

Bupa Care Homes (ANS) Limited

Fountains Lodge Care Home

Inspection report

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23 March 2018

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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?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2018 and was unannounced.

Fountains Lodge 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.

Fountains Lodge Care Home is a purpose built detached building with the accommodation spread over two floors. Fountains Lodge Care Home is a dementia residential and a dementia nursing home. The ground floor provides support to people who require residential dementia care and the first floor provides support for people with nursing dementia care.

At our last inspection in June 2017, the service was rated Inadequate and placed in special measures. We asked the provider to take action and they sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breaches we found. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. At this inspection we found that all the breaches of regulation we previously found in relation to risks, medicines, safeguarding, quality monitoring, dignity and respect, and staff training and supervision had all been met and the service is no longer in special measures.

There was a registered manager employed at the service. 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.

Quality monitoring systems had been improved and implemented effectively so that shortfalls were being identified and acted upon. However, there were several vacancies in the service and we will need to be able to evidence that improvements can be sustained over time, and if and when the service admits new people. We have made a recommendation about this in our report.

People were being kept safe from abuse. Staff understood their responsibilities in keeping people safe from abuse and had been trained. Staff knew how to report any possible concerns. People were supported safely around risks and were encouraged to take positive risks after control measures were applied. Environmental risks were managed safely and there were protections in place in relation to possible hazards such as fire. Staffing levels met people's needs and people told us that they could find staff to help them when they needed to and we observed staff were not rushed when helping people.

People received their medicines safely and when they needed them by staff trained to administer them. Medicines were stored and managed safely. The risk from infection was reduced by effective assessments and cleaning rotas and the housekeeping team kept the home clean. When things went wrong the service

had learned from these and had shared that learning with staff.

People had received an holistic assessment of their needs and their needs were tracked through care plans to ensure effective outcomes were achieved. Staff had the necessary skills and competencies to support people and had been trained in key areas such as moving and handling, food safety as well as in additional areas that met people's needs, such as dementia training. Some staff supervisions recorded in 2017 were not of a high quality and although these had improved in 2018 we want to see this improvement sustained to ensure staff are supported adequately. We have made a recommendation about this in our report.

People received enough food and drink to maintain good health and they told us that they liked the food. Staff worked in partnership to provide consistent support when people moved to or from the service, or moved between the two floors of the service. People had access to healthcare professionals and were supported to maintain good health. Staff responded in a timely way when people were unwell and medical guidance was followed correctly.

The premises were suitable to meet people's needs and there had been changes made to the environment to meet the needs of people living with dementia. People were supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful, and the least restrictive option.

Staff treated people with kindness and compassion. Staff knew people's needs well and people told us they liked and valued their staff. People and their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to be as independent as safely possible.

There was a complaints policy and form, available to people. Staff were open to any complaints and understood that responding to people's concerns was a part of good care. People received a pain free and dignified death at the end of their lives. Staff supported people with compassion and worked with local hospice teams. People were supported in a personalised way that reflected their individual needs. However, some people's care plan documentation was not written in a way they could understand. We have made a recommendation about this in our report.

There was an open and inclusive culture that was implemented by the management team. People and staff spoke of a friendly and homely culture that was empowering. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice, and working with other professionals and local health providers to ensure partnership working resulted in good outcomes for people.

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 

Fountains Lodge Care Home was safe.

People felt safe and were protected from the risk of potential harm and abuse.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were consistently met.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated with learning fed back to staff.

Is the service effective?

Requires Improvement 

Fountains Lodge Care Home was not consistently effective.

Staff received effective training to meet people's needs but supervision was not consistently effective.

People received extensive assessments that ensured effective support outcomes were set and worked towards.

People were supported to eat and drink enough to maintain good health.

Staff members worked effectively with other agencies and organisations to ensure the care people received was effective.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice.

Is the service caring?

Good 

Fountains Lodge Care Home was caring.

People were supported by staff who were caring and respected their privacy and dignity.

