Care Quality Commission

Sentinel Health Care Limited

New Forest Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection took place on 24 February 2015 and was unannounced.

New Forest Nursing Home provides accommodation and nursing care for up to 48 older people, some of whom may also be living with dementia or have a physical disability. The home is in a rural location in Fritham, near Lyndhurst. The home is a period house which has been altered for use as a nursing home. Accommodation is split over two floors with 38 single occupancy rooms and 5 double occupancy rooms. There is access to landscaped gardens and grounds.

New Forest Nursing Home has a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service.

Summary of findings

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.

At the last inspection on 4 June 2014, we asked the provider to take action to make improvements in respect of medicines management, staffing levels and quality assurance. This was because medicines were not always stored safely, there were not always enough staff on duty and quality assurance processes were not robust enough to identify the areas of concern. The registered manager submitted an action plan which stated that the home would be compliant by 31 October 2014. At this inspection although the actions had been completed, there remained a concern around staffing levels in the home.

Staffing levels were insufficient, answering call bells was problematic especially during peak times and people told us they had to wait more than ten minutes for their call bell to be answered. The lay out of the home exacerbated the issue of responding to call bells in a timely way. Staff told us that this was a busy home and sometimes there weren't enough staff to meet everyone's needs.

Staff had completed safeguarding training and told us they knew how to keep people safe and report suspected abuse. Recruitment and induction practices for staff were safe. Not all staff understood the term 'whistleblowing.' We have made a recommendation about checking people who provide a service in the home, but are not employed.

There were a range of risk assessments in place to meet people's individual risks and clinical tools were used to assess risk where appropriate. Care plans documented actions required to reduce identified risks. Medicines were stored and administered safely.

Some people did not always have fluid available to them. Several people were unable to reach their drinks or had empty cups without access to a jug to refill them.

People were supported to have sufficient to eat and maintain a balanced diet. There were appropriate systems in place to ensure people ate food in line with their assessed dietary requirement. The chef spoke to people on a daily basis and prepared food around people's likes, dislikes and personal preferences. Staff told us they monitored what people ate and offered alternatives such as yogurt, chocolate and ice-cream if people were not eating well.

Mental capacity assessments and DoLS were in people's care plans and had been generally applied appropriately. However, we found some inconsistencies which were reflective of a training requirement rather than an impact on people using the service.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and health and safety. The registered manager was a trainer for moving and handling and assessed all staff annually

The home had a pleasant atmosphere and people received care from staff, delivered with kindness and affection. Staff were knowledgeable about people's backgrounds and their likes and dislikes. Staff told us they respected people's dignity and encouraged them to be as independence as they were able. People were offered choice in all aspects of their daily life.

Care records addressed people's wide ranging and changing needs and care delivered reflected care planned. Care plans included people's abilities and outcomes.

The home employed two activities co-ordinators and various activities were available to people including quizzes, baking, discussion of the day's news and visits from entertainers. An aromatherapist was visiting on the day of the inspection.

There was a positive and open culture within the home. Most staff said they felt able to raise concerns and there was generally good morale amongst staff. Staff clearly understood their role and the priority of tasks.

The provider had a good working relationship with the Care Quality Commission and had submitted relevant notifications. Following the inspection, feedback was responded to.

During our inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we asked the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not always safe.

Staffing levels were not sufficient to meet people's needs in a timely way at peak times. People told us they felt safe.

Staff had received safeguarding training and knew how to recognise the signs of abuse.

Medication was stored and administered safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people did not receive sufficient fluids because jugs and glasses of water were not always in reach or kept topped up.

Mental capacity assessments and DoLS were in people's care plans and had been generally applied appropriately. However, we found some inconsistencies which were reflective of a training requirement rather than an impact on people using the service.

Training was delivered appropriately. People were supported to have sufficient to eat to maintain a balanced diet. Staff were aware of special diets and dietary preferences.

Is the service caring?

Good

The staff were caring.

Staff treated people in a kind and compassionate way. They made sure that people were safe and comfortable and felt included in conversations.

Staff described how they provided care to people and respected their dignity.

People were complimentary about the care received. People said that staff were short of time but this did not impact on the caring way care was delivered.

Is the service responsive?

Good

The home was responsive.

Staff responded appropriately to people's needs.

Care planning was person centred and detailed care plans gave guidance to staff about the delivery of care.

People with complex illnesses had their medical and personal needs met.

