Care Quality Commission

Burlington Care

Figham House

Inspection report

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Ratings

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

Overall summary

This inspection took place on 19 February 2015 and was unannounced. We previously visited the service on 19 September 2014 and made three compliance actions in respect of shortfalls identified. These included: concerns about staffing levels, the lack of an emergency contingency plan, gaps in staff training, insufficient recording on food and fluid charts and the lack of an effective quality assurance system. We received an action plan from the provider stating they would be compliant with these identified shortfalls by 31 December 2014.

The service is registered to provide accommodation, personal care and nursing care for a maximum of 55 people, some of whom are living with a dementia type illness. On the day of the inspection there were 49 people living at the home. Most people are accommodated in single rooms with en-suite facilities. The home is in Beverley, a town in the East Riding of Yorkshire. It is close to local amenities and has a car park.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was not yet registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager told us that she intended to apply for registration very soon.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse.

The arrangements for ordering and storing medication were robust and medicines were administered safely by staff who had received appropriate training.

The manager was aware of good practice guidance in respect of supporting people living with a dementia type illness and had introduced signage in the home to assist people with orientation.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and compassionate and this was supported by the relatives and health / social care professionals who we spoke with. People also told us that staff were effective and skilled. Staff told us that they were happy with the training and support provided for them.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct documentation was in place to confirm this had been authorised.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home. New staff had been employed in line with the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that lessons were learned from any issues identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff received appropriate training on the administration of medication and the arrangements in place for the management of medicines were robust.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met and staff recruitment was robust.

Is the service effective?

Good

The service was effective.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making.

Progress was being made to ensure the environment was suitable for people living with dementia.

Staff told us that they completed training that equipped them with the skills they needed to carry out their role.

People's nutritional needs were assessed and met, and people told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed and continually reviewed. People's preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities and that they were consulted about the service they received.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Summary of findings

Is the service well-led?

Good

The service was well led.

There was a manager in post at the time of the inspection. They had only been appointed six weeks prior to the inspection and intended to submit an application to the Care Quality Commission to be registered as the manager.

The manager carried out a variety of quality audits to monitor that the systems in place at the home were being followed by staff to ensure the safety and well-being of people who lived and worked at the home.

Identified issues were dealt with and lessons learned were shared with staff so that improvements could be made to the service.

There were sufficient opportunities for relatives, staff and health / social care professionals to express their views about the quality of the service provided.

Figham House

Detailed findings

Background to this inspection

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

The inspection took place on 19 February 2015 and was unannounced. The inspection team consisted of two inspectors from the Care Quality Commission.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. We did not ask the registered provider to submit a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adult's team and quality monitoring team to ask if they had had any recent involvement with the home.

On the day of the inspection we spoke with six people who lived at the home, four members of staff , three relatives / visitors, the manager and a service manager for the organisation.

We spent time informally observing the interaction between people who lived at the home, relatives and staff.

We looked at all areas of the home, including bedrooms (with people's permission) and office accommodation. We also spent time looking at records, which included the care records for six people who lived at the home, records for five members of staff and other records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with six people who lived at the home and they told us they felt safe living at Figham House. One person told us, "I have always felt safe and never witnessed anything of concern." This view was supported by relatives who we spoke with.

We saw that staff induction training included information about safeguarding vulnerable adults from abuse and the training record evidenced that all staff apart from two had completed additional training on this topic. The two staff who had not completed this training were already booked on a training session. Staff were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation.

The manager told us that there was a policy on people's dependency levels and how this related to staffing levels. However, she said that they were going to look for a more formal tool to assist with this process.

The manager told us that staffing levels had increased since she was appointed in January 2015. She told us that occupancy levels had reduced recently but staffing levels had not decreased. There were ten staff on duty each morning; this consisted of two nurses and eight care workers, including a senior care worker. In the afternoons / evenings there were 1.5 nurses plus six care workers on duty, including a senior care worker and overnight there was one nurse and four care workers on duty. The manager said that she had worked a night shift to monitor staffing levels and had identified that, although three care workers were usually sufficient, if someone needed to be taken to hospital during the night and a staff member accompanied them, this would mean the remaining staff would not be able to offer optimum care. We checked the staff rotas and saw that safe staffing levels had been maintained.