People were involved in the development of their care plans and their personal preferences were recorded.

Staff had access to people's likes and personal histories and used the information to support people in a way that upheld their dignity and protected their privacy.

Is the service responsive?

Requires Improvement 

Fountains Lodge Care Home was not consistently responsive.

People's needs were assessed, recorded and reviewed but some care plans were not written in a way people could understand.

People received personalised care and were included in decisions about their care and support.

A complaints policy and procedure was in place and available to people.

People received a dignified and pain free death and could choose to stay at the service for the end of their life.

Is the service well-led?

Requires Improvement 

Fountains Lodge Care Home was not consistently well-led.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people. However, we need to evidence that this has been sustained over time and when more people are admitted to the service.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

Staff understood their responsibilities and knew who the management team were, and felt able to approach them.

The views of people and others were actively sought and acted on.

The service continuously learned and improved and staff were

given opportunity to progress.

The service worked effectively in partnership with other agencies.

Fountains Lodge Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 March 2018 and was unannounced. Four inspectors and an Expert by Experience carried out the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We did not ask the provider to complete a Provider Information Return (PIR) before this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the previous inspection reports and any 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 contacted the local safeguarding and commissioning teams for feedback before the inspection.

We spoke with the provider, the registered manager, three nurses, nine members of care staff and the cook. We looked at nine people's support plans and the associated risk assessments and guidance. We looked at a range of other records including five staff recruitment files, the staff induction records, training and supervision schedules, staff rotas and quality assurance surveys and audits.

During our inspection we spent time with the people using the service. We observed how people were supported and the activities they were engaged in. Some people were unable to tell us about their experiences of care. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We asked the registered manager to send additional information after the inspection visit, including staff training records, policies, and the staffing rota. The information we requested was sent to us in a timely manner.

Is the service safe?

Our findings

At our previous inspection in June 2017 the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that some people had not been protected from abuse, had restrictions imposed and received improper treatment. We served a warning notice on the provider and registered manager which told them what needed to improve and gave a date by which to make the improvements. At this inspection we found that people were protected from abuse, there were no unlawful restrictions to people and people were treated well and the breach had been met.

People were protected from abuse by staff who had been trained in safeguarding adults and understood their role in keeping people safe. Safeguarding alerts had been made appropriately to the local authority. There had been 16 safeguarding referrals made in the 12 months preceding our inspection. The registered manager had been pro-active and referred some incidents that did not meet the threshold for safeguarding. Each referral made had been tracked by the registered manager to record key details such as the type of incident and whether the allegation had been substantiated. The local authority safeguarding adults policy and protocol was available to staff and the registered provider had a safeguarding adults policy that was up to date and contained relevant information. There were posters and information sheets displayed within the service for relatives, visitors and people. During this inspection we did not observe any inappropriate restrictions being used to support people living with dementia. Staff supported people who may walk without purpose, with positive behaviour support techniques.

Unexplained marks and bruises were being managed safely and transparently. Where staff had seen unidentified bruising on people each mark or bruise had been clearly recorded using body maps and incident reports, and these had been investigated by a senior member of staff and reported appropriately. Staff understood and managed behaviours that may challenge and individuals were supported in line with best practice. De-escalation and distraction techniques were seen to be used effectively to reduce people's anxiety when they were disoriented to time and place. One person was becoming anxious about their spouse visiting the service, and was safely reassured when they became upset. The registered manager telephoned the spouse to ask them to visit the service earlier than usual due to their partner's distress. This was seen to be an effective strategy and the person was calmed by this intervention. Staff used observation charts that they completed following an incident and these records were used to review triggers and the management of behaviours.

At our previous inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that the provider had not ensured that people received care and treatment in a safe way; risks relating to people's care and support were not always adequately assessed or mitigated and medicines required on an 'as required' basis were not always recorded properly. We served a warning notice on the provider and registered manager which told them what needed to improve and gave a date by which to make the improvements. At this inspection we found that people received care in a safe way; risks relating to people's care had been safely assessed and mitigated; and all medicines had been recorded correctly and the breach had been met.

