Pear Tree Care Limited

Blossom House

Inspection report

1-3 Beech Grove
Hayling Island
Hampshire
PO11 9DP

Tel: 02392462905

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 October and was unannounced.

Blossom House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Blossom House provides accommodation for up to 31 people. At the time of our inspection, there were 26 people living in the home. This home provides a service to older people, including people living with dementia, a physical disability or a mental health need. The service was arranged over three floors, with bedrooms on each floor. There was a mix of single and double bedrooms and communal bathrooms on each floor. The service had three lounge areas for people to use, a large dining room conservatory and an accessible garden.

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

At our last inspection of the service, in February 2018, the service was rated 'Inadequate' overall and we identified breaches of Regulations 9, 11, 12, 17 and 18 of the Health and Social Care Action 2008 (Regulated Activities) Regulations 2014. We found the following concerns; people did not receive person-centred care which met their needs, people's rights had not being protected in line with the Mental Capacity Act 2005, risks to people's health and safety had not always been identified and assessed, systems and processes to assess and monitor the service were not effective and there were insufficient levels of staff.

At this inspection, we found that significant action had been taken to address these issues and there were no longer any breaches of Regulation. However, some areas of further improvement were identified and there was a need for embedding of improvements to be sustained.

Quality assurance systems were in place, based on a range of audits. However, we found these were not always effective and had not identified the concerns raised during the inspection.

Staff did not have a clear understanding of legislation to protect people's freedom and staff were not able to identify which people living at the service were subject to restrictions in law.

Information and guidance for staff about people's nutritional and hydration needs was not always fully recorded in people's care plans, which meant staff could not easily identify if people's needs were being met.

People's care plans had been completely re-written since the previous inspection, however we identified that information was not always consistent and further improvement was needed.

There were sufficient levels of staff available to ensure that people were cared for safely.

Individual and environmental risks to people were managed effectively. Risk assessments identified risks to people and provided clear guidance to staff on how risks should be managed and mitigated.

People felt safe living at Blossom House. Staff knew how to keep people safe and how to identify, prevent and report abuse. They engaged appropriately with the local safeguarding authority.

People received their medicines safely, as prescribed, by staff who were trained appropriately to do so. There were comprehensive systems in place to ensure the safe ordering, storage and disposal of medicines.

Staff received a variety of training and demonstrated knowledge, skill and competence to support people effectively. Staff were supported appropriately by the management of the service.

People were cared for with kindness and compassion. Staff had developed positive relationships with people and their relatives and knew what mattered most to them.

Staff took action to protect people's dignity and privacy at all times and encouraged people to be independent with all aspects of their daily routines where possible.

There was an open and transparent culture in the home. Relatives could visit at any time and were made welcome.

Staff took a positive and person-centred approach towards supporting people at a personal level.

Where people's needs changed, staff acted promptly to ensure they received effective care.

People's end of life wishes and preferences had been considered and were recorded clearly in people's care plans.

People had the opportunity to access a range of suitable activities. There was an appropriate complaints procedure in place and people knew how to make a raise concerns.

Staff were happy in their work and felt supported by management of the service. The provider worked closely with the registered manager and was actively involved with the day to day running of the service.

The service worked in partnership with health and social care professionals, for the benefit of people living at Blossom House. Links had been made with the local community to ensure people did not feel socially isolated.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient levels of staff available to ensure that people received safe care and support.

Individual and environment risks had been identified and recorded in people's care plans, along with actions for staff to take to minimise the risk of harm.

People felt safe with staff and staff had received training in safeguarding, which enabled them to identify and report potential abuse appropriately.

Systems were in place to ensure that medicines were managed safely and people received them as prescribed.

Procedures were in place to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had a lack of knowledge about legislation to protect people's freedom and were not able to identify which people this applied to.

Information about people's nutritional and hydration needs was not always fully recorded in their care plans, which meant that staff could not easily identify if people's needs were being met.

Staff were skilled, knowledgeable and competent to carry out their roles.

New staff received a robust induction period before they worked independently with people and staff felt supported in their role.