We saw that there was a cook, a kitchen assistant, a laundry assistant and a domestic assistant on duty each day and that there was also a housekeeper, a maintenance person on three days a week and an activities coordinator on six days a week. This meant that care staff and nurses were able to concentrate on supporting and caring for the people who lived at the home.

People who lived at the home told us that they were happy with the number of staff on duty and two people told us that staff responded quickly when they activated the call bell. They said, "If I buzz it is not long before they are here."

The manager told us that only one agency worker had been used to cover staff absence since she was appointed in January 2015. There was a folder in place that included a summary of each person's care needs for agency staff to refer to in addition to shift handover information. This ensured that any agency staff could provide care safely for people who lived at the home.

We saw that care plans included risk assessments for any areas that had been identified as posing some level of risk. These included risk assessments for the use of a wheelchair, moving and handling, the risk of malnutrition / weight loss, the risks associated with percutaneous endoscopic gastrostomy (PEG) feeds, the risk of falls and skin integrity. We noted that risk assessments were updated regularly to ensure that staff had up to date information to follow. In addition to risk assessments, care plans included a 'safe system of work' document that recorded any equipment needed to assist people with mobility and the number of staff that would be needed to carry out transfers and tasks. This ensured that staff had information to follow to ensure that moving and handling tasks were carried out safely.

People had risk assessments in place for the risk of falls. We saw that any concerns had been referred to the falls team. One person's care plan recorded, "Increasingly unsteady – referred to falls team." This evidenced that advice from health care professionals was requested to ensure people received optimum care.

We checked the recruitment records for three new members of staff. We saw that application forms had been completed and that they recorded the person's employment history, the names of two employment referees and a declaration that they did not have a criminal conviction. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work with vulnerable people, such as references, a Disclosure and Barring Service (DBS) first check, a DBS check and identification documents. We saw that a thorough interview had taken place and that interview questions and responses had been retained.

Good

Is the service safe?

One person's employment checklist recorded that they started work on 28/01/2015 but another record in their personnel file stated they worked on 26/01/2015 and 27/01/2015 as supernumerary staff. Although there was a DBS first check in place, the full DBS disclosure was not received until 02/02/2015. The manager assured us that this person did not start to work on the staff rota until their DBS check had been received but the records were unclear and did not evidence this. The manager assured us that this recording would be more robust in the future. For the other two people the records were clearer and we could see that all safety checks were in place before they commenced work at the home.

There was a system in place to monitor that personal identification numbers (PINs) to confirm a nurse's registration to practice had not expired.

We saw that medication was stored safely and medicines that required storage at a low temperature were kept in a medication fridge. We saw that the temperature of the fridge and the medication room were checked daily and recorded to monitor that medication was stored at the correct temperature. Controlled drugs (CD's) were stored in a CD cabinet. We checked a sample of controlled drugs and saw that the records in the CD book matched the number of medicines in the CD cabinet. There were three medication trolleys stored in various areas of the home; these were locked and fastened to the wall when not in use. Items for external use were stored in one side of the trolley and items for oral application were stored in the other side of the trolley, as recommended by the pharmacy. The date of opening had been recorded on packaging so that medication would not be used for a longer period than recommended.

Medication was supplied in small plastic pots (known as a bio dose system) that were colour coded to identify the times that the medication needed to be administered. The pots recorded the name of the person, the name of the tablet and the dosage of the tablet; this reduced the risk of errors occurring.

Staff who administered medication had received training. Nurses administered medication to people who were receiving nursing care and senior care workers administered medication to people who were receiving residential care. The manager had designed a drug competency assessment that was being trialled by staff at the home; it was intended that this would then be completed by all staff within the organisation. This meant that staff who had responsibility for the administration of medication had received appropriate training.