People were being protected against risks and action had been taken to prevent potential harm. Risk assessments were effective in mitigating any potential hazards. Falls were being managed safely. For each person there was a falls assessment that used a nationally recognised model to record falls in terms of day, time and location. There was also an aggregation function whereby each person's falls were analysed to determine any patterns. The service used a monthly falls tool kit that listed how many falls had occurred, what was their outcome, and confirmed any remedy. As a result of the analysis the service had increased one-to-one supervision at high risk times in the morning for one person and increased staff presence at meal times. These actions were confirmed by care staff to have been followed through in practice. We also reviewed examples of appropriate referrals to the falls clinic and to GPs for investigation of suspected medical conditions.

People who were at risk of their skin breaking down were having their needs met safely and the risks reduced through effective control measures. We saw care plans which contained information about people's skin integrity alongside the risk assessment to identify people's individual risk to pressure ulcers. Equipment used to minimise the risk of skin damage such as pressure relieving mattresses and cushions were checked daily by staff to ensure they were on the correct setting for the individual. We found all were correct and working.

People who required support to manage risks around their weight were supported appropriately. One person had lost weight and they had been referred to the dietician who discharged them after they had gained weight. The person was since being supported with a dietary supplement and was on a food and fluid intake chart and was being weighed monthly. Another person had lost weight and received input from the dietician during monthly visits. A Malnutrition Universal Screening Tool (MUST) had been completed, food and fluid charts were being used, and a daily fortified drink was put in place. MUST is a tool that identifies adults who are underweight and at risk of malnutrition, as well as those who are obese. The person showed a weight gain of five kilos and had sustained that gain over two months resulting in food charts and the fortified drink being removed. Staff at the service replaced these with homemade milkshakes twice a day between meals to sustain the person's weight and this had been proven to be beneficial.

Risk assessments were completed to reduce hazards around manual handling, Control of Substances Hazardous to Health (COSHH) and food safety. The fire risk assessment was effective and up to date. Fire drills were happening and records showed that this included night time drills when staffing levels were lower. Staff were aware that each person had a personal emergency evacuation plan (PEEP) for the risk level associated with evacuating people safely in the event of a fire. A PEEP gives details of the support each person would need to leave the service in the event of an emergency such as a fire.

There were sufficient staff deployed to keep people safe and meet their needs. At our previous inspection we noted that the dependency tool used to determine how many staff were needed to meet people's needs did not accurately reflect the assessed changes in people's needs. As a result the staffing levels were increased following our inspection. At this inspection we checked the tool against the rota and found that staffing levels continued to be consistent with the levels recommended by the dependency tool and that the score generated by the tool had reflected changes in people's needs. The dependency tool allocated a care band to a person based on their level of need and this automatically generated a set amount of hours. The registered manager held weekly meetings with the clinical services manager and unit manager (who each oversee one of the two floors in Fountains Lodge) to discuss people's needs. This meeting was used to feed back if people had deteriorated or if their banding on the dependency tool was not accurate. We observed that there were enough staff deployed to meet people's needs and to respond when people required assistance. One relative told us, "The staffing levels feel more comfortable and mum has definitely benefited from the current ratio." The management team had successfully reduced the amount of agency staff being

used through successful recruitment and offering incentives to current staff to stay. Where agency staff had been used we noted that the same staff were deployed to ensure consistency.

Safe recruitment processes had been followed and recruitment systems were robust. We checked the recruitment files for four members of staff. In each case thorough recruitment procedures were followed to check that staff were of suitable character to carry out their roles. Criminal records checks had been made through the Disclosure and Barring Service (DBS) and staff had not started working at the service until it had been established that they were suitable. The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered provider had consistently tracked the employment history of each newly recruited person to maintain the safety of the recruitment process. References had been taken up before staff members were appointed and were obtained from the most recent employer where possible.