Summary of findings

Is the service well-led?

Good

The home was well led.

There was a positive and open culture within the home.

The registered manager clearly understood her responsibilities and took a lead role in ensuring that care was effectively delivered.

The provider was responsive to CQC feedback.

New Forest Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 24 February and was unannounced. The inspection was carried out by two inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses nursing and dementia care services. A specialist advisor is someone who has clinical knowledge and experience of working with people who require nursing care and who may be living with dementia. The inspection was observed by a Director of the Care Quality Commission.

Before the inspection, we reviewed all the information we held about the home including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the provider is required to tell us about by law. We used this information to help us decide what areas to focus on during our inspection.

We spoke with 19 people using the service and three relatives. We also spoke with the registered manager, the Director of Care, the Managing Director, the chef, two nurses, three care workers, two domestic staff and the activities co-ordinator. We reviewed records relating to six people's care and support such as their care plans, risk assessments and daily monitoring records. We reviewed medicine administration records (MARs) for all people using the service and we also looked at various records in relation to the running of the home such as staff rosters and training and recruitment records.

Where people were unable to tell us about their experiences due to their complex needs, we used other methods to help us understand their experiences, including observation of their care and support. For example, we used the short observational framework for inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who are unable to talk with us.

During the inspection we spoke with a GP and an aromatherapist, both of whom were visiting the home on the day of our inspection. Fire risk assessment officers were also present in the home and we spoke to them briefly.

Requires Improvement

Is the service safe?

Our findings

Everyone we spoke with, who was able to express an opinion, said they felt safe. One person said "Yes, it's nice and welcoming here – I've settled very well."

Staffing levels had been identified as insufficient during our previous inspection on 4 June 2014. Since then, the management told us, they had recruited an additional staff member to each day shift. We also established that the number of people using the service had reduced from 47 in June 2014 to 39 on 24 February 2015. This meant that the ratio of staff to people using the service had increased since the last inspection. However, because no dependency tool had been used to ascertain staffing levels it was difficult to judge the impact of this. The registered manager and managing director told us that staffing levels are reviewed as occupancy changes and monitored on a day to day basis by nurses. On the day of our inspection there were two nurses on duty (one on each floor) and eight care workers on duty (four on each floor working in teams of two).

Staffing levels were strained on the day of the inspection. Staff were task focussed and answering call bells was problematic especially during peak times such as during the morning when people were receiving personal care. 70% of people using the service required two people to mobilise. Since two people were required for a high percentage of personal care delivery, it made it difficult for one person to be free to answer call bells. The layout of the home was challenging as it was spread out with long corridors and was compounded by call bell displays being widely spaced. Staff were required to find a call bell display to identify the caller before being able to answer. This added to the time it took to assist people with personal care.

People consistently told us they waited more than ten minutes for call bells to be answered; some said they waited more than twenty minutes. One person said "It can take half an hour for the call bell to be answered and that's when I want to go to the toilet." People said they especially had to wait in the morning when people were being "Got up." There was a reluctance from people to complain as the general feeling was that "Staff were doing their best" and couldn't answer the call bell, "When they were busy."

There was mixed feedback from staff in respect of staffing numbers although the majority of staff felt that staffing levels were less than ideal. One member of staff said "No, not really enough staff, depends on the needs of the residents but if someone is poorly, it's not enough. We struggle to push fluids and we can't always get to the half hourly checks if you are washing or bathing someone. It's a very busy home with a lot of hoisting."

The managing director provided a call bell monitoring print out for the day of the inspection which showed that call bells had escalated to emergency three times during the day (this would happen if the call bell wasn't answered within six and a half minutes). He provided an explanation for each escalation. However, we identified that call bells were not always placed within people's reach. On the day of the inspection we observed two people in wheelchairs and two people unsupervised in the lounge area who were unable to reach their call bell. One person in a wheelchair in his room was unable to ring his call bell because it was tightly tangled around the bed rail and the bed height control pad in such a way that neither could be used properly. Two other people in their rooms didn't have their call bells in reach although one person's call bell plan said 'ensure it is near to me.' Staff told us that the other person didn't use their call bell so they kept going "In and out." One person told us they felt very isolated in their room when they didn't have a call bell. They were in a wheelchair and said that their call bell had been left out of reach three times in the last week. The registered manager said it was the home's policy to have call bells in reach even if the person was not able to use it. The home was not complying with it's own policy in respect of call bells and this impacted on people's care because they could not always summon help when needed.