We observed staff administering medication on the day of the inspection and noted that they carried out this task safely; they wore a tunic that alerted people to the fact that they were administering medication and should not be disturbed, and did not sign the MAR chart until they had seen the person take their medication. People were encouraged to take a drink after taking their medication to make sure they had swallowed it.

The system in place to check that the medicines prescribed by the GP were the same as those supplied by the pharmacy was robust. We saw that the arrangements in place for the destruction of medication or the return of medication to the pharmacy were satisfactory. Audits of the medication system were carried out each week.

We checked medication administration record (MAR) charts and saw that these included a sheet for each person that recorded their photograph, any known allergies, their bedroom number, the name of their GP and information about how they liked to take their medication. MAR charts also included a picture of each medicine; this reduced the risk of medication being given to the wrong person or someone being given the wrong medication. Two staff had signed hand written entries to confirm that they were correct and we saw just one gap in recording.

There was a business continuity plan in place that recorded advice for staff on how to deal with emergency situations such as power failures and communication disruptions. The plan contained details for each person who lived at the home including their GP and next of kin, and relocation arrangements in case the home needed to be evacuated.

Each person who lived at the home had a personal emergency evacuation plan (PEEP) in place. The PEEP included the person's full name and the number of the room they occupied, plus information about any equipment used, any complex needs and the number of staff required to assist the person to mobilise. The manager told us that she also intended to develop a risk assessment for each bedroom.

Overall, we found that the premises were well maintained to ensure the safety of people who lived at the home, although we saw that combustible material was stored in a

Good

Is the service safe?

stair well and there was a stool causing an obstruction at the bottom of the stairs. The linen cupboard had a sign stating that it should be locked at all times as it was a fire door, but it was open at the time of the inspection. These issues were rectified immediately when discussed with the manager. There was evidence that health and safety risk assessment for areas such as slips / trips / falls, sharps injury, the use of hoists, smoking and radiators / hot surfaces had been reviewed in January 2015. We saw there were service certificates in place for lifts, hoists and slings and portable appliances. There was evidence that the fire alarm system had been maintained and there was a gas safety certificate in place.

Staff told us that they understood it was important to maintain a safe environment, to use observation charts, to record any falls or accidents and to identify changes in a person's behaviour to help to keep them safe from harm.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected. Discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS and senior staff had completed training on the MCA and DoLS. The manager told us that they had discussed with the local authority the number of people at the home who required a DoLS application to be submitted. It had been agreed that the manager would submit one per week until all DoLS applications had been considered.

We saw that each care plan had a record of the person's capacity to make decisions. One person's care plan recorded, "(The person) has full capacity. All care plans and choices to be discussed with them." A visitor told us that their relative had capacity to make decisions and that "Staff respected their wishes." When people did not have the capacity to make important decisions, we saw that a best interest meeting had been held to support the person with decision making. For example, there had been a best interest meeting to discuss physiotherapy intervention for one person to maintain their current mobility levels. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf.

The manager told us that five people who lived at the home had a diagnosis of a dementia condition, although other people presented with a dementia type condition who had not been formally diagnosed. We sat in one of the lounge areas for several hours and our observations did not highlight any concerns about the way in which staff interacted with people who had a dementia related condition. We saw that staff communicated with people who had limited verbal communication by using appropriate touch, eye contact and gestures to help them understand and interact. Staff did not restrict people's movements or try to influence their behaviour. This demonstrated that staff had some knowledge of how to work with people who were living with dementia.

The new manager had introduced signage so that people living with dementia could identify toilets and bathrooms, and other areas of the home. The manager told us that she had consulted the CQC website, guidance provided by the National Institute for Health and Care Excellence (NICE) and the Stirling University website to check the latest guidance on environmental design to understand how to improve the day to day experiences of people living with dementia. There were plans in place to introduce more colour when decorating doors and corridors to further assist people living with dementia to identify different areas of the home.

Most staff had completed training on dementia awareness to help them to understand the needs of people living with dementia. The manager was booked on more advanced dementia training with the local authority and the registered provider has agreed that she could undertake a qualification on this topic. All staff at the home were in the process of signing up to be a 'dementia friend'. Dementia Friends is a scheme that aims to give more people an understanding of dementia and the small things that could make a difference to people living with dementia.

