New Century Care (Ash) Limited

High View Oast Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visit was carried out on 23 and 24 March 2017 and was unannounced. The previous inspection was carried out in September 2016, when areas requiring improvement were noted.

High View Oast Nursing Home is a converted Oast house, and is nursing home for up to 33 people. The bedrooms are situated on both ground floor and first floor, and consist of a mixture of single and double rooms. There is a lift providing access between floors. The communal accommodation is situated on the ground floor and consists of two interlinking lounge areas, a dining room, a small quiet lounge, and a porch area. On the day of the inspection there were 16 people living at the service.

There was no registered manager in post. The service had an interim manager who had been managing the service since September 2016. A new manager had been appointed but was not due to start at the service until April 2017. 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 and associated Regulations about how the service is run. We were supported by the interim manager, the regional manager, and the quality manager.

We last inspected this service in September 2016. We found significant shortfalls in the service. The provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people, supporting people with their behaviour and health care needs. Staff had not ensured the proper and safe management of medicines. Safeguarding alerts had not been raised with the local safeguarding team. Staff were not deployed in sufficient numbers. Staff were not suitably qualified, competent, skilled and experienced to meet people's needs. Authorisations to deprive people of their liberty in line with the Mental Capacity Act had not been made. Care plans were not person centred or regularly updated when people's needs changed. The registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They had failed to seek and act on feedback from relevant people, on the service provided to continually evaluate and improve the service. Records could not be found, were not clear and completed accurately.

We took enforcement action and required the provider to make improvements. This service had been placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us information and records about actions taken to make improvements following our previous inspection.

At this inspection we found that significant improvements had been made. There was, however, one continued breach in the regulations in the safe management of medicines and further improvements were needed in moving and handling risks assessments, details in care plans of what people could do for themselves and to eliminate an odour on the second floor of the premises.

People's medicines were not well managed, stored and recorded accurately. Some people had not received the medicines they needed.

Although staff were observed moving people safely, some risk assessments to support people with their mobility did not have sufficient information to guide staff how to move people consistently and safely.

Checks had been carried out on the service, to ensure the premises was safe and environmental risk assessments were in place. However, on the second floor, improvements were needed to ensure that the service was free from offensive odours.

Emergency procedures were in place and the service had a business continuity plan. There was a 'grab file' which was available in case of an emergency such as a fire, and each person had a personal emergency evacuation plan in place. Regular fire drills for all staff had been carried out apart from one week when the staff member responsible had been on annual leave. The interim manager told us that this would be addressed and an additional staff member would be identified to cover this duty.

Risk assessments to show staff how to positively support people with behaviour that challenged now had detailed information about what may be triggering this behaviour and how to reduce the risk of this happening again. Accidents and incidents had been investigated and analysed to ensure action was being taken to reduce the risks of further events.

Staff had been trained protect people from harm, and were aware of the service's whistle-blowing policy. They knew how to raise any concerns with the interim manager, or with outside agencies if required. Systems were in place to ensure that people's finances were protected. There were clear systems in place to record and receipt any monies spent which were regularly audited.

Staffing levels had been reviewed to ensure that there was enough staff deployed in the service to meet people's care and support needs. Staff had been recruited safely.

Staff had completed training including competency training to help them carry out their roles effectively. All staff had received regular supervision, including clinical supervision for the registered nurses. Staff told us they felt supported and were confident to raise issues in their supervision or at the regular staff meetings.

The interim manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and people's mental capacity to consent to care or treatment had been assessed and recorded. People were supported by their relatives to be involved in planning their care and to make decisions about their daily lives.

People's health care needs were monitored and when required health care professionals were involved in their care. Staff were familiar with people's likes and dislikes, and supported people with their daily routines.

People told us they enjoyed the food and a varied menu was provided to ensure people received a nutritious diet. Records showed that people were assessed to make sure they received a healthy diet to ensure their nutritional needs were met.

People told us that their privacy and dignity was maintained and they were treated with kindness and respect. Staff greeted people as they went about their duties and people were offered choices about their daily routines, and where they wanted to sit or what they wanted to eat.

People's care plans had been reviewed and contained detailed information of how they would like their care to be provided. The plans were more personalised but further detail was required to show what people could do for themselves, and how they were being encouraged to remain as independent as possible. Staff were able to describe in detail how they supported people to remain independent but this was not always reflected in the care plans.

Staff told us that the ten minute meetings each day had improved communication and ensured that all staff were as aware of people's changing needs and what was going on in the service that day.

There was a new activities co-ordinator who encouraged and supported people to maintain their hobbies and interests. People were enjoying the singing during the afternoon, smiling and singing along with the songs. The co-ordinator talked about involving all staff with the ongoing activities plan to promote a family atmosphere in the service.

