very fulfilled life. You should sit and go through their life to get to know who they are". They added this was important because, "They can get frustrated if this isn't recognised, as then they are just a person in a care home". Another staff member said to us, "I know people, I talk to them, but it can take time to get to know them". Other staff told us that family members were a good source of information about people and they often spoke with them to understand people's likes and dislikes. A relative told us, "They know all about you and what you like".

We found staff and a registered manager could evidence their knowledge of people's lives when we spoke with them. A registered manager told us of how some people had been eminent figures in their careers and they gave specific examples of this. They told us how staff could then show respect for this by talking to them about the peoples' past achievements and initiating conversations about their professional backgrounds. However, people's care plans contained varying levels of detail about their backgrounds and lives; some people had little information recorded. We discussed this with the registered managers who told us they were in the process of developing 'About Me' books. These books would provide more detail about people's life histories and explain how this informed their character and individual preferences. Although the current staff team knew people well, the introduction of the books would help any new staff to get to know people quicker and promote compassion and empathy.

People felt their privacy, dignity and independence was respected. One person said, "I am always treated with dignity and respect. They ask for my consent to take care of my personal care and they are discreet at

all times. I don't have to do anything I don't wish to do". People's preference for only receiving intimate care support from staff of a particular gender was respected. Staff we spoke with understood the importance of promoting people's dignity and treating them with respect at all times. One staff said, "You offer full respect like how I would want my Dad to be treated". Another staff member told us, "I always check people are ok if I am supporting them with personal care, make sure the curtains are drawn and a sign is on the door saying the person is engaged. You must be sensitive and put yourself in their shoes". Another staff member told us, "Give people choice, involve them in decisions and always allow them to do things for themselves where they can".

We observed staff responding in an appropriate way where people were distressed. One person said to a staff member as they were passing that she was worried about an issue. The staff member immediately took time to stop and engage with the person and asked, "Is there anything I can do to help?" The person could not articulate the exact cause of their concerns, but repeated it several times. The staff member patiently listened and did not interrupt. They then explained they were not going to do anything at this point but the person could talk to them about this issue whenever they wanted. The person became calmer and stopped repeating the concern.

We saw people had frequent visitors from family and friends during our inspection and the registered managers told us this was actively encouraged. People had signed individual 'Consent to Information Sharing' agreements that stated all persons' personal information would be treated confidentially and in compliance with the Data Protection Act. Staff were aware of their responsibilities to maintain confidentiality and respect people's privacy. One staff told us, "We only tell people about other people's information on a need to know basis". Another staff said, "We know the resident's families quite well but we would, never discuss other residents with them".

Good

Is the service responsive?

Our findings

People told us that they contributed to the planning of their care and support. Relatives told us that if appropriate they, or other people acting with authority on the person's behalf, were involved with planning people's care. A relative told us about how a person's levels of independence and quality of life were taken into account during the support planning process, saying, "They have lost their independence [to live at home] but this is a wonderful place to be, they try to keep her going".

People's care plans identified a range of support people required to meet their individual physical, mental, emotional and social needs. We saw each person had undergone a thorough assessment and had a corresponding care plan in place to manage any clinical health needs. However, we sampled plans and saw a variation in the level of detail recorded about individual preferences and aspirations and how staff should take this into account when offering support to people.
One person's plan stated although they received their care in bed, it was important for staff to support them to dress smartly every day and explained how the person wanted this to be done. For other people, their plans were less descriptive and person centred and only stated the minimal details of the task that was required to meet their need. For example, one person's plan identified a need for regular personal care support but only stated this should be done between a certain amount of hours and following a non-descriptive personal care task. There was no detail about how the person preferred to be supported during these tasks, what they were able to manage on their own, or actions to be taken to ensure their dignity and privacy were respected.