Medicines were being managed, stored and administered safely. People's medicines were securely stored in a clinical room and they were administered by registered nurses who had received appropriate training and updates to ensure competency. We observed two separate medicine administration times and saw medicines were given safely to people and staff signed the medicine administration records (MAR) after administration. There was a clear audit trail that defined what action was taken following errors, such as medicine retraining and competency tests. There were systems to check that staff were following best practice in the management of medicines, including a document that staff signed after medicines were administered and when shifts changed. When necessary, medicine errors had been reported to the local authority and the registered manager had followed the guidance for the professional duty of candour. This meant it had been disclosed to the individual or their next of kin, an apology offered and an action plan discussed to prevent a recurrence. This ensured as far as possible lessons had been learnt. Controlled drugs (CD's) were kept in a locked cabinet in the locked medical room and the CD book had been audited accurately. Some prescription medicines are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs.

People who were prescribed as required medicines received them safely and risks associated with them had been managed well. There was clear advice on how to support people to take their medicines including 'as required' medicines, such as paracetamol. They gave clear guidance to guide staff in monitoring pain and in how to recognise pain symptoms; staff used the abbey pain chart and we saw that staff monitored the effectiveness of 'as required' medicines for symptom control.

People were being kept safe against the risk of infections by the prevention and control of infection hazards. The registered manager had completed an infection control audit every three months and there had been no outbreaks of infection in over a year. There was an outbreak management plan in place to coordinate response to infectious outbreaks and this had been signed by all staff to indicate they had read and understood the contents. The plan signposted staff to report any concerns to Health Protection England in order to keep people safe and to manage and respond to infections appropriately. There were effective cleaning rotas in place and housekeeping staff had kept the service clean and free from malodour. In bedrooms, communal toilets and bathrooms there was suitable provision for hand washing including dispensable soap and paper towels. Staff were seen to be using and disposing of personal protective equipment in the correct way. People were seen to be wearing clean clothes and were clean in their person. At lunch a person was seen to have spilt food down their blouse. It was noticed that when the inspector saw them half an hour later the blouse had been changed.

Lessons had been learned when things went wrong in the service. Any accidents or incidents had been recorded, investigated and tracked by the registered manager. Any learning had been shared initially with

staff at the '10 at 10' meeting every morning. This was a 10 minute meeting where all staff including, kitchen and housekeeping staff, met to discuss any developments, news, or plans for the day. We reviewed recent incident reports relating to medicines errors and saw that the errors had been identified by internal audits and reported openly, investigated thoroughly and action taken promptly. Learning from these incidents had resulted in a protected medicines round at meal times where the staff member giving medicines to people was not interrupted or asked to do other tasks. Medicines administration was also spread throughout the day so that the morning round was not so busy. The registered manager told us, "We identified issues and had a big staff meeting with nurses and senior carers and asked if anything was affecting the process [of administering medicines]. Staff came up with the idea of phone calls being diverted to the manager during meds round so there was no disruption."

Is the service effective?

Our findings

At our previous inspection in June 2017 the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that not all staff had received training related to people's needs and not all staff had received regular supervision and appraisal. At this inspection we found that staff had received appropriate training, supervision, induction (including for agency staff) and appraisal and the breach had been met.

Staff members had appropriate skills, knowledge and experience to deliver effective support to people. One person said, "The staff know how to look after people and have been trained well: no doubts at all." One relative told us, "The staff know not to try and change mums blouse [if it is dirty] when this will upset her, and when to come back later to do it." Staff had received training in key areas in order to carry out their role. For example, we checked how many staff had been trained in safeguarding adults and 96% of staff had received this training. There were similarly high rates of training for other courses such as behaviour that challenges and dementia. Staff had been trained in courses to meet people's specific needs at Fountains Lodge. Staff had been trained in a dementia essentials course which was delivered face to face and were able to demonstrate a better understanding of the needs of people living with dementia. The registered manager had arranged additional 'person first dementia second' training that was more advanced and had booked all nurses, the care services manager and all senior carers on the course. The registered manager told us that all staff would be trained in this advanced dementia course in six months' time. Nurses were supported to keep up to date with their professional practice and to obtain re-validation. Nursing staff had been put on additional training courses such as in venepuncture (drawing blood from patients).