People and relatives felt confident that any concerns raised would be listened to and acted on. All complaints had been recorded and responded to appropriately.

People had opportunities to provide feedback about the service provided. Quality assurance surveys were sent out annually directly from the organisation's head office. Although other stakeholders and visiting professionals had been sent surveys no one had responded. People and relatives could view the outcome of the survey on the notice board. Resident meetings were held regularly and minutes taken, relatives who could not attend were sent the minutes to keep them up to date with the service.

The systems in place to review the quality of all aspects of the service had been reviewed and they were now working effectively. There were now regular checks and audits in place to make sure that any issues were picked up and actioned to address shortfalls and continually improve the service.

People, relatives and staff felt the service was well led, and the interim manager had made 'huge' improvements in the service. Staff told us they were valued and the interim manager listened to them and their opinions were taken into consideration.

Record keeping had significantly improved. The records were now very organised, including the audits, staff records, care plans and relevant documentation. All records requested at the inspection were provided promptly and were in good order.

The provider had ensured that the published rating from the previous inspection was on display.

As this service is no longer rated as inadequate, it will be taken out of special measures. We acknowledge that this is an improving service however there was one continued breach in the regulations to ensure that people receive their medicines safely. The interim manager took immediate action to ensure the person was safe when this was raised and an investigation is on-going. We will continue to monitor High View Oast to check that improvements continue and are sustained.

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.

People's medicines were not well managed, stored and recorded accurately. Some people had not received the medicines they needed.

Some risk assessments to support people with their mobility did not have sufficient information to guide staff how to move them consistently and safely.

Staff reported incidents to the local safeguarding team when people were at risk of harm.

There was enough staff deployed in the service to meet people's care and support needs. Staff had been recruited safely.

Checks had been carried out on the service, to ensure the premises was safe.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision, to ensure they had the knowledge to effectively support people.

People were asked for their consent before care was given. Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
People's health care needs were monitored effectively to ensure they were met.

People told us they enjoyed the food and a varied menu was provided to ensure people received a nutritious diet.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect. Staff were observed engaging with people in a caring and kind manner.

People were offered choices and were encouraged to remain as independent as they could be.

People's relatives and friends were able to visit at any time and were made welcome.

People's personal information was stored securely.

Is the service responsive?

Good

The service was responsive.

Care plans were person centred but lacked information of what people could do for themselves to maintain their independence.

Care plans had been regularly reviewed and updated.

Complaints had been recorded, investigated and resolved appropriately.

People enjoyed a varied activity programme which included group and individual activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Although there was an interim manager in place the provider had not appointed a registered manager since April 2016.

Since the last inspection the provider had taken appropriate steps to ensure there was oversight and scrutiny to monitor and support the service. Effective audits were now in place to monitor and improve the service.

People and staff were positive about the new leadership at the service.

Staff told us that they were valued and supported by the interim manager and provider.

People, staff and other stakeholders had opportunities to provide feedback about the service they received.

Records had improved and were now suitably detailed and accurately maintained.

High View Oast 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 23 and 24 March 2017 and was unannounced. It was carried out by two inspectors 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

A Provider Information Return (PIR) was submitted by the service before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Notifications are information we receive from the service when significant events happen, like a serious injury.

We looked around all areas of the service .Conversations took place with people in the communal rooms and their bedrooms. People were able to talk with us and tell us about the care and service they were receiving. We observed the lunch time meals and observed how staff spoke with and interacted with people.

We spoke with twelve people, three relatives, three nurses, eight staff, the chef, the regional manager, and the quality support manager and two health care professionals.

The previous inspection was carried out in September 2016, when enforcement action was taken due to breaches of regulations.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe living at the service. They told us "Yes, I feel safe here". "I feel safe when the staff help me". A relative told us that they were confident their relative received good care and they were safe living at the service.

At our last inspection September 2016, the provider did not have sufficient guidance for staff to follow to show how risks were mitigated when moving people, supporting people with their behaviour and health care needs. The provider had not ensured that medicines were managed safely. People were not receiving their medicines safely and in line with the prescriber's instructions. Medicines were not being monitored to ensure they were stored at the correct temperatures to ensure they were safe. We started to take enforcement action against the provider. The provider sent us an action plan telling us how they were going to improve.

At this inspection, although some improvements had been made there remained shortfalls in the safe management of medicines. Medicines were not ordered and managed safely to ensure people received their medicines as prescribed. One person was prescribed Lansoprazole 15mg twice a day, to reduce irritation of the stomach lining. Records showed that the medicine had not been in stock and available from 16/03/2017. The medicine was not available on 23/03/2017, the day of the inspection. This placed the person at risk of vomiting and discomfort. This person had not received their medicine as prescribed which resulted in the person vomiting on the 19/03/2017.

