

Stowlangtoft Healthcare LLP

Brandon Park Residential and Nursing Home

Inspection report

Brandon Country Park
Bury Road
Brandon
Suffolk
IP27 0SU
Tel: 01842812400
Website:

Date of inspection visit: 25 January 2016
Date of publication: 21/03/2016

Ratings

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

Overall summary

The inspection took place on the 25 January 2016 and was an unannounced, comprehensive inspection. At the last comprehensive inspection on the 15 January 2015 we rated this service as requires improvement. Improvements were required in three out of the five key lines of enquiry we inspect against, and we identified a number of breaches in the following areas: medication

administration, Mental capacity and records. During this inspection we saw improvements had been made in the management and running of the service and felt people's care needs were being met.

The service provides residential and, or nursing care to up to 55 people. On the day of our inspection there were 39 people living in the service. The service had a registered

Summary of findings

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

The manager was experienced and being well supported by a deputy manager and the providers of the service who were in regular contact and completed regular quality audits of the service. We had every confidence that where improvements were identified these had either already been identified or were being addressed immediately.

Staffing was adequate for the needs of the people using the service and we were reassured that staffing levels were reviewed in line with occupancy rates and individual assessments of need. Staff spoken with were kind, confident and for the most part well trained. Some staff felt the induction for new staff could be improved upon depending on the level of experience staff had and some of the mandatory training required updating. Staff felt well supported but the frequency of supervision and records of direct observations of practice also required improvement. However we were confident that staff were familiar with people's needs and the management team now in place were making improvements to the service.

Staff understood their responsibilities and how to safeguard people in their care. Staff understood legislation around safeguards and capacity and acted in people's best interest. The Mental Capacity Act 2005 and

Deprivation of Liberty Safeguards when implemented correctly ensures that, where people lack capacity to make decisions for themselves, decisions are made in their best interests according to a structured process.

Medication practices were mostly robust but could benefit from more audits and a review of processes to ensure people received their medicines as intended.

People's health care needs were met and relationships with other health care providers were improving. Some staff said they would benefit from additional training to help them meet the specific health care needs of individuals such as people with Parkinson's.

People were mostly supported to eat and drink enough for their needs but this was not always adequately recorded. People's dining room experience was positive. People had enough to occupy them and staff helped to promote people's well-being through social stimulation.

Records of people's needs were adequate and showed that people's needs were assessed and a plan put in place to show how needs and risks should be addressed. These were kept under review.

The provider was proactive in monitoring the service to determine where improvements were required and developing care and support which was centred around the needs of the people using the service.

Relationships with the local community, other health care professionals and relatives were being developed to help enhance people's experiences.

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?

The service was safe.

There were effective recruitment processes in place to ensure only suitable staff were employed.

Risks to people's safety were effectively managed and staff were aware of how to safeguard people in their care.

Medication practices were acceptable but some improvements were identified in how the service monitored its own practices.

Good



Is the service effective?

The service was mostly effective.

Staff had an induction and further training relevant to their job role but some felt this could be improved upon. Some training required updating.

People were mostly supported to eat and drink sufficient to their needs but this was not always demonstrated by clear records. A positive dining room experience was promoted.

Staff felt confident in how the service was managed and felt supported.

Staff understood legislation around promoting people's choices and involving them in decision making. Where they were not able to do this staff acted lawfully to ensure their rights were protected.

People's health care needs were known to staff and monitored to ensure conditions were carefully managed.

Requires improvement



Is the service caring?

The service was caring.

Staff promoted people's independence and gave them choice about everyday decisions.

People were encouraged to stay active and staff were mindful about supporting people in accordance with their needs and wishes.

Staff provided care in a respectful way.

Good



Is the service responsive?

The service was responsive

People's needs were known by staff and staff worked accordingly.

People were offered a range of activities based around their individual needs and interests.

Good



Summary of findings

The service was pro-active in asking people for their views about the service and responding to any concerns they might have.

Is the service well-led?

The service was well led.

The service had a Registered manager in post who was working hard to improve the team morale and support provided to the staff. They had a deputy manager in post both the manager and deputy manager were fairly new to post so we found some gaps in terms of training and support to staff. However the providers were actively involved and there was good quality monitoring so we were assured actions would be quickly addressed.