Adaptations had been made to the environment to ensure the service was supportive of people who lived there.

Is the service caring?

Good

The service was caring.

Staff had built positive relationships with people and engaged with them on a personal level.

Staff interacted with people, including those who were living with dementia, in a patient and considerate manner.

People were treated with dignity at all times and staff respected their privacy.

Staff encouraged people to stay as independent as possible in all areas of their care.

Staff supported people to meet their cultural and religious needs.

Is the service responsive?

Good

The service was responsive.

Staff had adopted a positive, person-centred approach to ensure that people received personalised care and support.

People's individual communication needs were considered to ensure that people received information in a way that they understood.

Staff acted promptly to people's changing needs and contacted health care professionals appropriately.

People were supported to make choices about their end of life care, which were clearly recorded within their care plan.

A robust complaints procedure was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Further time was needed to fully embed improvements that had been made since the previous inspection.

A quality assurance system was in place; however, this had not identified all areas of concern raised during the inspection.

Staff were organised, motivated and worked well as a team. They

felt fully supported by the registered manager.

The provider was engaged in running the service and there was a positive and open culture.

The service worked in partnership with external health and social care professionals and positive links had been made with the community.

Blossom House

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 16 October 2018 by three 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law

We spoke with five people living at the home and two family members. We spoke with the registered manager, the deputy manager, six care staff, an activities co-coordinator, a member of maintenance staff and the head cook. We also spoke with two visiting healthcare professionals. We looked at care plans and associated records for eight people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance.

The home was last inspected in February 2018 when it was rated as 'Inadequate' overall with five breaches of the Health and Social Care Act 2008.

Good

Is the service safe?

Our findings

At our last inspection in February 2018, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people were supported by an adequate number of suitably skilled staff. We issued a warning notice requiring the provider to become compliant with the regulation by 30 April 2018. At this inspection we found action had been taken; the warning notice had been met and there was no longer a breach of this regulation.

People and their relatives told us there were always enough staff available to support them effectively. One person said, "A member of staff is always around, so if I need them they are always available." A family member said, "It is one of the things I like about the home, whenever I come to visit, there is always a member of staff around." Following the last inspection, the provider had conducted a review of staffing levels and had introduced new tools to assess the required staffing levels based on people's needs and levels of dependency. We saw this had led to an increase in the number of care staff available at night and at key periods, such as mealtimes. Staff told us this had improved the level of support they were able to give people. One staff member told us, "The [extra staff on nights] makes such a difference. It's now a pleasure to work there. Everybody is happy, the staff, the residents. You don't feel there's pressure on you to do set tasks." Records from the electronic call bell system confirmed that people were responded to promptly, with most calls being answered within two minutes. Gaps in the rota were covered by existing staff working additional hours or by a small number of agency staff who worked at the home regularly. This helped ensure people were only supported by staff who knew them well.

People told us they felt safe at Blossom House. On person said, "I feel very safe, I don't have anything to worry about." Another person said, "I feel very safe, I am well looked after." We spoke with people's relatives, who told us they were confident their relatives were cared for safely at the service. One family member said, "Although my loved one has only been here for a few days, I feel that they are in good hands and safe."

Individual risks to people were managed effectively. Risk assessments identified potential hazards to each person and detailed actions taken to reduce the risk of harm. For example, one person had been identified as at risk of malnutrition and dehydration. A risk assessment was in place which detailed actions for staff to take in order to promote the person's food and fluid intake, such as using charts to monitor what the person ate and drank and encouraging high calorie drinks. Other potential risks to people had also been considered and recorded within people's care plans, including falls, manual handling and choking.

Where people were at risk of pressure injuries, actions were taken to reduce the risk of further injury and promote the healing process. For example, we saw special pressure-relieving mattresses had been provided and there was a process in place to help ensure they remained at the right setting according to the person's weight. Clear information was available to staff in people's rooms to remind them of the correct steps to take to support people's skin integrity, and records showed people were supported to change their position regularly to further reduce risks of pressure injury.