Medicines in liquid form are not effective for long periods of time once the bottle has been opened. It is best practice to mark the date the bottle was opened, so that staff can dispose of the medicine when it stops being effective. One person was prescribed Metoclopramide liquid, the medicine is used to stop people feeling sick. The bottle was opened on the 11/01/2017 and guidance stated to only be used for one month once opened. The bottle was in the medicines trolley on the day of the inspection which was well over a month later. The medicine had been given on the 19/03/2017. There were medicines in the trolley that were out of date and should not be used. The medicines were not to be used after 12/09/2016 and 09/12/2016. There were other bottles of liquid medicines that did not have the opening date of the bottle. There was a risk that people would be given medicines that were not effective.

The administration of medicines had not been recorded accurately. One person was prescribed insulin in the morning. The medicines administration record (MAR) chart, was marked for the insulin to be given at 9am, however, night staff were giving the insulin between 7.30 and 8am. The night staff had signed the MAR chart for 9am, medicine administration had not been recorded accurately. One person had been prescribed medicine three times a day. Staff had not signed to confirm that the medicine had been given at 1 pm on four days and at 10 pm on two days. There was a risk that the person had not received their medicine at the times prescribed.

The provider had failed to order and manage medicines safely, people had not received their medicines as prescribed. This was a continued breach of Regulation 12, Health and Social Care Act 2008 (Regulated

Activities) Regulations 2014.

Some people were prescribed 'as and when' medicines, such as pain relief. Guidance was provided to staff about when to give the medicines and how much. People told us they were offered pain killers if they needed them and staff took the time to explain what medicines they were taking. Medicines were stored at the correct temperature to remain effective. Tablets and liquid medicines were stored separately following best practice guidelines. Stock medicines were rotated and were not overstocked. The equipment used by nursing staff such as needles and specimen bottles were in date.

At the last inspection there was a risk that people were not being moved consistently and safely. At this inspection we observed staff moving people safely, talking them through the procedures and letting them know what to expect.

People told us they felt safe when staff were supporting them. However, although some parts of the moving and handling risk assessments had improved there was still a lack of detailed step by step guidance of how to move people as safely as possible. In some risk assessments details included the hoist required, the size of sling, and the colour strap to use and where to place the sling but there was no guidance to show staff how to move the person safely. For example, one risk assessment stated, 'unable to weight bear since a stroke, hoisted with full body hoist, medium sling and two staff, explain each step prior to assisting' but there was no information to show what the steps were and how to do this consistently and safely. There was no mention of how this person's medical condition affected their movements. Another plan stated "ensure two staff to assist manoeuvers", with no further detail of what those manoeuvers were.

People felt safe when staff supported them with their mobility. They said, "I feel safe when I am moved" another person said, "I feel safe when staff help me with the stand aid hoist". Staff were able to describe how they used slide sheets to help people move safely in bed, but this guidance was not always in the moving and handling risk assessments. Staff also told us that when people's mobility changed, they were promptly risk assessed and staff were informed of the changes in their care.

At the last inspection, the information provided to staff to support people living with diabetes varied. People's care plans now had detailed guidance about the levels of high or low blood sugar, the symptoms to be aware of, and what to do about high or low levels. Staff knew the signs to look for when people living with diabetes became unwell. Staff told us, "I would call the nurse if the person was sweaty and they appear sleepy."

One person was living with epilepsy, had a history of seizures and was prescribed medicines to control the seizures. At the last inspection there had not been detailed guidance for staff about how to support and care for the person should they have a seizure. The staff now had detailed guidance on how to support the person. The guidance included the type of seizures the person may experience and the symptoms displayed such as their whole body shaking and may become stiff. The care plan also stated 'if the seizure lasts for more than five minutes call an ambulance.' There was detailed guidance available to support the person safely.

Staff provided support to people who had a poor swallow and were at risk of aspiration. There was detailed guidance available to staff to support the person if they vomited to prevent aspiration. Staff had guidance about how to clear the person's mouth and to use suction if clinically indicated. There were guidelines on what symptoms to look for if aspiration had occurred. Staff had the guidance to support the person safely and consistently.

When people needed support with their behaviour, detailed guidance was now available in their risk assessments to guide staff how to manage the risks and keep people as safe as possible. For example, there were details to guide staff on what action to take if one person wanted to leave the building and became anxious. The plan clearly gave staff instructions of how to calm the person and what may trigger this behaviour so they could positively support them to reduce their anxiety and try to prevent this from happening again.

Accidents and incidents were recorded. The manager had completed analysis and had put an action plan in place to reduce the risk of the accident happening again. The manager had referred incidents, when appropriate, to the local safeguarding team.