Overall satisfaction with the service was high from people, staff and relatives we spoke with.

Good



Brandon Park Residential and Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on the 25 January 2016 and was unannounced. The inspection team was made up of four

inspectors. Before the inspection we looked at information already held about the service such as notifications which are important events the provider is required to tell us about. We looked at previous inspection reports. During the inspection we spoke with ten people using the service, carried out observations, spoke with three relatives and twelve staff: including one of the Directors, the Registered manager, deputy manager, two nurses, two domestic staff, the activities coordinator, three care staff and the chef. We carried out a medication audit and looked at records relating to the smooth running of the service.

Is the service safe?

Our findings

The service had enough staff with the right skills to meet people's needs. Staff did say they would like to be able to spend more time with people and were more likely to be able to do this in the afternoons. Staff said that staffing was getting better but they could be short at the weekends. Everyone we spoke with thought there were enough staff. They said if they used their call bells these were answered quickly. Some people commented on how busy staff were.

The service had a good ratio of nursing and care staff to people living in the home. The provider had appointed an experienced manager who was in the process of going through a registration process with the Care Quality Commission. They were supported by an experienced deputy manager who oversaw the manager's role in their absence. The manager was currently supporting two homes whilst a manager for the second home could be recruited to.

On the day of our inspection the service had the number of staff it said it needed including two registered nurses, one on each of the two floors. There were seven care staff on duty in the morning, six in the afternoon and four at night. The service was not fully occupied. It had thirty nine people using the service just over half with some level of dementia. The manager told us people's needs were regularly reviewed and staffing levels would be increased if the level of need also increased. There was one full time activities coordinator and the service was advertising for another so they could provide activities over a seven day period, rather than five as they did at the moment. They were also recruiting for a clinical lead and said they were fully staffed in relation to nurses. They said there was ongoing recruitment for care staff and they looked to use their own bank staff rather than agency staff. They said they were currently not using agency staff. The manager told us that in the last year they had some staff that had left and some of them had been subject to disciplinary action and termination of contracts. They said they felt they had a stable staff team.

We noted staff were suitably deployed and were allocated to different areas of the home. This meant the morning went smoothly. At lunch there were additional staff helping

out such as the cook serving the meals and the administrator sat with people. This meant the lunch time worked well. In the afternoon care staff supported the activities co-ordinator with activities.

Staff knew how to safeguard people in their care and what actions to take if they perceived people to be at risk. Staff told us that they had received training in safeguarding vulnerable people. One staff member said they felt the training had been good and were confident that they would recognise signs of abuse. They said they raised a concern about another staff member and their conduct towards staff and this was dealt with promptly. The nurse we spoke with had a good understanding of the different types of abuse that could occur and the signs to look out for. They were aware of the whistle blowing policy. They said that they would be confident about reporting poor care practices or abuse both within the service and to outside authorities if necessary. Another staff member appeared less knowledgeable and this was flagged up with the manager so they could provide the staff member with appropriate support. The management team gave us examples of safeguarding concerns that they had raised. Records demonstrated that they responded promptly and appropriately to any concerns raised. Safeguarding notifications included concerns stemming from staff conduct which had resulted in disciplinary investigation/ actions and issues of concern relating to individuals

The management team were in the process of formally analysing accidents and incidents in the service. This included assessing people who developed pressure sores, wounds or infections or who had any falls. This meant that they could ensure that best practices were followed and put in place strategies to reduce the likelihood of the incidents recurring. We did not observe any obvious hazards in the parts of the service we inspected.

Individual risks were assessed and we saw there were sufficient control measures in place to reduce risk in relation to falls, skin integrity, diet and any other risk identified. Measures included specific equipment and agreed strategies to lower risk. Charts were in people's rooms to show how often people were monitored to promote their safety or support them with their health care needs. They had been regularly updated.

People's medication was managed safely but at the time of inspection there were only limited audit systems in place to monitor medicines management. We identified a few areas

Is the service safe?

where improvements were needed. The deputy manager confirmed that regular full medicine audits would be implemented following the inspection and the identified issues addressed immediately.