Environmental risk assessments had been completed appropriately to ensure each risk identified was

managed effectively. Gas and electrical appliances were serviced routinely and there were plans in place to deal with foreseeable emergencies. Fire safety systems were checked and audited regularly. Staff were clear about what to do in the event of a fire, had taken part in fire drills and been trained to administer first aid. Furthermore, each person had a personal emergency evacuation plan (PEEP) detailing the support they would need if the building needed to be evacuated.

The registered manager monitored accidents and incidents using individual records for each person. This had been effective in identifying interventions to protect individuals from further harm; for example, two people had experienced falls in the early evening, when tired, so staff had started offering them an early nap. This had proved successful and neither person had fallen since. The system did not allow the registered manager to identify patterns or trends across the service, but they told us they were developing a tool for this purpose and had nearly finished adding the relevant data to it.

A staff recruitment procedure was in place. This included pre-employment reference checks and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, during the recruitment process, staff were not asked to provide information about any physical or mental health conditions which might be relevant to their capability. This meant the provider was not able to assess whether new staff were fit enough to support people effectively and whether any reasonable adjustments needed to be made. We discussed this with the registered manager. They said they had already identified this issue and were developing the necessary forms to capture this information.

Staff had received safeguarding training and knew how to identify, prevent and report abuse. Staff had access to phone numbers for the local authority safeguarding team and were aware of how to contact them should the need arise. A staff member told us, "[The managers] take note and listen. For example, if there's a new mark on someone they would investigate and report it to safeguarding if they needed to."

There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of safely and correctly. Full stock checks of medicines were completed regularly to help ensure they were always available to people. We saw that people were administered their medicines safely by staff members who had received appropriate training and duty rotas showed there was always a trained staff member on duty, including at night, to administer medicines. Staff had their competency to administer medicines checked, to ensure their practice was safe. We saw a sample of these which showed the process was robust and included six observations of their practice. The deputy manager told us that they had built a good relationship with a local pharmacist, who had recently completed a medicine audit. We saw a copy of the audit, highlighting where changes and improvements had been made and commented on by the pharmacist. One section stated, "I can see how well you have been getting on with the actions from my last visit, it is very impressive." The service also completed their own internal audits to ensure all medicines were managed safely.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. There was a clear process in place to help ensure topical creams were not used beyond the manufacturers' 'use by' date. Staff recorded the application of creams to people and had clear information as to where each prescribed topical cream should be applied and when this was required. Care plans contained information for staff about which medicines people had been prescribed, common side effects and for what reason they were taking them. This helped staff to understand why the person needed the medicine and when to identify an adverse reaction. Clear guidance was available for staff to ensure each person received personalised support when receiving their medicines. For example, one person's care plans said, "I would like you to put my medicines

in my hand and give me a cup of water to swallow them with." The guidance also stated where the person had any difficulties when taking their medicines and how staff could assist to overcome this. Where people were prescribed 'as required' medicines (PRN), there was a clear protocol in place for staff to follow to ensure that the medicine was administered appropriately and they were aware of the expected outcome.

There were appropriate systems in place to protect people by the prevention and control of infection. Staff had attended infection control training and followed clear procedures to ensure the risk of cross contamination was minimised where possible. For example, staff described how they processed soiled linen using soluble red bags and confirmed they had ready access to personal protective equipment (PPE). All areas of the home were clean and cleaning schedules were in place to help ensure cleaning was done consistently, using appropriate products. A person told us, "The home is lovely and clean." Systems and checks were in place to ensure people were protected from the risks associated with water borne infections, such as Legionella. The registered manager was able to describe the actions they would take should there be an infectious outbreak at the home and infection control audits were undertaken at regular intervals as part of an overall quality monitoring process. The home had been awarded five stars (the maximum rating available), for food hygiene by the local environmental health department.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in February 2018, we identified a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure staff were appropriately trained and supported to carry out their duties effectively. We issued a warning notice requiring the provider to become compliant with the regulation by 30 April 2018. At this inspection we found action had been taken; the warning notice had been met and there was no longer a breach of this regulation. However, we identified that some further improvement was required.