At the last inspection people and relatives told us there were not enough staff on duty and the use of agency staff was high. At this inspection staffing levels had increased and the use of agency staff had been reduced. One relative said, "Staff are lovely and there is always enough on duty".

Staffing levels were assessed using a dependency tool to determine the number of staff required to meet people's needs. Each person's dependency was scored and the result added together to establish the number of staff required to meet their needs. There were two registered nurses and four care staff on duty to support 16 people living at the service. In addition there was a cook, kitchen assistant, housekeeper, and maintenance person. There was no agency staff being used during the day but there were some being allocated at night time. An ongoing recruitment drive was in place to address the shortfalls, some new staff had been recruited and there was less reliance on agency staff.

Staff told us there was now enough staff on duty and they were able to spend more time with people to ensure their needs were fully met. A new system of staff allocation had been implemented to ensure that staff were deployed efficiently.

At the last inspection people were not fully protected from abuse as policies and procedures had not been consistently followed. At this inspection, when required, the provider contacted the local safeguarding authority in line with safeguarding protocols. They had worked proactively to ensure that people were protected from harm. Staff had been trained in safeguarding adults, and were aware of the service's whistle-blowing policy. They knew how to raise any concerns with the manager or nurses and were aware that the local safeguarding team were responsible for investigating allegations of abuse.

Systems were in place to ensure that people's finances were protected. There were clear systems in place to record and receipt any monies spent which were regularly audited.

At the last inspection staff had not been recruited safely. At this inspection each staff file had been reviewed to ensure that all the required documents were in place. The recruitment process was robust with each person receiving an interview with set questions to ensure that they only employed staff that were suitable to work in a caring environment. The necessary checks had been carried out, such as police checks and proof of identity. Staff completed an application form and any gaps in employment were checked and discussed. Information about staff's conduct in previous employment had been obtained through satisfactory references. The manager had checked that nurse's registrations were valid with the appropriate professional body.

Emergency plans were in place in the event of an emergency such as fire and each person had an individual personal emergency evacuation plan (PEEP) to ensure that they could be safely evacuated from the service. Fire drills were carried out regularly and records showed that all staff names had been recorded including

night staff. There was one week when the person responsible for completing the tests was on leave and the fire call points had not been tested. We discussed this with the manager who told us that a member of staff would be identified to cover when the maintenance person was on annual leave. During the inspection a fire alarm test took place. The maintenance person came and explained to people that it was about to happen. One person said it was a regular event and all the doors closed when the fire alarm went off.

There were records to show that equipment and the premises were checked and servicing was carried out, including checks of the hoists, boilers, electrical system, nurse call system and temperature of the water. Environmental risk assessments were in place, and the manager also made checks of the service to identify and action repairs and maintenance.

Cleaning was of a good standard and two people told us one cleaner was 'amazing'. One person said, "One cleaner gets as much done in half an hour as others do in two hours" another person said "the cleaner even hoovers behind the door and washes the window frame down and talks to my plants when she waters them". Although the downstairs areas smelled pleasant, there continued to be an unpleasant odour at the back of the premises and upstairs on the first floor. We discussed this with the interim manager who told us the flooring was due to be replaced to eliminate the odours. This was an area for improvement.

Good

Is the service effective?

Our findings

People and their relatives told us that were receiving the care they needed. They told us that doctors were called if they needed further medical advice. One visiting professional told us that staff contacted them promptly if there were any concerns and acted on their advice or changes to people's care and support.

At the last inspection there was an on-going training programme for staff. However, not all the staff had completed all the training required to ensure they had the skills and competencies to perform their role. At this inspection, improvements had been made. Nearly all the staff, over 95%, had completed mandatory training. We observed staff putting the training into practice when moving a person. Staff were able to use the hoist and support the person safely when moving from their chair to a wheelchair. They spoke with the person constantly advising them what moves were going to be made. When the person was safely in their armchair they said, "Thank you for everything I really do appreciate it. Thanks".

Staff told us how they had enjoyed the training and were very positive about achieving 100% of the training. One member of staff told us how much they had enjoyed the training and how the competency checks were ensuring best practice. There was a programme for staff to complete specialist training, such as dementia training and this was now being completed. New staff followed an induction programme. This included shadow shifts with an experienced member of staff, to learn people's choices and preferences. There was a programme of training for new staff to complete in 12 weeks. New staff were assessed as competent by using observation and a workbook to show understanding. There was a meeting at the end of the 12 weeks to discuss the staff member's progress and end their probation period.

At the previous inspection the supervision/appraisal programme was not up to date. At this inspection a new programme had been introduced and staff were receiving regular supervision and an appraisal. Staff told us that they now received good support from the management team. They were confident to raise concerns with the interim manager or when having a supervision session with their line manager. They said there had been 'big improvements in the service with much more support and supervision'. One staff member said, "Staff are not scared now and have more confidence to raise issues. Any concerns get addressed and sorted out, the regional and quality manager are involved too, the whole service is more open and the flash ten minute meetings let us know what is going on each day".