Staff had been supported with supervisions and appraisals that now met the provider's policy on how often staff should be supervised. Supervision is a structured meeting with a line manager to discuss work and practice. Appraisals and supervisions had been tracked by the registered manager and staff had received an annual appraisal of their performance. We reviewed four people's supervisions and found that some supervisions conducted in 2017 since our previous inspection were vague, reactive and lacking in structure. Supervisions that had been more recently conducted were effective. We raised this with the registered manager who told us, "The supervisions from last year may have been a bit vague and in response to an issue rather than supportive."

We recommend that the registered manager supervises staff to a consistently high level.

At our previous inspection the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that the provider had not ensured that people received care and treatment in a safe way and that action was not always taken promptly in relation to people's health needs and guidance from professionals was not always followed. We served a warning notice on the provider and registered manager which told them what needed to improve and gave a date by which to make the improvements. At this inspection we found that people received safe care and support; action was taken promptly to meet people's needs; guidance from professionals had been followed and the breach had been met.

People had been supported to live healthy lives and had access to health and social care professionals. People at risk of developing pressure wounds had received appropriate care. One person at risk of skin breakdown had a Waterlow assessment in place that had been completed accurately. A Waterlow assessment is a tool that gives an estimated risk for the development of a pressure sore in a given patient. Where any marks to skin were noted they were recorded on body maps and photographs were taken to document the potential wounds. There were mental health plans in place to support people living with dementia or anxiety. These contained clear guidelines for staff to follow to reduce demands made of people and alleviate their anxiety. Guidance from professionals had been followed by staff. One person had lost weight and had been referred to the dietician. There was an eating and drinking care plan in place and this referenced advice from the dietician. We observed that the advice was followed in practice by the staff team during two meal services. People had access to a GP, dentist and an optician and could attend appointments when required. Care plans demonstrated that a wide range of professionals were involved in people's care. We reviewed one care plan and saw that the person had been seen by healthcare professionals eight times in the previous three months.

At our previous inspection we made a recommendation that the provider reviewed their documentation for recording mental capacity assessments, to ensure that they follow the principles of the Mental Capacity Act 2005 (MCA). At this inspection we found that action had been taken and the principles of the MCA had been adhered to.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. People were being asked their consent via consent forms in care plans for issues such as sharing of information with other health professionals. Where people could not consent mental capacity assessments and best interest decision meetings were carried out. One person at risk of malnutrition was being weighed but the person did not recognise they were at risk and did not want to engage with professionals, or strategies, to maintain a healthy weight. The registered manager arranged a MCA assessment and the person was found to lack capacity around this decision, and a best interest meeting with the presence of medical professionals and family was held. All parties agreed that a referral was to be made to the dietician in the person's best interest and this decision was reviewed monthly. People had been referred to the local DoLS office appropriately.

People's needs were assessed and their care was planned to ensure their needs were met. There were holistic assessments of people's needs prior to a service being provided. There was good use of nationally recognised assessment and management tools including for pressure wounds, malnutrition, pain management and wound care. The care plans were seen to have been reviewed at least monthly and the progress notes were sequential, detailed and signed by their authors. In each person's file there was a section that gave background information such as their current family members and their contact details, their past occupations, where they lived and their present interests. There was also information about their preferences such as the time of going to bed, preferred meals and the gender of care staff to attend them. Although we could not find information about protected characteristics, the care services manager described how issues such as ethnicity and sexual lifestyle choices were assessed at admission.