Information about people's nutritional needs was not always identified and recorded appropriately to ensure that staff could support people effectively. Staff monitored the intake for people at risk of malnutrition or dehydration using food and fluid charts. A staff member told us, "It's not one person's job to make sure people drink, it's all of our jobs." However, we found the fluid charts for people who could only drink with the support of staff did not always confirm that they had been offered or had received enough to drink. There was no guide to the amount the person should be encouraged to drink and the amount they drank was not totalled each day. Staff could not easily identify, therefore, whether the person's needs had been met. We discussed this with the registered manager, who told us they were reviewing the way people's fluid intake was calculated to help ensure their needs would be known and met.

Each person had a nutritional assessment to identify their dietary needs. However, we found these were not always accurate. For example, one person had diabetes which was controlled through diet and medication. Staff told us they encouraged the person to follow a low-sugar diet, but said the person would not always accept this. Their nutritional assessment did not specify the need for a low-sugar diet or provide information to staff about the action they should take if the person declined this. This posed a risk the person might not receive appropriate or consistent support for their diabetes. Another person's low-sugar diet had been stopped by the GP as the person had become frail; this was reflected in their care plan and understood by staff. The registered manager told us of a plan to review everyone's nutritional assessments immediately after the inspection to ensure they accurately reflected people's needs. Staff used a 'red' system to help identify people who needed support to drink or who were at risk of choking. People using the system had red trays, red clothes protectors or red tops on their water jugs. Staff understood the system and we saw it being used effectively to help ensure people's needs were met.

People were complementary about the food provided and were offered alternative choices at mealtimes if they wanted something different. Comments included: "The food is very good, the choices are the things I like" and "The food is good, there is a good variety and that is half the battle won." A relative said, "The food is very good, my loved one enjoys their food and they always eat well." Staff were available to support people during mealtimes and were attentive to people's individual needs. People who were being cared for in bed were supported to eat in a dignified way on a one-to-one basis. Some people needed their meals and drinks prepared in a special way to meet their needs and we saw these were provided consistently. A choice of meals was offered in advance, but people could change their mind at the point of service if they wished. Desserts were offered to people from a trolley, which enabled them to make an informed choice.

Staff did not fully understand legislation designed to protect people's freedom. 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 decisions made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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. We found DoLS applications had been made where needed. Any conditions imposed had been followed and there was a process in place to ensure DoLS authorisations were renewed before they expired. However, no staff member was able to tell us accurately which people were subject to DoLS and did not have ready access to the relevant information to clarify this. Some staff told us they would not allow any person to leave the home unaccompanied and lacked an understanding of DoLS legislation. For example, one staff member incorrectly told us that "Most people are on DoLS." They added, "It means we can do things in their best interests, like not allow them to leave the building on their own, to keep them safe." Another staff member said, "There is no one who would be safe to leave on their own. I certainly wouldn't let anyone out at night." Two staff members could not provide any explanation of DoLS and three could not tell us any of the people who were subject to DoLS. This posed a risk that people might be subject to restrictions not authorised in law.

Following the inspection, the registered manager wrote to us to advise that action had been taken to ensure that all staff had a full understanding of DoLS and knew which people living at Blossom House this applied too.

In other respects, staff followed the MCA when supporting people with daily decisions about their care. Senior staff had assessed people's capacity to make specific decisions, such as to receive medicines, a modified diet or use bed rails. Where the assessment concluded that the person lacked capacity to make certain decisions, relevant people, including family members, were consulted and best interest decisions were made and recorded in accordance with the MCA.

Staff understood their responsibilities regarding people's consent. Throughout the inspection, we heard staff seeking verbal consent from people before providing care or support; for example, at lunchtime we heard staff asking people for permission before putting a clothes protector on them or wiping their chins. One person told us, "The staff always ask me before they help me." Where people were able to, they had signed relevant forms to consent to different areas of their care, such as whether they were happy to receive personal care from both male and female staff. Staff described how they supported and encouraged people to make as many choices as possible. For example, one staff member said, "We always offer choices, even if [people] are not able to respond. We still ask what they would like and [for example] would offer two different coloured nighties and see if they indicate a preference for one over another." Throughout the inspection, we heard staff offering people choices, for example where they wished to sit and whether they wanted "another film or some music".