Staff have in-house induction training when they are new in post but may have to wait a couple of weeks for the company induction. One member of staff started work on 28/01/2015 and records stated that they had in-house induction and supervision on 06/02/2015. The supervision record stated that they required training on moving and handling, COSHH, fire safety, first aid, health and safety and safeguarding adults from abuse. We discussed this with the manager who said that they had obtained a copy of this person's training record in respect of training undertaken with previous employers so knew that they had undertaken appropriate training. They were booked on the company (full) induction training course in March 2015; they had originally been booked on this training in February 2015 but this had been changed (at the request of the employee). Records evidenced that new staff appointed a mentor to support them through their induction period and the manager told us that she had also been appointed a mentor to support her through the first few months of her employment.

We understood that the intention of the organisation was for people to complete a five day induction training programme prior to commencing work at the home. The

manager and service manager confirmed that this was the aim of the company for future new employees. On completion of induction training, an individual learning and development plan was produced.

We saw the training record for the home dated February 2015. This identified the training completed by each member of staff, including nurses, care workers and ancillary staff. Mandatory training for nurses included pressure care, PEG feeds, use of a syringe driver, phlebotomy, moving and handling, infection control, safeguarding vulnerable adults from abuse, dementia, health and safety, medication and catheter care. We saw that all nurses had completed training on catheter care, infection control and fire safety and most nurses had completed the other mandatory training. Any gaps in training were highlighted in red to alert the manager to the need to arrange refresher training. Mandatory training for care staff included moving and handling, safeguarding vulnerable adults from abuse, dementia awareness, infection control, fire safety and health and safety. All staff had completed training on most topics, with a small number of dates highlighted in red to identify that refresher training was overdue. Over 50% of care staff had completed or were working towards a National Vocational Qualification (NVQ) award or equivalent. We saw that ancillary staff had also completed the mandatory training identified for care workers. This training ensured that staff had the skills they needed to support the people who lived at the home.

We saw that some training courses had been attended by staff in January 2015; these included pressure area care (attended by 12 staff), catheter and stoma care (attended by 13 staff) and diabetes awareness (attended by two staff). We saw evidence of training courses booked for staff in the near future; these included nutrition and diabetes, fire training, infection control and the control of substances hazardous to health (COSHH).

Staff told us that communication at the home was effective. One member of staff described it as, “Miles better” than it used to be. They said that handover meetings were held to pass information from one shift to the next and that key information was recorded in a communication book and diary. This included information about any hospital appointments or accidents; the handover sheet included the name of each person who lived at the home to ensure that information was not forgotten at handover meetings. One member of staff told us that communication had improved at the home but that “There was still room for improvement.”

We saw a chart on the office wall that recorded staff supervision meetings. Staff were divided into seven supervision groups but the manager told us that she or the lead nurse had a one to one meeting with all staff. The staff who we spoke with told us that they were well supported by the manager and senior staff, and that they were able to discuss any concerns or training needs during supervision meetings. One member of staff told us, “I have developed personally and in my job role.”

We saw that care plans included people’s food likes and dislikes and any special dietary requirements. People had a nutritional assessment in place and any weight loss or gain was recorded as part of nutritional screening. When concerns had been identified about a person’s nutritional intake or weight gain / loss, we saw that a referral had been made to a dietician. We looked at the care records for one person who was fed by PEG. These were very detailed and included a specific care plan, a risk assessment in respect of PEG feeds and weight loss and a ‘gastrostomy passport’. A dietician had been consulted due to perceived weight loss (the person could not be weighed) and had prescribed food supplements.

People could choose where they wanted to eat their meals. Some people used the dining room, some people had small tables provided for them in the lounge and a small number of people had their meals in their room. Only one person who ate their meal in their own room required assistance from a member of staff. People told us that they enjoyed the meals provided by the home. One person said, “The meals are very good really” and another said, “There is a choice at lunchtime and teatime.” A visitor told us that their relative “Enjoys the food and is given plenty of choice.”