We discussed this with staff to see if they understood the importance of ensuring they maintained people's choice and control and respecting their individual preferences when responding to people's needs. Staff told us they were aware and shared this information informally if it was not explicitly included in people's care plans. One staff member told us, "Some people want to wash their own face and I wouldn't wash it for them". We saw the care plans were reviewed every two months and notes of the reviews were kept with the plans. In some plans the review notes included changes to the original plan. Staff told us that this process always involved the people being supported saying, "We go through with the resident and if there are any changes we discuss this with them and ask if it is ok. We get consent and then it will later be changed in the care plans". A registered manager told us they had been working on reviewing and making the changes to the care plans. They sent us some examples of reviewed plans following the inspection and some of these showed an improvement in the level of person centred detail included in them.

People's care plans identified how to meet the communication needs of people with a disability or sensory loss. For example, for a person who was hearing and vision impaired, their plan detailed how to communicate with them in the most accessible manner, by ensuring their hearing aid was switched on and speaking slowly and clearly. The person had signed their plan to say they had verbally consented to sharing the information in the care plan, including regarding their sensory loss related communication needs with others.

We saw there was one standard format of written care plan available for people. We discussed with the

registered managers about how they were able to ensure the accessibility of the information in the plans for people with a disability or sensory loss related communication needs, in line with the Accessible Information Standards (AIS). They gave us an example of how for people with a sensory loss the service was taking measures such as reading people's care plans aloud to them. The registered managers told us there were plans to develop different formal formats of accessible care plans for people with specific communication needs in the future.

There were arrange of activities that people could take part in if they wished, including arts and crafts, music, visiting entertainers, exercise, film and cultural talks. People we spoke with told us examples of activities they had done at the service and enjoyed including, "Exercise programmes" and "Musical entertainments and sing along". A relative told us, "I think they work hard with their activities". An activities co-ordinator designed the activity schedule based on people's preferences. People had an active input in choosing activities.. For example, people had opted to cancel a poetry reading, as they had not found it interesting and a card playing session was arranged instead. Group visits to theatres had taken place and a registered manager told us the service supported links with local charities. They were activities provided that were socially and culturally relevant to people. For example, a local church held regular meetings at the service.

There was a complaints policy in place and each person had an individual copy of this included in their 'Service User Guide' that was kept in their rooms. People we spoke with told us they had not had a reason to complain but they were aware of how to do this. People were confident the service would act on any complaints. A registered manager told us they always dealt with complaints by speaking personally with the person, keeping them informed of what was going on and sending a final written response. A staff member told us that sometimes the registered managers discussed complaints in general terms with the staff team to ensure the team learned from the incident and prevented it from happening again.

People's wishes and preferences for their end of life care were recorded in a separate 'Planning Future Care' document. This document evidenced the person's involvement in planning, managing and making decisions about their end of life care. The document had been signed by people, or relevant people acting on their behalf, and was kept under review. The registered manager told us they approached planning end of life care sensitively and made sure the end of life care plan detailed people's relevant spiritual and cultural needs during and after the end of life process.

Staff offered reassurance to people who were experiencing symptoms that indicated they were coming to the end of their life. Staff sought advice from Nurses, GPs, local authority palliative care teams and a local hospice to assess and manage people's end of life symptoms effectively. A registered manager told us if they could not guarantee they could provide the right support, equipment or medicines if someone's end of life condition was changing rapidly, they would not accept a referral or would transfer them to primary medical services.

Staff offered support to people when another person at the service passed away. Staff told us this was important. One staff member said, "Some residents form close bonds, so we make sure we are there for them and can contact other services for them if they want. There is a brochure to give them about bereavement". The service also offered support to staff when someone passed away. A staff member told us, "We talk a lot when someone dies and encourage people to express how they feel. Staff can talk to seniors and they will give them reassurance and let them know they can talk to the bereavement service at the GPs". We spoke with a relative of a person who had recently passed away who was visiting a registered manager and they told us the end of life care at the service had been "Excellent".

Requires Improvement

Is the service well-led?

Our findings

There were quality assurance and information governance systems in place to monitor the quality and safety of the service, however we found these systems required improvement.