The management team were in the process of developing medication profiles for every person. The profiles were held in the medicine administration records (MAR) folders. The profiles were person centred and described how people liked to take their medicines and the support they needed to take them safely. The usefulness of the profiles could be improved if information on the common side effects of the medicines were added. One person was administering their own inhaler and another person was administering their own eye drops. Risk assessments were in place and people's ability to take responsibility for their own medicines safely had been assessed.

Staff had protocols for administering medicines that were given when the person required them, rather than at set times. This reduced the risk that the medicines would be given in an inconsistent way by different staff. However, some additional detail about the individual person's needs or preferences in relation to the medicines would have made the protocols more effective. For example, one person had protocols for two different painkillers. They were identical in their guidance for staff despite the fact that one of the medicines was a much stronger painkiller than the other.

One person was prescribed medicines for their mental health condition. Staff had shifted the dose of the medicine to earlier in the day with the agreement of their GP. This resulted in their mood being much more settled in the evening, the time previously that they had regularly been very distressed. Another person was prescribed two different medicines to control their nausea and sickness. The medicines were prescribed to be given at regular times. However, they had missed 13 doses of one medicine and 12 doses of the other in a three week period because they were asleep. The deputy manager said that they would alter the time of day they administered the medicines to fit in with this person's individual sleep pattern. This person was also asleep on occasions or had refused to take an antibiotic for a urine infection. This meant that due to the missing doses their infection would

be more difficult to treat. Staff told us that they were monitoring the person's infection but had not discussed the situation with the person's GP. They said that they would do this immediately following the inspection.

Staff did not have a system to regularly monitor the balance of the medicines dispensed in boxes. The records of a medicine for one person's were not accurate. The amount left over from the previous month was not accounted for on the Medication Administration Record (MAR). The nurses' signatures were also difficult to read so that it was not easy to establish how regularly they were receiving the medicine. Another person was prescribed one painkiller four times a day but on a few occasions staff had administered two tablets. The person only needed the painkiller occasionally but the prescription had not been changed to 'as required'. The deputy manager said that they would introduce a system to monitor the balance of medicines dispensed in boxes and ask the GP to change the prescription.

Staff were monitoring the temperature of the clinical room where the majority of medicines were stored and the temperature of the medicine's fridge. They told us that they would monitor the temperature of the trolleys stored in different parts of the building. On the day of our inspection we found that the temperatures were all within the safe storage limits.

The nurses received medicines training and an assessment of competence before they were able to manage and administer medicines. A recent assessment we looked at was only completed with ticks, without any comments or supporting evidence. This meant that it was not possible to judge the quality of the assessment or compare the thoroughness of one assessor with another. This could potentially lead to nurses with different levels of competence being approved to administer medicines.

There were good interview processes in place and staff recruitment processes were sufficiently robust. The standard interview process included one or two interviewers who recorded applicant's responses against standard interview questions. We saw an application for a person seeking recruitment. There was a disclosure and barring check (DBS) to make sure staff employed were suitable to work with older people.

References had been requested and received. Staff were not able to start until both references and DBS had been

Is the service safe?

received. We saw proofs of the person's identity and residence such as passports, utility bills and copies of training certificates. In addition nurses had relevant check of their professional registration. The Director confirmed they carried out record audits.

Is the service effective?

Our findings

We spoke with staff who were all very positive about their jobs and the training and support they received. We spoke to one member of staff who told us they had completed enhanced care qualifications up to level three. Staff said the manager was approachable and they felt listened to and valued. They were up to date with their training and were able to demonstrate sufficient knowledge around key aspects of their role such as how to safeguard a person and knew how to manage risk and provide person centred care.

We looked at the staff training attendance folder. This showed a high majority of staff had completed a recognised induction programme and other mandatory training although there was still some work to do to ensure all updates were complete. So for example: Dementia training - 44% completion, Dignity, respect and person centred care 61%. Only 4% equality, diversity & human rights. Prevention and control of infection 93%, Safeguarding vulnerable adults 96%, Mental Capacity Act/ Deprivation of Liberty Safeguards 91%, Manual Handling 61%, Health and Safety 93% Food hygiene/handling 37%, Fire safety 84%. This figures demonstrated that all training had not been updated as required. However we were given evidence of the courses due to take place shortly and saw that staff had signed up for these.