We observed the lunchtime experience and saw that there was a calm unrushed atmosphere. There was a choice of lunch on offer and people were asked which meal they would prefer. We saw that staff took their time in explaining meal choices to people and that they chatted to people in an animated way whilst they took their orders. We also observed that drinks were provided throughout the day. One person who lived at the home told us, “I always have some juice in my room.”

Good

Is the service effective?

We noted that some people were seated at dining tables a long time before the meal was served. For people living with dementia, sitting at a dining table indicated that a meal was due to be served. We were concerned that this could lead to people becoming agitated or disinterested in their meal.

We saw the food and fluid charts that were being completed for eight people who needed to have their food and fluid intake monitored. Liquids were recorded in millilitres and liquid intake was totalled each day so that staff could check that these people had taken sufficient fluids and were not at risk of dehydration.

People were provided with appropriate assistance to eat their meal. However, we were concerned that one person took a long time to eat their meal and this meant it would be cold and unappetising by the time they finished it. We discussed this with the manager who acknowledged that food should be re-heated or replaced after a certain period of time.

The manager told us that the cook was informed by care staff of people's special dietary requirements. When people required a liquidised diet, moulds were used for each part of the meal so that people could identify the different flavours of the food. The cook intended to speak to people who lived at the home and / or their relatives once a month to check that people's needs had not changed. A kitchen assistant told people each day about the menu choices but we saw that staff explained this again when they were serving the meal.

The manager told us that the kitchen was open until 6.30 pm in the evening but that staff were always able to access the kitchen to prepare snacks for people.

Staff said they felt they were alert to people's physical health needs and we saw that health care professionals were contacted when needed. All contact with health care professionals was recorded and we saw that any advice given was incorporated into care plans. Documentation from hospital appointments and correspondence from health care professionals was held in people's care plan files. The manager told us that, if someone had an accident or a fall, they would be initially assessed by the nurse on duty and the input from other health care professionals would be requested if needed. We saw that one care plan recorded, "(The person) seen by out of hours GP due to swollen lips. Suffering with oral thrush. Nystatin prescribed." Any bruising, skin tears or injuries were recorded on a body map to assist staff to monitor the person's condition.

The manager told us that only one person currently had a wound chart in place, and that the tissue viability nurse had been involved in this person's care. Records of the wound were made every three to four days; this has been agreed by the tissue viability nurse. The entry in the person's records on 4 February 2015 stated, "Sore is improving. Granulating. No infection." The manager said that the tissue viability nurse was to have no further input as the wound was improving.

We checked one person's care plan as we were notified by the manager (as required by regulation) that they had developed a pressure sore. We noted that this was not recorded on a body map in the person's care plan. The manager told us that this injury was recorded on a body map in the district nursing notes but assured us that she would add a body map with the injury recorded on it to the person's care plan.

Good

Is the service caring?

Our findings

We asked people who lived at the home and relatives if they felt staff really cared about them. All of the responses were positive. One person who lived at the home said, “A good home – staff really care” and another told us, “Staff care – they are always very nice.” One relative said, “I find the staff to be considerate and attentive” and another said, “Staff are very caring and attentive.”

We observed good rapport between people who lived at the home and staff. Staff were skilled in engaging people in activities and in conversation, and interacted with people using eye contact and appropriate touch.

We also observed that people were encouraged to be as independent as possible. People who we spoke with told us that they could get up and go to bed when they chose and that staff encouraged them to do as much for themselves as they could.

We asked people if their privacy and dignity was respected by staff. One person told us, “When staff help me they make it as private as they can.” We saw that staff knocked on doors before entering bedrooms, indicating that they respected the privacy of people who lived in these bedrooms. We saw that some care plans, but not all, recorded a person’s preference about being supported with personal care by a male or female member of staff.

We asked people if their relatives could visit at any time and they told us that they could, and that they were always made welcome. This view was supported by visitors who we spoke with on the day of the inspection.