The managing director felt that improvements had been made to staffing since our last inspection and cited the call bell print out from the day of the inspection and random call bell checks. Whilst we agreed that staffing had improved within the home, there was sufficient evidence that there were not enough staff at all times. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to staffing. Following the inspection the managing director told us that he was reviewing the call bell system with a view to using pagers for staff.

Requires Improvement

Is the service safe?

Recruitment and induction practices for staff were safe. Relevant checks such as identity checks, obtaining appropriate references and Disclosure and Barring Service (DBS) were being completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. On the day of the inspection we spoke with a visiting aromatherapist who told us she had never been asked for evidence of her qualification or insurance. They said they had a DBS (previously criminal records bureau) check but this had not been renewed for five years. We recommend that the service follows relevant guidance about the checks which should be carried out in respect of volunteers, students, temporary and ancillary staff and practitioners.

Staff had completed safeguarding training and were able to explain to us how they protected people from abuse. One staff member told us "I have done safeguarding training four to six times in the last six years. Abuse can be verbal, physical, sexual or ignoring the person is abuse as well, I look for bruises and if you know the person, you know if they are not behaving normally." Staff told us they would report concerns to a senior nurse, matron or the Care Quality Commission (CQC). The safeguarding policy was available for staff to review and relevant telephone numbers were displayed on notice boards. People had individual care plans in relation to their safeguarding.

Although the home had a whistleblowing policy, staff were not clear on the meaning and understanding of 'whistleblowing.' Most staff showed little understanding and whilst one staff member knew that whistleblowing was about raising a concern. They were not clear about the protection they could expect if they did report under the whistleblowing policy.

We saw a range of tools were being used to assess and review people's risk of poor nutrition or skin damage. There were specific risk assessments for each person in relation to falls, moving and handling, safeguarding and skin integrity. Support plans were written in relation to each identified risk such as personal care, elimination or mental state. Although a wide variety of risks had been identified in relation to each person and detailed support plans written to mitigate any identified risk, we found some inconsistencies in risk assessments. For example, one person was at high risk of falls. The risk assessment had last been updated on 5 January 2015 following two falls, however records showed that the person had fallen again on 8 January 2015 and risk assessments had not been reviewed or updated following the incident. For another person, it had been identified that they were at high risk of chest infections and there was a care plan in place to address this. A physiotherapist had assessed and recommended specific cushions and their arrangement to support the person's side and back to retain the correct position. A care worker said "If (the person) gets too hot (they) have a fit, so we open the windows but (the person's) cushions are plastic so that makes (them) too hot so I use pillows." This meant that the correct action to mitigate risk was not being followed. Nursing staff said that heat was not a trigger for this person's seizures and therefore no risk assessment was required. The Director of Care told us that the person would be referred to the physiotherapist for a review.

The daily handover sheet included information about people's individual risks in relation to their health, risk of falls, dietary needs and behaviours. The information was detailed and accurate and care staff said they relied on it to provide care.

On the day of our inspection, an external company was in the home carrying out a fire risk assessment. They said they carried out the assessment annually and had no concerns about the home. Minor concerns raised such as a smoke seal lifting were always dealt with immediately. They also said they carried out fire training four times a year. The emergency evacuation plan for the home was linked to people's individual evacuation plans in their care plans and kept up to date when people entered or left the home.

Medicines were stored safely. Medicines were stored in a locked treatment room or in locked medicines trollies secured to the wall. Some medicines were required to be kept in a fridge. Fridge maximum and minimum temperatures were recorded and monitored to ensure medicines were kept at safe temperatures. We carried out a full check of controlled drugs and found there were no discrepancies. Controlled drugs are medicines which require a higher level of security.

Medicines were administered safely and accurately. Medicines were dispensed from tamper evident trays. This means when the seal is broken it will not stick down again. The system employed a tray of 28 (for the month of February) individual tamper evident pods. Each pod was presealed into the tray and contained detailed information

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about the person to whom it related including a photograph, details about the medicine including the time it needed to be administered. Medication administration records (MAR) were kept for each person, were laid out to match the system described above and were colour coded.

Some people preferred to manage their medicines themselves. There were risk assessments in place for this and individual lockable cupboards in people's rooms to store them safely.

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Is the service effective?