We spoke with and looked at records of staff recently employed including a nurse. They told us they had a two week induction. They spent one week working with the deputy manager and one week with the other nurses learning about the service. They told us, "I also learnt about residents' medical histories, their nursing needs and any health concerns." They had a range of training related to safe working practices, such as moving and handling training and safeguarding vulnerable adults, in their first month. They told us that they had undertaken an end of life care course and training in urinary catheterisation. They said that they would like to have some more in depth training in diabetes and training in Parkinson's disease to help them meet the needs of people in the home.

One staff member told us they thought new care staff should have a longer induction. They said "Some do not seem to fully understand their responsibilities." They said new staff shadow carers. Depending on the nurse who is

allocating new carers may, or may not, be placed with an experienced carer. Until they have done manual handling they were not allowed to use any equipment or assist with moving people (even pushing a wheelchair.)

We saw a Carer's handbook which contained an induction checklist on which new staff can record when they have had training in different areas. Detailed instruction regarding different aspects of care e.g. mouth care; pressure sores.

One of the nurses told us that they carried out supervision of a group of care staff. They said that they worked with care staff on occasions and monitored standards of care. However, there were no formal and documented observations of care practices as part of their supervision. The nurses had recently taken overall responsibility for a group of people living in the service. They had started to meet with the manager and deputy manager to discuss people's medical conditions and nursing needs. This was to ensure that people's clinical needs were being appropriately met. Nurses were receiving support and guidance to enable them to complete the revalidation of their registration with the Nursing and Midwifery Council. They told us that they appreciated the support provided by the management team.

There was a line manager allocated for all staff. Each registered nurse supervised named care staff. The new managerial hierarchy started in September 2015 and the supervisors were just completing their first round of supervisions. The previous week the Director completed an audit of supervisions and identified where staff had taken away their supervisions to sign and not returned them and identified staff who had not had supervision or returned their paperwork in the last 3 months. An action plan was in place.

Most people were complimentary about the food although one person described it as adequate. The chef told us how they got to know people's dietary needs and how they liked the food cooked and presented. For example if people liked one egg or two. They said people were very particular how they would like things cooked and this is how food was presented to them.

People's fluid intake was monitored where a risk was identified. We observed people with drinks in front of them and people were offered drinks throughout the day. The manager said the GPs were reluctant to agree individual

Is the service effective?

fluid levels for people and what was sufficient in line with their needs. They said they had introduced a hydration calendar so they could assess how much people were drinking so they could go back to the GP with this information where they had concerns. The manager said when people first moved to the home if there was a need they would record their fluid intake for the first seven days to assess if there was a risk of them not drinking enough. The manager said they were developing a nutrition and hydration monitoring tool so they could see at a glance who was at risk. We felt this necessary because it was not easy for us to find this information unless we looked at each person's care plans individually. Several relatives said their family member had lost weight and when we looked at their records they had. However actions were being taken so their weights remained steady. For one person they had not been weighed for two months and then were found to have lost weight and were now on weekly weights. A greater oversight would clearly benefit people at the service and steps could be taken before a rapid decline. We also noted there was a tendency to state in care plans make sure the person has a drink in front of them. However there was also a recognition that some people might not recognise when they were thirsty so actions to prevent dehydration were insufficient.

We observed lunch, it was well organised and staff were efficient. The chef served the food so could see if there was any wastage. People were given appropriate food choices and portion sizes. Staff where assisting people did so appropriately and sensitively. Overall the atmosphere in the dining room was pleasant and could only been improved by staff sitting with people and socialising with them. One staff member told us, 'that getting all residents together for meals would improve socialising. They said some people never leave their rooms for breakfast, although they said most get down for lunch.' The provider said most stay downstairs until after they have had their supper.

We noted there were no menus on the table, these were brought through whilst people were having their lunch. Food choices were not adequately promoted and there was no use of pictorial menus or offering different food plated up options.