Staff completed daily care notes that were included in people's care files. Daily audits of people's records took place by senior staff and registered managers. The registered managers undertook more in-depth monthly audits of accident and incidents, medicines, health and safety and infection control. However, there was not always an action plan in place, including timeframes for a response, where some of the individual systems had identified areas needing improvement. This meant that it was not always evident effective action was taken to rectify issues.

For example, we sampled medicine audits for the past year and these consistently identified areas of non-compliance. However, there was no corresponding action plan outlining how to rectify the issues within a set timeframe and the areas of non-compliance had re-occurred over the course of the year. Medicine audits had also not always been effective in identifying areas of poor practice, including issues such as not disposing of expired medicines and failure to check stock which we highlighted at this inspection.

We discussed this with the registered managers who told us they were in the process of developing their quality assurance systems. The registered provider had recruited one of the registered managers recently in acknowledgment that, currently, more human resources were necessary to help monitor the quality and safety of the service delivery effectively. The provider told us there were plans to invest in a paperless care notes system that would allow information to be stored centrally to help the registered managers maintain an accurate oversight of service quality more easily in future. However, we identified this as an area of practice that needs improvement.

The registered managers told us they had a clear vision for the service and were committed to creating a culture of delivering high quality care. One registered manager told us the service vision included, "Care from the heart, we are passionate about people feeling they have that level of care". The other registered manager told us the service could deliver person-centred care through displaying the values of, "transparency, integrity, honesty, practicality and by being realistic". Staff we spoke with showed a good understanding of the vision and values the registered managers expected. One staff member said, "We aim for the best possible care for the residents…we are open and discuss when things go wrong with people and their families".

The registered managers told us they looked to build a culture that reflected the service vision by being visible and valuing their staff. Staff told us they felt there was an open and positive team culture and that the service protected their rights and well-being. One staff said, "I love working here. We are well looked after. Everything is completely transparent and nothing is ever hidden from us".
There were recruitment and equality and diversity policies which upheld staff employment rights. This included any protection from any form of work related discrimination for staff with protected characteristics

under the Equality Act 2010.
There were management processes to outline expectations for staff responsibility and accountability. Both the registered managers and senior staff carried out such as supervisions, appraisals and disciplinary and probation procedures. Staff told us these processes were effective. One staff member said, "We agree what I need to do". Another staff member told us they found their supervisions helpful and the feedback they got was "constructive".

Surveys were sent to staff asking for their feedback on how the service could be improved. There were regular staff and management meetings to share information about the challenges and achievements occurring at the service. These meetings allowed staff put forward ideas to overcome issues and to raise any concerns. Staff told us, "We are involved in developing the service, we are asked about how we can improve things and can ask about resources and support".

The provider sent out annual surveys to people and their relatives to get their views on the quality of the service and took actions based on any issues raised in the feedback. We saw recommendations following the most recent survey that cleanliness at the service could be improved. This had resulted in the head housekeeper now attending staff meetings, so they were more aware of issues people were raising with staff and could act on them.

There were resident meetings every month to allow people to raise any concerns. Changes had been made based on issues raised during the meetings. One person had requested a change to their alarm bell system, so they could call for help more easily and the service had provided them with a call bell they could wear around their neck. Other people had requested menu changes and times to meals and the service fulfilled these requests.

The provider service sent annual surveys to relatives asking for their involvement in developing the service. There were regular relatives' meetings. We spoke with relatives who said they had on occasion attended the meetings but most said they preferred to communicate on a daily basis via phone, or call into see one of the registered managers while they were visiting.

Care homes and other health and social care services are required to notify the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check the action the service took and if necessary request additional information regarding about the event itself. The registered managers had submitted notifications to the CQC as required regarding all notifiable events that had occurred at the service.

We saw examples where the registered managers had notified external stakeholders such as the local authority and healthcare professionals when important events involving people at the service had taken place. The registered managers had shared information and worked in partnership with these outside agencies in an open and honest way. This had allowed them to identify and implement actions and improvements in response to any notifiable incidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Failures to ensure medicines are managed, recorded, stored, disposed of and administered safely.