A process of clinical supervision and assessment of nurse's competencies had also been started. Nurses had been asked to identify their training needs through self-assessment. The nurses then had a clinical supervision to discuss training needs and their competency would be assessed. The quality assurance manager would be completing this with the nurses.

Staff also said that communication had improved through meetings and handovers. They told us they had regular staff meetings and felt more involved in the running of the service.

At the last inspection people's capacity to consent to care and support had not always been assessed and the assessments that had been completed were not in line with current practice. At this inspection people's

capacity to consent to their care and treatment had been assessed. There were decision specific documentation for people. If the person did not have capacity to make the decision the care plan documented who had been involved in the planning of care. One care plan stated 'Care plan written in (the person's) best interests based on what we know about them and information from their family.'

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in 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 whether the service was working within the principles of the MCA , and whether any conditions on authorisations to deprive a person of their liberty were being met.

Some people had a DoLs authorisation in place and the interim manager had made further applications to the supervisory body and was awaiting their decision. The conditions on authorisations to deprive a person of their liberty were being met. People's care plans showed that the assessments and decisions had been recorded to guide staff how to support people in the least restrictive way. Staff told us they were aware of who had a DoLs authorisation in place and were able to describe how they supported people to make decisions, such as being patient to give them time to understand the situation.

People's health care needs were monitored. People told us that staff contacted health care professionals when required. During the inspection two GP's visited, staff had contacted them as people had not felt well. The outcome of all professional visits was recorded in the care plans to ensure that staff were up to date with people's changing health care needs.

Some people had catheters (a catheter is a tube that goes into the bladder to drain urine) and required catheter care. Full guidelines were in place in the care plans for staff to follow, for example, when the catheter needed to be changed or signs and symptoms of infection. Staff described what they would look for and when they would report their concerns to the nurses. People had regular appointments with chiropodists, dentists and opticians.

People at risk of developing pressure sores had re positioning charts in their rooms to ensure they were moved regularly to reduce the risk of pressure areas. Equipment such as special mattresses and cushions were used to ensure people were comfortable and protected from the risk of developing pressure sores. The settings of the mattresses were recorded and checked to ensure they were at the correct setting for each person.

People and relatives told us about the new chef and said that the food was good. They said they were given a choice of breakfast, lunch and tea and a full cooked breakfast was available if they wanted it. On the day of the inspection they had a choice for lunch, spaghetti bolognese or vegetarian Kiev and for pudding treacle sponge and custard. There was also always an alternative of jacket potato or salad. All of the food was fresh and homemade. People told us that the chef had a pasta machine and makes fresh pasta.

There was a four weekly menu which was set by the organisation. The chef told us that they had a 'Chef's day' each Wednesday and they were able to cook what was requested by the people living at the service.

People told us they had lots of choice and were satisfied with the menu. The chef told us that they regularly involved people in choosing meals for the menu and this information was also fed back to the organisation to enable them to vary the menus. People had commented about the meals such as, "The chicken curry was amazing", other residents had commented how wonderful the lunch was today and how they enjoyed it.

People said, "The food is quite a good variety, new chef does vegetarian, which doesn't affect me but I just tried it out of curiosity because my relative is vegetarian" another who didn't like 'fancy food' and would rather have traditional commented "I don't like spices and curries and wine in my gravy, so I have something else". "The food is very good; we've got a good chef". "The food has really improved I'm having salad today". "Today's lunch was fit for a queen".

The majority of people ate in their room whilst others went in the dining room. We observed people being assisted to eat in a sensitive way. Staff were encouraging people to eat at their own pace and enjoy their meal. They chatted to the people whilst they were eating and gave them time to swallow and have a drink before the next mouthful. People were offered a variety of drinks with their meals, including sweet or dry sherry.

Staff supported people to eat in their rooms, one person was being observed by a member of staff as they were at risk of choking. The staff member supported them to ensure they ate their meal safely.

Each person had a dietary profile in their care plan which contained details of their needs when eating, such as if they needed their food to be cut up, their likes, dislikes and any allergies. When people had lost weight, appropriate action had been taken to inform health care professionals so that people would receive the advice and support they needed with regard to their dietary needs.

There was also information about their medical needs such as if they needed a diabetic diet or soft food. The chef talked about people that needed supplements in their diet to boost their calories, such as adding creams and using full fat milk. One person was not keen on eating and the chef told us how they left them snacks such as sandwiches and sausage rolls to 'graze' to encourage them to eat regularly.

Good

Is the service caring?