We spoke with the chef and they were very knowledgeable about people's dietary needs. They told us food and fluid charts were in place for people at risk of losing weight.

Some people were weighed weekly and were on a fortified diet. Snack plates of cheese, crackers, fruit, and cake were sent round regularly. They told us they used different coloured plates to indicate when a person was on a fortified diet. Staff told us they tried to speak with family about bringing in cakes, chocolates etc. for people who are inclined to over-eat. They tried to cut down portion sizes where appropriate and with people's consent. They told us one staff member with a background/education in nutrition had the role of managing and monitoring people's nutritional intake. This was a new role.

The nurse we spoke with had received training in the Mental Capacity Act 2005 and Deprivation of Liberty safeguards, (MCA and DoLS). They had a good understanding how mental capacity could vary and how staff could support people to make as many of their own decisions as possible. Staff were able to tell us where an application had been made to deprive a person of their liberty and the reasons for this. They told us If people want to go out, try to encourage them to stay inside if the weather is inclement but if they insist carer will accompany them outside. One staff member was less clear about supporting people who may lack capacity; and also about 'whistle blowing, this was reported back to the manager to enable them to support the member of staff.

Staff understood about making 'best interest decisions' on behalf of people living with dementia on a day to day basis and involving relatives or those with power of attorney when appropriate. Care staff had also undertaken training around the (MCA) and (DoLS) and knew how to support people with decision making and act lawfully where people lacked capacity.

The service staff were working hard to meet people's health care needs but had a number of obstacles in doing so. Staff told us that the support people received from the two local GP surgeries was variable and could at times be very poor. Many of the problems related to getting the GPs to review and prescribe people's medicines. The deputy manager said that the GPs had refused to prescribe the medicines recommended for use towards the end of a person's life. They had to obtain the prescriptions from the local hospice. They told us that they were now planning to report any concerns as they arose to the local Clinical

Is the service effective?

Commissioning Group to improve experiences of people using the service. People saw a range of other health care professionals such as dentists, opticians and chiropodists when they needed to.

The manager had developed good links with other services particularly around end of life care and links through the local hospice to ensure people received the treatment they need without delay.

Is the service caring?

Our findings

One staff member said, “Comparing this with previous experience of care homes, ‘It is amazing really lovely.’” One person said “All the staff are very good and helpful.” Another said, “I would give them 10 out of 10.” Staff were described as polite.

One relative described their family member’s behaviour since their illness and told us how difficult they could be. They said staff were kind and patient and they were very grateful for this. They said a calming view helped them relax and staff took them outside when possible as the service was set with the forest in the background.

One person told us how good the care staff were but did say staff did not regularly offer them a bath. They said they had a strip wash and care staff promoted their independence and dignity by enabling them to do as much for themselves as they could. They said night staff did not always lower their voices when checking people at night.

We observed staff to be caring and inclusive. In the afternoon of the inspection there was a poetry and singing session to celebrate Burns night. We observed two staff members ensuring that those who had limited communication were included fully in the activity. We observed that whilst the group were singing, a staff member stood up and danced with one person, which they appeared to really enjoy, and observed to be laughing. People looked happy and involved in the activity.

We observed staff on several occasions knocking on people’s doors before entering. We saw that staff were attentive to people’s needs and demonstrated a good understanding of their needs and exercised patience whilst talking with people giving them the time they needed.

Individual rooms within the service could be booked for family events, for example, one person had a 90th birthday coming up and the family had booked the room so they could have a private family party. Relatives were informed of this so they could make plans for events coming up.

Staff told me how they consider how each room can be made ‘individual and special’ for the person coming to live there. Rooms were individualised, with personal items and belongings which were important to the person.

Staff explained how lunchtime seating was a considered activity. For example, two people do not like eating in a

large group as they find it overwhelming, so a table in the next room was set up for them. We checked this at lunchtime, and they were both sat at their individual table in what was referred to as the ‘snug’ room.

Staff also told us that those who needed support to eat were positioned so as to protect their dignity, but so they could still be involved in the lunchtime group.