People had been supported to eat and drink enough to maintain a balanced diet and good health. People at risk of malnutrition or dehydration had their food and fluid intake monitored with food and fluid charts, and these had been completed accurately. At mealtimes we observed that food was presented well and people were shown examples of each meal plated up to help them choose between the two main options for the first course. There was a desert prepared by the kitchen and the choice of ice cream if people preferred. Trays were seen to be taken to people dining in their bedrooms and these were covered with plate protectors and the trays were neatly laid out to encourage people to eat. We observed that people in their bedrooms who required support to eat their meals were supported well and without delay. People with complex needs in relation to their eating and drinking had these identified and managed well. There were choking assessments completed and dietary supplements, fluid thickeners, and fortifications were seen to be in use.

Staff worked together to ensure that people received consistent and person-centred support when they moved from or were referred to the service. Pre-admission assessments were previously conducted at people's homes, but the registered manager preferred to now invite people to come to the service so they got a more accurate assessment and observed what the person was like outside their usual environment. If people were transferred to hospital, the person was sent with all their medicines. There was transfer documentation which held information such as allergies, medical history, capacity, mobility, any injuries, what jewellery people may be wearing, if they had epilepsy, their current weight, and whether the person was prescribed warfarin. A manager would ensure that the next of kin was contacted to inform them and also ensure that medicines charts and any instructions on resuscitation were sent. When accepting new people to the service a manager would ensure a discharge summary was sent from the hospital or care setting and check medicines had been returned and any changes were reflected in paperwork.

People's needs were met by the adaptation, design and decoration of the premises. The service was well decorated, with good lighting and wide corridors. People chose the lay out of their own rooms. Some communal areas had televisions and one had a radio playing. There was 1960's music was playing on the radio on one floor and staff were singing along to the songs with the residents. Lighting in the service was well thought out and had been adapted to make it easier for people to walk around corridors at night time.

People had glass boxes outside their rooms which contained personal items and photos that helped people living with dementia to orient themselves to their own room. On the nursing floor residents had thought the soft furniture in communal areas belonged to people, so didn't use them to sit on. The registered manager changed the soft furnishing to garden furniture and people were now sat on these chairs. There were cardigans, handbags and bags hanging up in communal areas for people living with dementia to pick up and use if they were distressed at misplacing their own belongings. People had made pictures of flowers and other decorations to put on the glass in doors to prevent people walking into them. Some renovation work had been done to the garden to ensure that it was accessible to people in wheelchairs. We observed people walking in the garden. People did all the gardening in raised beds as they wanted to garden and had asked to do it.

Is the service caring?

Our findings

At our previous inspection in June 2017 the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that people were not always treated with respect or dignity. At this inspection we found that staff supported people in a way that was respectful and upheld their dignity and the breach had been met.

People's privacy, dignity and independence was respected and promoted by staff. Personal care was delivered in private in people's bedrooms and communal toilets with the doors being closed. When staff used the mobile hoist they ensured that people were covered in order to protect the dignity of people wearing skirts or dresses. There were suitable arrangements to promote independence in that staff enabled people to do things for themselves. Before mealtimes people were offered the chance to wash and dry their hands with clean wipes and people drinking from plastic beakers were offered a 'proper glass' where it was safe to do so. At lunchtime one person ate very slowly but liked to do this without assistance. Half way through the meal care staff asked the person if they would like some more and hotter chips so they could enjoy the rest of their meal and these were then brought to the person.

Files that contained confidential information were seen to be kept locked away and computers were password protected. There was a computer back up system. A relative recounted how a care worker had questioned whether a private consultant should be in the room while her father received personal care. The relative considered this to have been a brave and appropriate thing for the member of staff to have done. One staff member told us, "I try to treat people with dignity, like covering them with a towel. I'll ask if they want a wash and say, 'I can do your back, why don't you try the rest. You can choose what you wear.' People can do it with a bit of prompting and guidance. Half the time I get as soaked as they do but that's part of the fun of the job, helping people be independent."

People were treated with kindness and compassion in their day to day care. People and their relatives told us that staff were caring. One person told us, ""All staff are very attentive: they don't make people wait. This home is the best you are going to get. It is the staff that make it." One relative commented, "The staff are the model of kindness. I've called here many times and the staff are just genuinely kind people and this is the right place for my family member." Another relative said, "I call every day to see my wife and I can see that she's well cared for. The staff know her and her ways and nothing is too much trouble for them."