Our findings

Fluids were recorded and an individualised daily fluid intake goal was set. This was recorded on daily monitoring charts in people's rooms and also a central record of all fluid intake was kept which meant that staff could see at a glance whether people had been consistently achieving their fluid intake target over a longer period. Some people were consistently not achieving their daily fluid target by significant amounts. We were told that staff did their best to push fluids where necessary but that some people refused to drink. One member of staff said "It's not always possible to achieve targets because people don't always want to drink as much as they need to." Another member of staff said "We struggle to push fluids, we can't get there every hour." It was not clear what action was being taken in these cases. This meant that people were not always receiving sufficient fluids.

It was not evident that the central record of fluid monitoring was used as part of the monthly care plan review so we could not see this was an effective monitoring tool. Care plans we reviewed did not refer to individual fluid targets or an updated assessment as to whether an effective strategy was in place to address people's hydration needs.

People did not always have fluid available to them. One person who received their nutrition and hydration through a **percutaneous endoscopic gastrostomy (**PEG) had discrepancies in their records between the amount of fluid prescribed in their daily regime and the amount they actually received. For example they were prescribed to receive 2,075mls of fluid per day but the on the day prior to the inspection they received 1,950mls. Whilst the discrepancy was not significant there were notes in the person's care plan about needing to maintain the regime due to 'dark urine.' Several people were unable to reach their drinks or had empty cups without access to a jug to refill them. Six people in their rooms did not have drinks to hand. One person was banging their cup asking for a drink, both their cup and their jug were empty. Their last recorded drink had been one and a half hours previously. Another person drank very keenly after we refilled their cup, obviously thirsty.

We did not see that drinks and snacks were readily available throughout the day, but the registered manager told us that the kitchen porter prepared individual trays to meet individual requirements and served these to people in the morning and the afternoon. The registered manager told us that the kitchen was 'always open' and people could have whatever snacks and drinks they liked. However, people had to specifically ask and some people, with communication needs, may not have been able to do this whilst others may not have felt able to ask. One person told us they had been reluctant to ask for extra tea, coffee or drinks.

These concerns about hydration represented breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to nutrition and hydration.

People were supported to have sufficient to eat and maintain a balanced diet. People's dietary needs including their intolerances, allergies, likes, dislikes and individual requirements were recorded on admission. The information was given to the chef and an up to date record of requirements was kept in the kitchen to inform menu planning and ensure information about people's needs was available to all kitchen staff. Records kept in the kitchen, information on the handover sheet and observations of what people actually ate was consistent, which meant that the consistency of people's food was in line with their requirement. The chef visited all people living in the home each day to discuss their choices for the following day and exchanged cheerful banter with people and staff. The chef told us that other options were available on the day if someone changed their mind. The chef had been working in the home for six weeks and had proved popular with people. One person said "The food has improved immensely since we got the new chef." During lunch, the food was hot and plentiful and there was not much waste. Eating aids were in use such as plate guards and specially shaped cutlery. Staff told us they monitored what people ate and offered alternatives such as yogurt, chocolate and ice-cream if people were not eating well.

People with diabetes were catered for. The chef told us "We treat diabetics the same as everyone else but we give smaller portions and fortified food such as fortified milk in mashed potato – we only give this to people identified as needing it." A person with insulin dependent diabetes told us they were concerned about eating the custard tart served for pudding and had chosen to eat fruit instead. We noted that information in the kitchen did not include people's individual relevant nutritional considerations for

Is the service effective?

their diabetes, for example, whether people taking medication for diabetes had particular dietary requirements such as types of carbohydrates, fibre and regular snacks. The chef told us he was getting advice about insulin dependent diabetes diet including carbohydrate recommendations.