People told us staff were competent and provided effective support. One person told us, "The staff know what they are doing and the way I like things done." Written feedback sent to staff by a family member praised the "exceptional, over and above care" given to their relative. Staff were suitably trained. New staff completed a structured induction programme before being allowed to work on their own. This included a

period of shadowing a more experienced member of staff and the completion of training deemed essential by the provider. Staff who were new to care and staff who did not have a vocational qualification in care, were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.

Experienced staff received regular refresher training in all key subjects and were encouraged to access additional training in subjects relevant to their role. For example, a manager was being supported to obtain a level five diploma in health and social care and care workers were supported to obtain level three qualifications. One staff member told us, "There are things I would like to do, like a wound care course and they are putting me forward for it."

Staff told us they felt supported in their roles by managers. Each received regular one-to-one sessions of supervision, together with annual appraisals to discuss their role, their well-being, and any development needs. Comments from staff included: "[The registered manager] is so approachable and wants to teach us. There is an open-door policy and I feel supported absolutely, including by the owners" and "I feel I'm very supported by all the managers; they take note and listen." Staff told us they had also been supported in practical terms; for example, a staff member with dyslexia told us they had been given a laptop to support them.

The home was clean, tidy and well-decorated. One person commented, "I like the new décor. It makes the home look well looked after." Some adaptations had been made to the environment to support people's needs. The corridors were wide and uncluttered; chairs in communal areas were arranged in small clusters to promote conversation; large signs helped people find the bathrooms; a chair lift had been installed to enable people to reach the upper floor and some handrails had been painted in contrasting colours to make them easier for people to spot and use. The registered manager told us of plans to enhance the environment further by extending the building and converting shared rooms into single use rooms with en-suite bathrooms. Specialists in developing supportive environments for people living with dementia had been involved in the planning, as had the people currently living at Blossom House. The work was planned to start in March 2019.

Staff made use of technology to support people to receive timely care and support. For example, pressure mats were used to alert staff of the need to support people when they moved to unsafe positions. Special pressure-relieving mattresses had been installed to support people at risk of pressure injuries. An electronic call bell system allowed people to call for assistance when needed and produced data to enable managers review response times. The registered manager described how they had also used the data to review the care needs of people who called frequently, especially during the night, including referring people to their GPs for medicine reviews. They said this had led to people becoming more settled, enjoying better sleeping patterns, reduced levels of anxiety and fewer falls.

Good

Is the service caring?

Our findings

People were supported by kind, caring and compassionate staff. People spoke positively about the staff and told us they were looked after well. One person said, "The staff are caring and lovely. They cannot do enough for me" and another said, "The staff are great, they always go the extra mile."

We saw that staff interacted with people in a supportive and respectful manner. Staff addressed people using their preferred name, knelt to their eye level and used touch appropriately to provide reassurance. Staff spoke with people in a polite manner and took time to engage with people on a personal level. For example, we observed one staff member, who was busy with a task, asking a person if they were OK, after noticing them showing signs of discomfort. The person initially replied that they were 'fine', however when the staff member checked a short while later, they advised they had back pain. The staff member asked the person if they wished to receive further medical support, to which the person agreed and this was arranged. One person told us, "I am never rushed; the staff always support me with a smile. They cannot do enough for me, they are always willing to help me when I need it."