There was a good activity programme. 1-1 time for those people who do not like groups or who could not get to the activity areas. 1-1 time was set aside on a Tuesday and Wednesday. The cookery club considered people’s ability, and some recipes were quite complex, (Quiche and Chelsea buns) allowing those that could cook well to do so, and not just cooking simple recipes.

The service were looking to set up a garden for people so they can grow vegetables and enjoy the outdoors. They told me that people from the local community were going to come and help with the practical side of setting this up.

Staff were respectful and very caring in their interaction with people living in the service. There was a warm, friendly and supportive atmosphere in the service. One member of staff told us, “It’s a good atmosphere in the home. The residents are lovely; it’s a pleasure to look after them.”

Staff told us that they received excellent support from the local hospice when they provided end of life care to people living in the service. Staff were able to access the hospice training. One of the nurses said, “The end of life care in the home is of a very good standard.” They had undertaken a six week end of life care course at the hospice.

The service had received a number of very complimentary letters from relatives. Many of whom praised the support they personally received when their relative was receiving end of life care. One relative wrote, “The past few months have been very draining at times but you kept my spirits up. We were very impressed with how helpful and caring you all were. It made such a difference to us.” Another relative said, “You gave her time, care and love in abundance. She spent her last few months with such caring people, who tried their utmost to make her as happy and contented as possible. We have only admiration for the commitment and patience you give all the residents at Brandon Park.” A third relative wrote, “We received care and support during this difficult time. You made her as comfortable and pain free as was possible in her final days. We will not forget the kindness shown to all our family.”

Is the service caring?

There were resident and family meetings but not everyone we spoke with were aware of these but all felt they were sufficiently involved in making decisions about their care.

The manager told us these had been poorly attended in recent months and they had decided to hold two separate meetings and at different times to try and encourage attendance.

Is the service responsive?

Our findings

People were complimentary about the service. One person told us, "My room is lovely, clean and warm, staff clean it every day." They said they liked reading and there were always books for them to read. They said they were not keen on all the activities but said staff always told them what was going on. We spoke with other people who told us about the gentleman's club (gender specific activities) such as sports or knitting club. They told us they specifically enjoyed the musical entertainment. One person felt the activities were a little limited and not what they were use to.

Staff tried to engage with people in a way that reflected their interests and background. For example one person who was used to be in a very well connected position enjoyed participating in office routines, including interviewing applicants and had played a positive role in these interviews.

During the inspection this person was playing the piano (which they own) in the entrance foyer.

Activities were planned by a staff member specifically employed to do so but we observed all staff being involved in activities. The provider also told us that they were recruiting part time staff to organise activities as the weekend to enhance people's experience.

During the day we saw in the morning a small group of ladies were folding laundry and appeared to be enjoying this and told us, "It keeps us busy." "It's a job that needs to be done." As well as being engaged in activity people were communicating with the activities co-coordinator and each other and thus receiving social stimulation.

We noted in this room were lots of examples of art work people had been involved in. This included painted bottles and a tree with hearts containing special messages to loved ones. Staff told us people released balloons for loved ones no longer with us and made cards and chocolates with staff for family and friends.

We spoke with the staff member facilitating activities and they told us of some of the things they had done. They said at Christmas they had both the American service men and school children in who sang carols. In addition the home had health and social care students and volunteers from the local hospice. They said people made mince pies and

often cooked or helped prepare vegetables. They said in celebration of Burns night, they were being visited by people who were going to recite poetry and sing songs. They said they had made shortbread ahead of this planned visit. In terms of one to one activities, they said the foot spa was very popular and people had their nails and hair done. They said they recorded what they were doing to show what had been offered and who had taken up what was offered. This helped them decide what worked and who had been reluctant to join in so they could think of other things in line with people's life story work which were being developed.

Some people said they chose not to do laundry or housework but told us the activity programme was varied and there was always something they could join in with as they chose. They told us staff always asked and they had copies of the planned activities. At lunch time haggis was on the menu as it was Burns night which some people said they had never tried.

Regular handovers were held after each shift and information about each person was conveyed. Staff said they felt the dissemination of information was effective. However some staff felt handover could take quite a while causing delay of people receiving their breakfasts sometimes not until 8.45. Other staff said notes on each person were very brief and not always in sufficient detail particularly if a member of staff had been off duty for a while.