1. We checked whether the provider was acting in accordance with the requirements of the Mental Capacity Act 2005 (MCA). The MCA protects and supports people who do not have the ability to make decisions for themselves. We found that most care staff and most nurses had received training in respect of the principles of the MCA. The registered manager (also known as matron within the home) had not completed MCA training. Although care staff had received the e-learning training, some staff said that more training in this area would be helpful. The inconsistency in the training was reflected within care planning, where mental capacity was addressed appropriately in some cases but not others.
2. Mental capacity assessments had been undertaken which were decision specific in some care plans and included all aspects of the care plan and were regularly reviewed. This was important because people's capacity can fluctuate. Some care plans did not have the same approach. One person's care plan had been signed by a relative even though the person had capacity. We were told this was because the person was blind, however verbal consent could have been recorded. One person with a learning disability and high dependency needs had a care plan which stated they were unable to make choices and had no communication or understanding. There were mental capacity assessments within their care plan for different aspects of their care such as in relation to their **percutaneous endoscopic gastrostomy (**PEG) feed. The plan included best interest process records but they had not been signed by people named as part of the decision making process and the outcome wasn't recorded. A consent to using a wheelchair with a lap belt had been signed by their next of kin but there were no records of a mental capacity assessment or best interest decision in relation to this. A consent to having a photograph taken had been signed by a nurse. The care plan included conflicting information about the person's ability to communicate, for example they had been assessed as being deaf, blind and having confusion but then the plan went on to say it was difficult to assess the level of deafness. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, relating to consent to care and treatment.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been agreed by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made and was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. Relevant applications had been submitted and staff were aware of which people were subject to a DoLS. Staff were not aware of the restrictions these authorised, and the registered manager told us that details would be added to the handover sheets used at each shift changeover. Although DoLs applications were appropriate it was not clear why one person's advocate had not been involved in the DoLS process as the person had a learning disability, was deaf, blind and had no communication or understanding. Staff had not received training in respect of DoLS and staff we spoke with did not know what it meant.

Staff had received appropriate training to meet people's needs. Records showed that staff had received training in key areas such as infection control, fire training, moving and handling, food hygiene and health and safety. The registered manager was a trainer for moving and handling and assessed all staff annually. Staff told us they had received the right amount of training to meet people's needs. One member of staff said "Training is ok, we get e-learning and videos and matron does the manual handling update." An external company provided face-to-face training on a regular basis in addition to the e-learning. Key training areas were covered such as safeguarding and infection control but additional topics such as behaviour management and dementia were also included. These were provided on a regular basis throughout the year so that staff had several opportunities to be able to attend. Staff were issued with a learning and development training work book which included training information for staff, a section for them to sign to say they

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had read the policy and procedure in each area and then a brief knowledge check. Areas included philosophy for care, company mission statement, strokes and difficulties chewing and swallowing.

Care staff were given an 'Employee clinical experience record.' This was designed for care staff to improve their clinical skills and included areas such as maintaining skin integrity and understanding wound management. Staff completed each part of the record under the supervision of a clinically qualified mentor, who then signed off the record. The records were designed to be pocket sized and carried around by staff when on duty so they could be completed accurately each time a section was completed.

Nurses had completed clinical training in specific areas such as safe administration of medication, catherisation and venepuncture (the process of obtaining intravenous access). Some care staff had been supported to obtain health and social care qualifications and said that this was encouraged.

Staff were knowledgeable about providing people's care. One member of staff explained and demonstrated the use of the hoist and also explained what person centred care meant. We observed that the staff member practised person centred care. Person centred care involves putting people and their families at the heart of all decisions about their care. One person said "I think it's very good here, efficient and pleasant, I have no complaints. Staff are efficient, they get on with their jobs." Staff showed knowledge about people's individual communication methods and difficulties; one member of staff said "We have five residents who are non-verbal but we will know if they are not comfortable, for example if a person becomes agitated we have a routine to check them, we talk to them even though they can't respond properly."

People were supported to maintain good health through access to ongoing health support. On the day of the inspection we spoke to a visiting GP who told us he visited the home twice a week and was happy that the home were raising concerns to him appropriately and in a timely way. Records showed that healthcare professionals had been appropriately involved in people's care planning, such as a nutritionist, a physiotherapist and a speech and language therapist. People using the service had access to a hydrotherapy pool, located at another home run by the same provider.

Good

Is the service caring?

Our findings

The home had a pleasant atmosphere and people received care from staff, delivered with kindness. There was evidence in the library of craft activities and equipment was available for exercises and ball games. One keen group of ladies were enjoying doing jigsaw puzzles. During lunch one person brought in a large amaryllis plant as a table centre and talking point. There was much discussion about the plant.

Care staff treated people with kindness even though they appeared 'task driven' especially when providing personal care. There was not sufficient time available for good social interactions. One person who was leaving the service on the day of our inspection said that staff had given them attention and they had slept very well, however they said they had spent most of their time in bed and would rather have had more exercise. One person said, when asked whether staff socially interact with them, "Care staff don't have time for that, they've got too much to do." Although there was general agreement that staff didn't have much time for social interaction, people were complimentary about the kindness and attitude of staff. One person said, "I'm very pleased, very comfortable, they are very kind" whilst another person stated "I like it here very much, they are very kind and the food is good."