The manager told us that people were always accompanied to hospital. She said that they were not happy about people attending hospital appointments or being admitted to hospital without someone who knew them well being with them. Each person had a patient passport in place; these are documents that people can take to hospital appointments with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person’s physical and emotional needs. In addition to this, there was a hospital admission checklist in use. This was used as a reminder for staff and recorded; Has patient passport / MAR been sent? Is someone escorting the resident? Have family been informed? Was DNAR form sent? There was another checklist used for when people returned from hospital. This included a record of any sores, bruising or injuries and a reminder that the person’s care plan needed to be reviewed.

We saw that people had ‘end of life’ plans in place that recorded their wishes at the end of their life. ‘Do Not Attempt Resuscitation’ (DNAR) notices were in place when this decision had been made by the person concerned or their GP or consultant. We saw that other people had been consulted as part of this decision making process and that DNAR forms had been appropriately completed. We noted that DNAR forms were placed at the front of care plans so that they were easily accessible to staff. Both prior to and during the inspection no issues were raised about the end of life care provided to people at the home.

Good

Is the service responsive?

Our findings

We checked the care plans for six people who lived at the home and saw that these included a photograph of the person to assist staff with identification, especially when they were new in post. We saw that a person's care needs had been assessed either prior to their admission or when they were first admitted to the home.

We saw that a care plan had been developed for each area of need; these included falls, personal hygiene, mobility, skin care, eating and drinking, health needs, communication / sight / hearing, mental health / cognition, pain, bedtime routine and social activities. Care plans were reviewed and updated each month, or before then if the person's needs changed. Diary entries were made each day to record the care provided and the general well-being of the person concerned.

Care plans included information about a person's previous lifestyle in documents called "All About Me." These helped staff to get to know the person. We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. On the day of the inspection we observed that staff were skilled in understanding people's individual needs when they were not able to verbalise these, including their body language, their facial expressions and their gestures. One person who lived at the home told us, "If I have asked for anything special they have done it."

Two people who we spoke with told us that they were able to make decisions about their care and that staff listened to them.

We saw that two activity coordinators were employed at the home. One of the home's activity coordinators was booked on therapeutic and reminiscence activities training with the local authority. It was hoped that this would provide them with additional skills to enable them to provide activities that were specifically designed for people living with dementia.

The manager told us that activities on offer included flower arranging, embroidery and a poetry group. They said that they had the use of a local mini bus on alternate Fridays so that people could go out and planned to have a 'clothes show' and to buy some chickens. A local sweet shop had started to visit the home to sell 'old fashioned' sweets and this was very popular with people who lived at the home. The home's newsletter recorded the activities on offer and also featured an article about one person who lived at the home each month.

The activities folder included a programme for February and March 2015 and we saw that an activity was planned on most days. People told us that they received a copy of the activities schedule so they were aware of the programme of activities. We saw activities taking place on the day of the inspection; this included a singer who encouraged people who lived at the home to take part. Three people who we spoke with told us that they had enjoyed listening to the singer. We heard a member of staff ask someone who lived at the home if they would like their nails painted. They told her, "No – I am not in the mood" and this was acknowledged by the member of staff.

People who lived at the home had been given a questionnaire to complete in January 2015; the manager had produced an 'easy read' version of the questionnaire so that each person who lived at the home would be able to access a copy. The responses had been collated and this had led to a number of actions: a community mini bus would be booked every two weeks so that people could be taken out, people who lived at the home would be included on the interview panel for prospective employees and cookery/baking classes would be introduced. We saw the activities coordinator baking with someone on the day of the inspection. The manager told us that people with a dementia related condition had not been given a survey; staff met with them on a one to one basis and asked straightforward questions that they would be able to understand. In addition to this, the relatives of these people had been given a survey to complete.

There was a policy and procedure in place on how to make a complaint and this was displayed within the home. People told us that they knew who to go to with concerns and complaints and said they were confident in doing so. One person who lived at the home told us, "The manager or other staff would listen" and another person said, "(Staff) would listen to my concerns and complaints. They seem to know my needs."