Most people at the service were living with dementia and the registered manager described how they had worked with staff to help improve their understanding of the support that was needed. They said, "Staff get it now. They understand the approach and response required. People [living] with dementia still feel and pick up on body language. They now work with the emotion [of the person] rather than being task orientated. The person has to be calm and relaxed before you can [perform the task]. You have to find what the person likes and how to distract them, for example by singing." During the inspection, we saw staff interacting people in a supportive and patient manner, whilst being sensitive to their emotional needs. For example, we overheard one person, who appeared distressed, approaching a staff member saying, "I don't know where to go, I am in a right muddle. I don't want to be by myself" The staff member spoke with them calmly, acknowledging they were worried about this and said, "You don't need to worry at all, you stay here with me and [another person]." We saw this instantly reassured the person and they gratefully sat with the staff member.

People's dignity was protected at all times by staff who were considerate in maintaining people's privacy. For example, staff had suggested that the doors of two bedrooms, by the front entrance, should be kept closed to protect the privacy of the people using them. It was identified that one person in these rooms did not like their door closed and they accepted the offer of a move to a different room, where they could have the door open without compromising their privacy. During the inspection, we saw when a community nurse visited to examine a person in a communal area, staff set up a privacy screen to protect their privacy. Staff also used privacy screens in shared rooms when delivering personal care.

Staff demonstrated respect for people's dignity by ensuring they were clean and well-presented. For example, one person had spilt food on their trousers during lunch and was trying to clean it off with their hands. Shortly afterwards, we saw staff had supported the person to change their trousers. Staff told us another person frequently needed to be supported to change their top; to save them the effort of having to go back to their room each time, staff kept a supply of tops nearby and helped the person change them in

the bathroom. Staff described the practical steps they took when ensuring that people's dignity was upheld during personal care. One staff member told us, "I'd make sure the door was closed, all equipment to hand and offer to leave the bathroom while [the person] used the toilet."

People were encouraged by staff to remain as independent as possible in all aspects of their day-to-day routines. Staff demonstrated a clear understanding of the importance of maintaining people's independence to assist in improving their overall well-being. A staff member told us, "We don't automatically assist people [to eat] unless we see they are really struggling. First, we would try adaptive cutlery or coloured plates and a plate guard." Another staff member said, "If people can use a flannel, we give them it so they can do the parts they can reach. [One person] can manage in the bath, so we fill it for them, leave them to bathe, then go back later to help them out." A further staff member said, "I would always offer for people to wash their own hands and face. If they were able to wash other parts, I would encourage that. I try to ensure they are as independent as possible." During the inspection, a person helped a staff member lay the table with placemats before lunch, which we saw they enjoyed. Involving people in day to day tasks like this promotes their independence and sense of self-worth.

People's cultural and diversity needs were explored during pre-admission assessments and were further developed in people's care plans over time. We saw that people had been supported by the service to maintain their faith. For example, the registered manager spoke with us about a local minister who visited the home regularly to conduct a service, and visited people in their bedrooms for one-to-one conversations if requested. We saw that people's care plans clearly referenced their preferences and how they wished to be supported to maintain their faith. One person's care plan said, "The home now has a visiting church service and [the person] prefers to have the priest visit her room."

Good

Is the service responsive?

Our findings

People received care that was personalised and staff demonstrated a good awareness and understanding of people's individual needs. A relative commented, "The staff are very good, they know my loved one very well." Another said, "Although my loved one has only been here a few days, the staff are getting to know them and the way they like things done."

Staff told us they had adopted a far more person-centred approach to supporting people since the last inspection. For example, one staff member said, "We used to have to get an allocated number of people up [before the day shift arrived]; we don't now and it's so much more positive. That's been a massive shift. We now only get people up if they want to get up." Another staff member told us, "Everyone is different, so you have to adapt to each person's needs." They provided examples of how they did this, such as adapting their communication style to support a person with impaired hearing.

People's care plans had been completely re-written since the last inspection. The registered manager told us they had spent a lot of time researching people's backgrounds and obtaining medical information from their GPs. They said they now had comprehensive information about people's needs. Although this had started to be incorporated into the new care plans, they acknowledged that further time was needed to complete the work and to review all the care plans. We confirmed this was necessary, as aspects of some people's care plans had not been reviewed for six months and contained contradictory information, for example about how often people being cared for in bed should be supported to reposition. People and where appropriate, their relatives, were involved in how they wished to receive care and support at Blossom House. A relative commented, "I have been asked about my loved one's likes and dislikes and how they like things done. I have also been asked to provide information about my loved one's history. This fills me with confidence."