Staff were knowledgeable about people's backgrounds and their likes and dislikes. One staff member said, when asked about a particular person "They like talking, they don't like their feet high as this causes pain, they love to joke and have sweets and a sandwich." Staff spoke about how they respected people "We show them respect and we comfort them, I think people are happy here." Another member of staff told us how they supported people to maintain their independence as much as possible, "She didn't want to walk at home, but she was able to walk from the lounge to the toilet after being here for a while." Another member of staff described how they encouraged people to wash themselves and brush their teeth if they were able.

People's care plans included a 'This is my life' record which gave a brief life history. It included what name people liked to be known as, the places they had lived, their school, job, hobbies and interests. A member of staff told us "It's all in the care plan about them, children, career, interests." Staff understood the meaning of person centred care and were observed to be providing person centred care. Staff talked about a strong ethos that sought to respect independence, privacy and dignity for each person. We found nurses to be confident and caring with a calming influence on those around them. Staff put the comfort and needs of people first and were observed to be quietly professional.

People were involved in decisions about their care and were offered choices in all aspects of their daily life where they were able to participate. People were able to choose what they ate and what time they got up and went to bed. There were activities to choose from and trips. A library was available if people wanted a quiet area to read and people could choose to be social or stay in their rooms.

People's privacy and dignity were protected. Privacy screens were used in double rooms. We observed staff knocking on doors and doors to be closed when personal care was being delivered. One member of staff said "We let them choose what they want and then we give it to them. We give them a wash but make sure they are covered and the door and curtains are closed." People said that staff always included them in conversations.

Good

Is the service responsive?

Our findings

People looked happy and contented. In most cases care records addressed people's wide ranging and changing needs and care delivered reflected care planned. Specific tools were used as a means of assessing clinical risk in order to develop care plans. We observed that one person was being repositioned in line with their care plan in order to reduce the risk of acquiring pressure ulcers. On each occasion, we observed the person, they were in noticeably different positions and turn chart records had been updated to show the changes of position. Appropriate pressure relieving equipment was in place for those people that required it including pressure relieving mattresses. The mattresses, we looked at, were at the correct setting for the person's weight, in order to have the maximum pressure relieving effect.

Care planning was person centred ,for example, a person who was registered blind had a communication support plan that included how staff should support the person with their sight loss and how to explain to the person about the position of their food using the clock face method. An example of this might be "The meat is at six o'clock." The plan ensured that staff always introduced themselves, made sure the person was holding their call bell and how to check the room for trip hazards. Care plans included people's abilities and outcomes; for example, a person's eating and drinking care plan included what they could do independently and what they required support with.

There were some inconsistencies in some care plans however, for example, one person's care plan stated they were able to fit their own hearing aid however the person told us they were not able to do this because of pain in their arm. They were not wearing their hearing aid at the time we spoke with them. Their support plan also stated that the person's glasses should be close by however both the glasses and the hearing aid were out of reach. The person required hoisting and confirmed they were taken downstairs for lunch but said they struggled to hear people talk in groups. They said "Only my family come and sit with me in my room, that's ok, I don't really have a lot to talk about it." The person may have benefitted from some one to one time with activity staff. We were told that another activities co-ordinator was in the process of being recruited.

People being nursed in bed were quite isolated from the rest of the home, and would have benefitted from more one to one time. One person said "Time is long some days, there is not enough to do, but then again what can we do?" Another person told us they liked going out to see the trees. In the summer people were able to benefit from beautiful outdoor areas.

There was an activities co-ordinator on shift on the day of our inspection. She was assisted by a part time activities co-ordinator and a further full time staff member was being recruited to the role. The activities co-ordinator carried out a 'paper round' delivering newspapers and magazines to people's rooms and having chats with people. She told us that the company's mini bus was available to the home for use on Wednesdays and she used it as much as possible taking people out in the mornings, the afternoons as well as over lunch. A review of the activities programme showed that people were able to indulge in communion, word searches, card making, baking, jewellery making and quizzes. An entertainer was booked once a month and we were told this was a popular activity. On the day of the inspection, an aromatherapist and hairdresser were visiting the home and carrying out treatments. The aromatherapist said "I treat people for different needs, such as relaxation and one to one time, helping to keep limbs mobile and skin conditions."