Our findings

People told us the staff were very kind and caring. They said, "I'm very happy and comfortable here". "The staff are really good, they are always polite". "I'm hoping I'll stay here for the rest of my life". "I'm alright here, when you're ill they look after you like you're in hospital".

Relatives said, "The care is good here, terrific, no where's perfect but there's not a lot wrong here". "I've done a lot of homes and this one is very good". "My relative is treated with dignity at all times". "My relative is very happy; it is a very good home". "My relative is really happy here, they love it here".

Staff morale was high as they told us how much the service had improved and how they were passionate about giving people good care and support. They said, "Everything has improved so much I could now come to work every day, it's a pleasure to come to work now". "We are now a fantastic team of good caring and kind staff with a very supportive management team". "The atmosphere in the service has changed and everyone is much happier now".

People were treated with dignity and their privacy was maintained. When people were being supported with their mobility using a hoist, blankets were used to ensure their dignity was maintained. Staff knocked on people's bedroom doors before entering and ensured they were shut if they were providing personal care. People had the choice of having their bedroom door open or shut as each door had magnetic fire catches which enabled them to be left open safely.

Staff consistently explained to people what they were going to do and how they were going to do it. When a doctor visited a person in the lounge the staff put a privacy screen around them and spoke quietly to ensure their privacy and dignity was maintained.

People's independence was encouraged. Staff supported people to mobilise by gently encouraging them to walk slowly whilst supporting them with a gentle hand and giving them reassurance and confidence to move safely.

Staff had introduced a new 'postal' system to ensure that people and received their post promptly. This had improved communication with people and relatives especially around health care appointments. In some cases, if people asked, staff would get involved in reading their post and with their consent contact their relatives if needed.

Staff spoke with people as they went about their tasks; they were attentive to people's needs. One person asked for their personal belongings such as their glasses, staff responded promptly and went back to their room to get them. Staff noticed when a person was chilly and offered them a blanket or to wear a scarf. Staff checked if people were sitting comfortably and offered them cushions to help them relax.

People were offered choices of where they wanted to sit or what they wanted to do. People told us that that they could get up and go to bed when they liked. One person said, "The staff come in about 8.30 am and say

'Good morning can I open the curtains for you?'". Another person said, "You can go to bed when you like. I have breakfast at 8.30 am but you can have it when you like".

One person told us how the staff member with the tea trolley knew exactly how they liked they tea, they said, "The staff member knows just how I like my tea lovely and milky". Staff knew people very well and were able to chat to people about their family history, previous work and where they all had lived as well as knowing their individual care needs. Staff chatted to people about their lives, talking about where they worked and lived.

People were called by their preferred name and asked if they wanted to be supported by a male or female member of staff. People told us that they got up and went to bed when they wanted, and stayed in their room if they preferred their own personal space.

People's rooms were decorated to their own taste and they told us they were able to bring their own furniture and personal possessions into the service. People who chose to remain in their bedrooms were checked regularly by staff to ensure they were alright and had what they needed. Staff were observed asking people where they wanted to choose to have their personal possessions placed in their rooms.

Staff and relatives told us that visitors were welcome at any time and were offered refreshments. During our inspection there were a number of relatives who visited. They told us that they visited whenever they wished and could stay and have a meal with their relative if they wanted.

People were being supported with their religious beliefs. There were regular visits from the local church groups and people received Communion in their rooms if they wished. One person told us they had regular visits from the church and they enjoyed singing hymns and taking communion. Another person said that they enjoyed chatting to visitors from another church even though it was not their chosen faith.

Most people were supported by their relatives when they needed support to make decisions. Some people were being supported by an advocate to help them make decisions about their care. An advocate is someone who supports a person to make sure their views are heard and their rights upheld to ensure that people had the support they needed.

People's information was treated confidentially and their personal records were stored securely.

At the time of the inspection no one was receiving end of life care. Advanced care planning provides people and their relatives with an opportunity to talk openly and make their last wishes known. Some people had made advanced decisions, such as 'do not attempt to resuscitation' orders, to ensure their last wishes were recorded. This were clearly recorded in people's care plan together with their wishes such as requests to remain in the service with the support of the doctor and community health care teams.

Good

Is the service responsive?

Our findings

People and their relatives told us how they had been involved in planning their relative's care. One person said the staff went through the plan and they had even talked about their end of life wishes. Relatives told us they were asked to support their relative when the care plan was reviewed. Each day the service had 'a resident of the day' where the care plan was reviewed, the person's room was deep cleaned, and they had a one to one session with the activity co-coordinator. People told us they enjoyed this day and liked the special attention.

Staff responded promptly when people rang the call bell for support. The call bells were in easy reach and when people moved staff ensured the bells were moved to be close to them. People said that staff responded to their calls, they said, "The staff usually come quickly, they are a bit slow if there is a lot going on, but I have been told to ring it anytime and that is what it is there for". Another person said, "The staff come quite quickly or come and check and tell you they'll be back in five minutes".
Although there had been no admissions to the service since the last inspection, there were systems in place to ensure that people received a care needs assessment before moving into the service.