Prior to moving to the service, one of the managers completed a comprehensive assessment of the person's needs. This included falls, continence, identified risks, behaviour support needs, skin integrity, nutrition, moving and handling needs and psychological support needs. Care plans followed best practice guidance. For example, they used recognised tools to assess people's nutritional needs and skin integrity.

People's individual communication needs were considered to ensure they received information in a way that they understood. People had a 'communication care plan' in place to guide staff on the best way to speak with people or present them with information. For example, one person's care plan stated, "[The person] sometimes used hand gestures and facial expressions to communicate best." Another section of a person's care plan described how staff should communicate with them whilst they were assisting them with a specific piece of mobility equipment, to ensure they understood what was happening and were supported safely. The registered manager explained where people were not able to easily read their care plans or other care documents, their keyworker or a manager would sit with the person to read information to them and answer any of their questions.

The service was responsive to people's changing needs. Records showed that when people's health

deteriorated, the service referred people to appropriate health care professionals. People's care plans also contained detailed information for staff about what actions were required if people's needs changed. Health and social care professionals confirmed they were contacted appropriately, in a timely way and that staff always followed any recommendations they made. One social care professional said, "They keep me updated. They contact me when they need to and relay information to [the person], it's a good partnership." Staff were attentive to changes in people's physical and emotional needs and took action to ensure that any concerns were explored appropriately. For example, the registered manager told us about one person who was not socialising with others and they had identified that they needed a hearing aid. Since being fitted, the person had become more engaged and was able to enjoy the activities on offer. Staff were kept up to date on people's changing needs through verbal handover meetings which were held in between the day shifts. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

People were supported to make choices about their end of life care. People's care plans contained specific information with regards to their wishes and preferences, for example, one person's care plan stated they would like to have fresh flowers in their room and the radio turned on. Other information was recorded such as where they wished to be, who they wanted to visit them and information about their chosen funeral director. People's cultural needs were also recorded to ensure staff were respectful of people's faith at the end of their life. The registered manager advised us that if they wished, people's family members were offered accommodation and meals, to ensure that they were able to stay with their loved one during their last few days.

People were supported to access appropriate mental and physical stimulation. People spoke positively about the range of activities available at the service and told us there was "always something going on." A dedicated activities co-ordinator was employed for five days a week and an additional staff member was employed at the weekend to facilitate activities. During the inspection we saw three different activities taking place in a communal area of the service, which included singing and a sensory quiz game. We spoke with the activities co-ordinator who told us that the range of activities offered was dependent on what people requested to do. Furthermore, they often took place over a short time frame, as this suited people's level of interaction. People were encouraged to participate in the activities, but could sit and watch if they wished. One person told us, "There are always activities going on, but they don't force you to participate."

A complaints procedure was in place and complaints forms were available in the entrance lobby. The registered manager told us the complaints procedure was included in an information pack given to people when they moved to the home. This was available in large print if needed. People and their relatives told us they felt able to raise a concern. One relative said, "If I have an issue, I talk to the manager and it is sorted." We viewed records of recent complaints; we saw these had been investigated thoroughly and responded to promptly, in accordance with the provider's policy. For example, complaints about missing or damaged clothes had been addressed by the introduction of a key worker system. This provided each person with a named staff member who took a particular interest in them, their clothes and their personal grooming needs.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in February 2018, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to operate effective systems to assess, monitor and improve the service. At this inspection we found action had been taken and there was no longer a breach of this regulation, although some further improvement was still required.

Quality assurance systems had been developed to assess, monitor and improve the service, however these were not always effective. Audits carried out by the provider and registered manager had not identified the areas of concern we found during our inspection. For example, they had not identified that staff lacked knowledge about DoLS. Furthermore, although audits had picked up the need for other improvements, these had yet to be implemented. These included,a system to identify patterns and trends of accidents and incidents across the home, a system to assess the health of staff during the recruitment process and improvements to the monitoring of people's fluid intake.