Staff were observed throughout our inspection to be supporting people with good humour, warmth and genuine affection. One person who was living with dementia was not eating their breakfast and looked confused about the food or what was expected of them. A staff member came and sat with the person, held their hand and started whispering in their ear. The person started laughing and the staff began dancing in their chair to the music and encouraging the person to do the same. After a while the staff encouraged the person to eat their breakfast, which they did. Shortly after a nurse walked by and said in a very positive tone, "Well done! That's what I want to see: you eating your food." The person smiled at this and finished their meal. We checked the person's care plan and saw they were at risk of malnutrition; without this attentive support the person would most likely not have eaten their breakfast.

People's relatives told us that staff went the extra mile to support people. One relative told us that a staff member had gone home after promising to give one lady a manicure. As the staff had made a promise, they got in their car and returned to work to do the manicure as agreed. Another relative told us about their mother's birthday. They had wanted a small family get together at the home and as the celebration room was already reserved they just decided to have a small gathering in their mother's room. When they got to the home staff had decorated a sitting area with bunting, balloons and then took photos of the event which they framed and placed in the person's room as a reminder of the party. A third relative commented, "It's the little things; they will always make dad milkshakes which he loves, and make sure he gets to watch the football. They are fantastic and know him so well."

People were supported to express their views and be involved in decisions around their care. There were regular 'residents and relatives' meetings. The registered manager explained to us that the frequency of these meetings had changed recently from every fortnight to once a month as people's confidence in the nursing floor increased. We reviewed the minutes of two meetings and several different areas concerning the service had been discussed openly with people free to make suggestions and requests. For example, some people had mentioned that the gardens were not as tidy or welcoming as they could be and that some areas of the service required attention such as pelmets on curtains and had requested the registered manager addresses this. These issues had been swiftly addressed by the provider.

Staff recognised when they needed to support people, particularly when they were displaying signs of distress. One person became distressed and staff were with them immediately. They spoke quietly to the person and knew why the person sometimes got upset. Staff found that if they sat with the person and talk about their family then they calmed down. Another person was struggling to reach all of their food, so staff turned the plate around so the meat the person could not reach was presented at the front. Another person had already had their meat chopped up but was experiencing problems eating. A staff member said, "Are you happy for me to give you a hand? I'll be your hands. Don't worry, you had a good go. I'll help you." Most people on the first floor had relatives and friends involved in their care. Two people had a solicitor involved and there were suitable arrangements to comply with lasting power of attorney's (LPA's) as this provision was recorded on the people's preadmission assessments and care plans. The management team were aware of who had an LPA provision and the detail of this in terms of whether it related to finance and/or health and welfare. None of the people living at the service had an advocate but there was information displayed about advocacy services and the management team knew about how to access advocacy services.

Information was explained to people in practical terms using objects of reference and delivered at a pace that was appropriate for their individual abilities to manage it. There was a religious service held in the home each month and there was evidence in the preadmission assessment to show that spiritual needs were considered at that point. There was also other evidence in the pre-admission assessment to show that Equality Diversity and Human Rights (EDHR) and issues around people's sexuality were identified. There was an EDHR policy and procedure and care staff confirmed that the subject was included in their induction training. People's relatives and visitors were able to freely visit the service and were encouraged to spend time with people including at mealtimes.

Is the service responsive?

Our findings

At our previous inspection in June 2017 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that the registered manager and the provider had failed to maintain accurate and complete records in relation to each person. We served a warning notice on the provider and registered manager which told them what needed to improve and gave a date by which to make the improvements. At this inspection we found that people had care plans that contained accurate contemporaneous information and the breach had been met.