The pre admission process showed that a detailed assessment of people's individual needs, preferences and social needs was carried out. Relatives were encouraged to be involved in the process so that everyone would have an understanding of what to expect from the service and to plan how their care needs would be met. This information was then used as part of the care planning process.

At the last inspection care plans varied in detail, were not well organised and were not all up to date. There were areas in the plans which did not give staff the guidance required to ensure that people received consistent, safe care. At this inspection new care plans were in place, they were regularly reviewed, more organised and up to date.

The detail in the care plans had improved and were more personalised with people's preferences. One person liked to clean his teeth in a specific way. There was detailed guidance for staff about what support the person needed and how they liked staff to do this. Another plan had details about how to support a person to make them comfortable so that they could go to sleep. Staff were given guidance on how to support people when they became upset when remembering people they had lost, this was specific to each person.

People told us they were able to have a bath or shower whenever they wanted one. One person said that they had a bed bath each day and the personal care was 'very good'. Another person said that they preferred showers at the weekend when a certain member of staff was on duty.

In some plans there was a lack of information of what people were able to do for themselves to ensure their independence was encouraged and maintained. Staff knew people well and could describe how they supported people to be as independent as possible by encouraging them to wash their own face, pausing and waiting for people with their mobility whilst being there for support if they needed them. We discussed

this with the interim manager who told us that this would be actioned without delay.

Staff also told us about the 'twist'n'view' chart hanging in each person's bedroom. This consisted of an attractive picture hung on the bedroom wall, chosen by the person, with their needs and preferences written on the reverse. The charts have a wipe-clean surface so they could be updated whenever necessary, and printed symbols and prompts help staff and family provide appropriate information.

One person was being supported with their nutrition via a PEG feed. (A 'PEG' is a Percutaneous endoscopic gastrostomy which is a feeding tube inserted directly into the person's stomach). Care plan's had guidance for staff on how to look after the tube and keep the site healthy. There was information on the signs of infection that should be observed for and what action to take if noticed.

Some people had wounds that the nurses were managing. At the previous inspection there had been limited information of when the wounds had been dressed and what dressings had been used. There had been no information to show if the wounds had improved. At this inspection the wound care plans had improved, there were detailed plans for each wound. Staff were aware of when wound dressings needed to be changed and staff had recorded changes to the plan.

Special mattresses were used for people assessed at high risk of damage to their skin. There was a record of the setting to be used for each person, and forms in place to check the settings to make sure they were correct. Checks were also in place to ensure the positioning charts were completed with details to confirm people had been moved in line with the recommended timings to keep their skin as healthy as possible.

A new activities co-coordinator had been employed who had already organised activities on Pancake Day and St Patricks Day. In the morning of the inspection the hairdresser was busy doing people's hair. They chatted to people about every day issues and people responded positively.

The activities co-ordinator visited people in their rooms for a one to one chat or read. People told us that the staff regularly painted their nails. One person said they liked quizzes but the new activities organiser had not organised any yet. The activities co-ordinator told us of their plans for an Easter parade, outings and involving people more with discussions about their ideas for a new activity programme and producing a news latter.

The activity on the afternoon of the inspection was a sing along which four people attended. They smiled and sung together and watched the activities co-ordinator dance. People said, "It's nice to hear music" and "Not enough people joined in". After the sing song people decided to watch a popular musical film on the television in the lounge.

People who stayed in their rooms were observed reading papers and magazines, watching television, doing crosswords, playing patience on an electronic tablet, and one person was knitting chicks for Easter. A person told us that the local women's institute group had brought their world war two exhibition to the home, local school children came in on bank holidays and a lady came and played the accordion regularly.

The provider's complaints procedure was on display in the entrance hall and a suggestion box was available to give people the opportunity to raise any issues they had. At the last inspection the provider was not able to locate all of the complaints records. At this inspection the systems had improved and all complaint records were available to assess.

People told us they did not have any complaints, although they would talk with a member of staff if they did

they have any concerns. They said, "I'm comfortable and I've no complaints". "I'm very happy I like everybody here, never have any arguments". "I would talk to the manager". "I had a problem some time back and my niece spoke to someone and it was quickly sorted".

A relative told us that they did not have any complaints but they would go to the interim manager if they had any concerns. They said that they were confident their issues would be listen to and acted upon.

Complaints were recorded and investigated in line with the provider's policy. Complaints that were not able to be settled by the manager were sent to the regional manager for their investigation. There were records of all correspondence and any action plans that had been put in place.

Requires Improvement

Is the service well-led?