We saw that complaints received were recorded and this included details of the response to the concern and of the

Good

Is the service responsive?

actions taken. Discussion with the manager confirmed she did feed this information back to the staff team but did not have any record of any learning or service development from concerns raised.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was not yet registered with the Care Quality Commission. The manager started to work at the home in January 2015 and told us that she intended to apply for registration very soon.

The manager said that the philosophy of the home was that the focus was on providing "What was best for the people who lived there." She said that this was discussed with every new employee during their induction period.

Since the manager was appointed in January 2015 she had introduced a variety of improvements. These included:

- Employee of the month (flowers and champagne) – families had started to nominate people
- People who lived at the home were included on staff interview panels. This had happened twice and their views had been taken into account.
- An easy-read complaints procedure had been produced
- The activity board included pictures as well as words
- The homes statement of purpose had been updated.

The manager had started to produce a newsletter. This introduced new staff, recorded forthcoming events in the home and included a short biography of someone who lived at the home. The most recent newsletter invited people who lived at the home to volunteer to take part in staff interviews and invited nominations for "Employee of the month." This involved people who lived at the home and relatives in the running of the home.

Visitors and people who lived at the home told us that the manager was approachable and was making improvements to the home. One relative said, "Our family are talking about the new manager in a very positive way" and another said, "The place has a very nice atmosphere." Two people whose relatives were having respite care at the home told us that their relative had decided that they would move into Figham House when they needed permanent care.

One relative told us that they attended the relatives meetings and that they found these to be worthwhile. We saw that the most recent relatives meeting had been held on 23 January 2015. In addition to this, a combined 'resident and relatives' quality survey was sent out in January 2015. The action plan included the statement, "To introduce an activities schedule and timetable" and we saw that these had been introduced. This evidenced that people who lived at the home and their relatives were listened to.

We saw that monthly staff meetings were held, both for nurses / senior care workers and for all staff. Staff told us that they were able to raise issues at these meetings and that they felt they were listened to. One member of staff told us, "Staff now know that it's OK to not know everything and to ask. We discuss things openly at staff meetings and any learning from issues raised is shared at staff meetings and supervision meetings." Another member of staff said that the new manager was keen to develop the service and to support staff to develop.

The manager told us that one member of staff was undertaking training on diabetes on the day of the inspection and would then become the diabetes 'champion' for the home. Another member of staff was due to undertake a "Train the Trainer" course on moving and handling and they would become the moving and handling champion for the home. There were also plans in place for staff to have training on nutrition and dignity so that 'champions' could be appointed.

A staff advocate had been appointed for the organisation. This was to give staff the opportunity to speak to someone independent when they had either work related or personal problems.

We noted that accidents and incidents were recorded and audited each month; this included information about accidents and incidents but also any falls, deaths, safeguarding incidents and notifications submitted to the Care Quality Commission. One visitor told us about an accident that had occurred involving their relative and that the home had taken responsibility for the accident and had then taken remedial action.

We saw copies of audits that had been undertaken for other areas including the environment, complaints, kitchen safety, medication and care plans. Care plan audits were seen in people's care plans; these had recently been carried out by the manager and any areas for improvement had been identified, for example, "Risk assessment to be done for (resident) for wandering overnight."

Good

Is the service well-led?

We saw that the outcome of health and safety audits was discussed at staff meetings and included in handyman records; this evidenced that people were aware of any identified issues.

We saw charts in people's bedrooms that recorded any positional changes that were needed to promote good tissue viability. The manager told us that an audit of these charts had identified that recording needed to be improved. Staff were recording a mix of, for example, 8.00 pm or 20:00 and this had resulted in some positional changes taking place at irregular intervals. The manager said that a meeting had been arranged with night staff to address this on 26 February 2015 and this would also be addressed in group supervision meetings. This evidenced that action had been taken when shortfalls in the service had been identified.

There was a health and safety policy in place and, along with some other policies and procedures, we noted the date that the policy had been written and was due for review was not recorded. This was fed back to the manager at the end of the inspection and she told us that this would be addressed.