Staff were knowledgeable about people's needs and preferences, for example, the moving and handling equipment they required, what they liked to eat and wear and where they liked to spend most of their time. One person was prescribed medicine which needed to be administered at specific times. Records showed that the person had received all prescribed doses at the correct times and the person verbally confirmed this to us.

The provider had a complaints procedure which detailed how informal and formal complaints should be dealt with including; who deals with the complaint, acknowledging the complaint, the timescales for response, the investigation and responding to the complainant. Records of complaints showed they had all been responded to in good time and included actions taken to address the complaint.

Good

Is the service well-led?

Our findings

There was a positive and open culture within the home. Most staff said they felt able to raise concerns and there was generally good morale amongst staff. For example, one member of staff said "The home is very good for me, we treat everyone as a family, we are here for the residents, everyone is happy." There was a view amongst some staff that the registered manager was known for raising her voice and not encouraging feedback and contribution. Conversely other members of staff said management listened, with one staff member saying the registered manager was hands on, worked hard and knew people well. There was an observation from staff that morale could fluctuate although they felt that morale had recently improved.

The registered manager was knowledgeable about people's care needs. She understood her responsibilities and this had a positive impact on people. During the morning handover process we observed the registered manager taking a leading role in understanding changes to people's health and wellbeing, making sure people were comfortable and ensuring clear information was sent to the GP, before his planned visit that day, so that test results or other information would be immediately available. This meant that staff clearly understood their role and the priority of tasks for the day.

The provider had a good working relationship with the Care Quality Commission. They had shown openness and honesty, submitting relevant notifications and discussing issues when they arose. Action plans were sent when requested. The provider responded immediately to our feedback about the call bell system, by arranging for the installation of a new call bell monitoring system which was planned to reduce the time taken to respond to call bells.

Staff meetings were held regularly and were planned to be held immediately following a residents meeting so that any concerns or suggestions raised by people could be addressed immediately. The consensus was that this was a good idea, however some staff were unhappy that staff meetings were always held on a Wednesday afternoon, as this meant that some members of staff weren't able to attend the meetings.

Attendance at staff meetings was low and the latest available minutes showed that the meetings were used to impart information to staff rather than an opportunity for staff to raise issues for discussion . One member of staff felt that nothing new ever came up at staff meetings as they only went the way the registered manager wanted them to. However another member of staff said "We have a staff meeting once a month and we can voice what is needed, if I want to say something then yes I will."

Resident meetings were held on a monthly basis and minutes showed that a number of items had been discussed with people such as preferred times for getting up, reminding people that snacks were available and a discussion around plans for a 'Gentleman's club.'

The registered manager summarised improvements made to the service since the last inspection. These included the recruitment of a deputy manager, new care plan documentation, a training pack for care workers and a clinical training booklet for care workers. There were plans in place to install overhead tracking hoists in particular rooms and to replace the maintenance van. A quality assurance audit was carried out monthly by the Director of Care and appropriate actions recorded.

Policies and management arrangements meant there was a clear structure for the efficient running of the home. There were policies in place which included a staff recruitment policy, an induction training policy, staffing levels policy, incident policy, staff supervision policy and a mental capacity policy. On admission to the home each person was given an information pack which included a company mission statement and a statement of values. These were linked to providing a standard of excellence around core values of dignity, choice, respect, fulfilment, inclusivity, independence, diversity, security, equality, rights, dignity and empowerment.

A business continuity plan was in place to ensure the continuing care to people in the event of an emergency. The plan considered accommodation loss, catering disruption, emergency lighting, frozen food, disruption to gas supply, loss of water supply and disruption to the laundry service. It described the circumstances in which the plan would be activated and also considered debriefing and learning lessons after the event.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs How the regulation was not being met: Where food and hydration are provided to service users as a component of the carrying on of the regulated activity, the registered person did not ensure that service users were protected from the risks of inadequate nutrition and hydration by means of the provision of a choice of suitable hydration, in sufficient quantities to meet service users' needs and support where necessary, for the purposes of enabling service users to drink sufficient amounts for their needs. Regulation 14 (1) (a) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users or establishing and acting in accordance with the best interests of the service user. Section 4 of the Mental Capacity Act 2005 (best interests) applies for the purposes of this regulation as it applies for the purposes of that Act. Regulation 18 (1) (a) (b) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person did not take appropriate steps to

This section is primarily information for the provider

Action we have told the provider to take

ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of the carrying on of the regulated activity. Regulation 22

This section is primarily information for the provider

Enforcement actions

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