Although we found improvements had been made, further work was still required in some areas, as highlighted above and time was also needed to ensure that the new practices that had been implemented were embedded to ensure that improvements made were sustained.

Staff were engaged in the running of the home and felt able to make suggestions for improvement, including during staff meetings. The registered manager told us there was a very high level of attendance at staff meetings. This was confirmed by the minutes of the meetings, which showed staff had been actively encouraged to make suggestions for improvement and had been listened to. For example, a staff member suggested finding suitable bags to carry people's clothes and possessions when they transferred to hospital. The idea was accepted and 10 bags had been purchased for this.

People benefited from a service where staff were happy, motivated and worked well as a team. Every staff member we spoke with praised the management and gave examples of how they felt the service had improved since the last inspection. One staff member told us, "Everything is so different; the atmosphere, culture, ethos and that resonates with the residents as well. Because we're not under stress with targets, staff are more relaxed, so there's no rushing and it's much more relaxed." A long-standing staff member told us the service was "the best it's ever been". They added: "There's been a big turnaround, 180 degrees. [The managers] listen to what we say and let us get on with the job. [The registered manager] is approachable and takes in what you're saying." The registered manager told us they were working with staff to help ensure they displayed the right attitude and took a team approach to supporting people. They said, "If you smile, they [people being supported] will smile." Staff told us managers promoted the ethos that staff worked in the people's home, as opposed to people living in the staff's work place. A staff member said, "I really believe that and [the managers] reinforce it all the time."

We observed a positive, open culture throughout the inspection and saw that staff spoke to each other and the registered manager with kindness and respect. Comments from staff included: "We have confidence in [the registered manager] and she has confidence in us. Staff feel more involved now. Morale is better and

there's a more relaxed atmosphere. We feel we can go and sit or sing with people without being nagged for not doing [tasks]"; "It's lovely here. It's not like going to work. We all get on well together and everyone is willing to help each other out, for example if shifts need covering"; "There's good team work, we're good at jollying each other when things are busy" and, "There's not a division now between days and night. We all work well together."

The registered manager told us they felt supported by the provider, who visited regularly. They said, "[The provider] is proactive. You only have to mention something and they are researching it and finding a solution." Staff also confirmed they felt the provider was visible and supportive. They commented, "[The provider] is great. She has made it clear that she is available to all of us if we need to contact her."

People were encouraged to provide feedback and become involved in the running of the service. For example, 'residents' meetings' were held regularly and suggestions made by people had been acted upon, such as requests for more vegetables and salad on the menus. During the inspection, we saw a residents' meeting taking place in the lounge, where people were welcomed encouraged to put forward their opinions and suggestions. Relatives' meetings were also held regularly and family members confirmed they were fully informed of what was going on within the service. A relative told us, "I receive a letter inviting me to family meetings. I try and go as often as I can." Furthermore, the registered manager told us that questionnaire surveys had recently been sent to staff, relatives and professional to provide their feedback.

The provider's performance rating from their last inspection was displayed in the entrance lobby. Visitors were welcomed any time and were able to come and go as they pleased. The provider notified CQC of all significant events and kept a record of all notifications sent, to track any patterns or trends. A duty of candour policy had been developed, and was being followed, to help ensure staff acted in an open and honest way when accidents occurred.

The service worked in partnership with the local authority, healthcare professionals and social services to help ensure that people received effective and safe care. Healthcare professionals described the positive relationships they had built with the registered manager and staff members for the benefit of the people living at the service. A professional commented, "The management are flexible and the communication is great." The registered manager told us about the work they had been involved in recently with the local authority, including the safeguarding forum, which enabled them with access to the latest guidance about protecting adults at risk of abuse. Community links had been developed which benefited people. For example, the registered manager spoke about the relationships they had built with the local church and a nursery school in the area, as well as a representative from a local Alzheimer's Society, who visited the service regularly to talk to people.