Our findings

People and relatives spoken with said they were satisfied with the service. People and relatives told us the service had improved since the last inspection.

At our last inspection September 2016, the registered provider had failed to take appropriate action to mitigate risks and improve the quality and safety of services. They had failed to seek and act on feedback from relevant people, on the service provided to continually evaluate and improve the service. Records could not be found, were not clear and completed accurately. We started to take enforcement action against the provider. The provider sent us an action plan telling us how they were going to improve.

At this inspection we found that apart one area of a continued breach in medicines, improvements had been made and the service had complied with the warning notices.

Since the last inspection an interim manager had been appointed. The service had improved significantly since the last inspection in September 2016. The regional manager and quality manager had been supporting the interim manager to achieve the improvements. Staff told us this had resulted in a much more open culture and they felt more valued by the management team. The interim manager, quality manager and regional manager had oversight and scrutiny of the service and had implemented the improvements in the service.

At this inspection we found there was a continued breach with regard to the safe administration of medicines. When the medicine error was identified by inspectors, the interim and quality manager took immediate action to address the issues. They informed health care professionals, including the doctor, and safeguarding authority of the error. They ensured that the person was safe and investigated the reasons why the error had occurred. This was completed by the second day of the inspection.
Staff morale was high and they were very positive about the changes the interim manager had made to the service. They were passionate about the improvements made and how they were working as a team to ensure they sustained the quality of care being provided. They said, "The interim manager has turned this home around, they are so supportive and such a good manager". "The interim manager listens and takes on board their issues". They said this gave them more confidence knowing they could approach them at all times. "It's so nice to work here now, the service is far more organised". "We are so much valued and supported now". "The interim manager seems to have been able to recruit good staff". "It is a lot better everything has changed and people are much happier." "I have been here for several years and it is better than it has ever been".

Staff understood the visions and values of the service. They told us they provided the service how they would like to be treated themselves or a family member. They described how to ensure people were treated as individuals, with dignity and respect and how to make sure their decisions and human rights were upheld.

The systems in place to record and analyse accident/incidents analysis had improved. All accidents and

incidents had been recorded, were in good order, with a record of the action taken to minimise the risk and to look for any patterns or trends so action could be taken to reduce the risk of accidents happening again.

There were now regular checks and audits in place to make sure that any issues were identified and actioned to address shortfalls and continually improve the service. The interim manager and staff told us that further improvements had been made by introducing 'the resident of the day', daily walk around and the daily ten minute meetings. People living at the service said how much they enjoyed being 'resident of the day' when all of their care and wellbeing was assessed. Staff told us that the ten minute meetings had improved communication and they were aware of what was going on each day. The senior management team were also involved in the daily meetings when they are at the service.

Staff were receiving regular supervision and appraisal to discuss their training and development needs. Staff were encouraged to share ideas and comments about the service and regular staff meeting were carried out with a high attendance. Staff told us this was because staff felt confident to raise issues and knew action would be taken in they had any concerns

The provider had a range of policies and procedures in place that gave guidance to staff about how to carry out their role safely, and these had been discussed during competency assessments and regular supervision. Staff confirmed that these sessions had taken place and told us that they had received guidance and support to ensure that they following the correct procedures. They said that completing the records, such as fluid charts, repositioning charts and daily notes was now standard practice and showed how they gave people their care and support.

At the last inspection the provider had not include other stakeholders or professionals when gathering opinions about the service. At this inspection the provider had actively encouraged feedback about the quality of care from a wide range of stakeholders, such as visiting professionals and professional bodies to ensure continuous improvement of the service. However, no stakeholder or visiting professional surveys were returned. The surveys were sent in May 2016 and the next survey would be sent out in June 2017. The results from the 2016 survey had been analysed and an action plan with changes to be made had been completed. For example, there were now hot trolleys to take meals up to the first floor. The outcome was displayed on the notice board for people and relatives to see what changes had been made.

Resident meetings were held regularly and minutes taken. When relatives who could not attend, they were sent the minutes to keep them up to date with what was happening at the service.

At the previous inspection records could not be found, they were not clear or completed accurately At this inspection record keeping and storage had significantly improved. The records were now organised, including the audits, staff records, care plans and relevant documentation. Nursing staff checked position charts and fluid charts were completed accurately at the end of each shift.. All records requested at the inspection were provided promptly and were in good order.

There was a development programme for managers and clinical lead roles had attended conferences to keep their practice updated. There were also meetings for managers from other locations to discuss current practice.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service, so we can check that appropriate action has been taken.

The provider had displayed the CQC rating from the last inspection in September 2016 on their website. A copy of the report summary was displayed in the entrance hall.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to order and manage medicines safely, people had not received their medicines as prescribed. This was a continued breach of Regulation 12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014