People's mental health was not being formally monitored but the deputy manager said that they would introduce a mental health assessment as soon as possible. They also said that they would improve the analysis of the effectiveness of staff support, when recording any episodes of people's disturbed behaviour. These changes would enable staff to more accurately monitor the progress of people's mental health conditions and the effectiveness of any treatment they were receiving. It would also enable them to provide more accurate information to people's GPs and the mental health professionals.

Care plans contain the information needed to provide appropriate care. Useful charts and one page profiles in people's room helped enable agency nurses to quickly pick up people's care needs. An electronic monitoring record was being introduced. Care staff wrote daily records in care

Is the service responsive?

plan and noted any concerns (e.g. developing redness/pressure forms) and to which nurse this has been reported. Notes were kept whenever people had declined assistance with personal care.

Care plans included a profile of the person and what was important to them and how they would like to be cared for. People we spoke with said their care preferences were met. Life stories were not in place for everyone but were being developed. It was acknowledged this took time to do properly but meant for some people living with dementia there was insufficient information about them which might mean staff might struggle to support them appropriately and stay connected with their pasts. Information in care plans was not always that robust. For example one person's care plan said they could become distressed and agitated particularly in the afternoon but there was no exploration

as to why this might be or how they might be assisted to feel more relaxed apart from the possibility they may be hungry or thirsty. We also noted poor recording of people's night care needs and how people could be settled to have a better night sleep rather than walking around and possibly disturbing others.

The complaints procedure was on display in the home. There was a record of complaints and the actions taken to address them. The home had good systems for investigating and responding to complaints. One of the directors told us that they were encouraging staff to report minor concerns as part of their quality assurance process. There was a suggestion box in the hall for people to raise comments and the home also had a full time receptionist who was able to meet and greet people and their families.

Is the service well-led?

Our findings

Staff were very appreciative of the support they received from the senior management team. They described an open, supportive, person centred and inclusive culture within the home. One member of staff told us, "Everything about this home is good. Communication is very good. We work well together, we are a good team. Staff get extremely good support. We can discuss any concerns with the managers and they'll address them." Staff told us the manager was approachable and feels listened to and valued. Another staff member said, "I find the owners very pleasant and managers are good. Good morale. Physical improvements have been made to the property and 'I think the residents are a lot happier. The staff are happier and there is a domino effect.' Food has improved 'food is fantastic'. Mostly good team working." Another staff member said they felt listened to if they had any ideas for improving service. Staff also told us they received praise when deserved.

The manager was supporting the provider's other home for two days a week as they were without a manager. The deputy manager was covering the manager's role when they were absent. They worked as a nurse for two to three days each week. This gave them very little time to carry out audits and supervisions. However, the directors were providing management support and carrying out some of the audits. They were also interviewing and hoped to appoint a clinical lead for the service in the near future. The manager told us that it was an improving picture with monthly staff meetings and heads of department meetings each day to discuss any immediate concerns as well as clinical monthly meetings. They said night staff rotated from night to day shift which helped in terms of continuity of care for people using the service.

'Resident of the day' was planned which is a system whereby each person's needs are fully reviewed at least once a month and this review covered their whole experience from housekeeping, to catering to care. Care plans were being reviewed monthly by the responsible, named nurse, manager and deputy manager.

The management team carried out a range of audits. They were aware that a number of the audits needed to be further developed. For example, the care records audit needed to be expanded to cover the effectiveness of care management within the home. The deputy manager told us that they were planning to carry out an audit of all the mattresses and pressure relieving equipment in the home. There were developing systems to monitor people's weight and identify those at nutritional risk but this needs improvement.

The service were inclusive and worked with the community to improve the overall experience of people using the service. Fundraising helped people stay connected and a number of volunteers were involved with the home. There were plans to extend activities to seven days a week and negotiate use of community transport so people could get out further afield. The manager also said they were planning on having a shop where people could get their essentials.

Staff recognition schemes including nominations for Regional and National care awards and incremental pay were in place. Care awards were held in recognition of staff who went the extra mile in their duties and made a positive difference in the workplace and to the people they supported. The home had made a number of nominations.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.