People received person centred care and care plans contained personalised information. We saw detailed plans which told staff how to meet people's individual needs. For example, continence care was identified and a plan of action for staff to follow was in place. People's continence needs were explained in 'going to the toilet' care plans that identified the exact support each person required on a day to day basis as well as the support they needed when they were incontinent. This detailed what type of incontinence aid was to be used what to say to the person if they were upset following incontinence, and people's preference for the gender of the care staff. We observed throughout our inspection that people were supported to use the toilet in a dignified and responsive way. For example, one person was trying to stand from their seat in the dining room. Staff quickly established that the person needed to use the toilet and may have been incontinent. Two staff very discreetly and quietly assisted the person to the toilet and supported them to return to the dining room clean and fresh. The support was done in a tactful way so that no other people were aware of the person's needs.

People living with dementia had their needs planned for. One person living with dementia had very limited speech, was frequently not oriented to place or time and had previously displayed behaviours that challenged others, including physical aggression towards staff. The person's care plan had identified a brief trigger point where the person would be seen to look physically different with heightened anxiety and increased vocalisations. By being aware of this presentation staff had learnt to distract the person and incidents and altercations had been better managed. It was identified that the person liked to walk, so staff removed them to another part of the home through walking. By supporting the person in this way staff had not had to use any form of physical restraint. Another person living with dementia had several incidents involving going into other people's rooms. As a result the registered manager spoke to the person's family and found out the colour of their old front door and painted the door to their room the same colour. This resulted in the person becoming oriented to place and not mistakenly going in to other peoples' rooms.

The service was not meeting the accessible information standard and some people's care plan documentation was not written in a way they could understand. There was no evidence to show that people were actively involved in the review of their care plans other than staff taking into account their observed reactions to the care they had received. The care plans were written in a standard format only with no use of multimedia tools. The font used was very small and the management team accepted that more needed to be done to increase the accessibility of information in the care planning and review paperwork. The registered manager said that pre-admission assessment and review paperwork largely depended upon

consultation with people's relatives. The management team acknowledged that most people on the ground floor and at least some of the people on the nursing floor could be engaged more if information was presented in a more accessible way. For example, the menu displayed on the nursing floor, the list of activities and the complaints procedure were all presented in small print and standard format. All care staff we spoke to about this accepted this was largely inaccessible to many people.

We recommend that the registered provider reviews their approach to compliance with the accessible information standard.

At our previous inspection we made a recommendation that the provider review the activities programme to ensure it met the needs of people living with dementia. At this inspection we found that action had been taken and the activities programme was varied and met the needs of people living with dementia.

The service employed three activities coordinators, including an activities coordinator working at weekends to ensure people had meaningful occupation. There was a monthly planner that showed that a range of activities took place both in house with the coordinators and through external entertainers who called at least twice a month. We saw evidence of both small group and one to one activities. The small group activities seen included a quiz and word game and also singing and gentle exercises. There were also morning sessions where one of the activities coordinators read from the daily newspaper and led a discussion about world events. Activities had been organised responsively when needed. We reviewed the care plan for one person and saw that their hobbies and interests had been identified as gardening, TV, films, music and walking. The person's daughter had contacted the registered manager to state that their mother seemed tearful and requested if staff could support the person to go out of the service. The next day there was a response from the registered manager stating they would ask the activities coordinator to speak to the person and the person was promptly taken to a garden centre and had photos taken to share with their family.

A number of person centred events were seen where people received individual assistance from an activities coordinator. One involved a person with contracted hands having their nails cut one by one with the coordinators carefully explaining what they were doing and offering choices about whether to apply a nail polish. There had been three trips out to local places of interest during summer 2017 and more were planned for 2018. There was a normal range of celebratory activities at Easter and Christmas and birthday arrangements included the person receiving a card and a gift from the service. We observed another activity session where songs from musicals were being played in the background whilst sensory objects were passed around. People seemed to know and recognise staff and most people smiled as the activities coordinator interacted with each person in turn. The staff knew people very well and told us what they liked doing and the music they loved to listen to. There was a very calm and gentle atmosphere.

At our previous inspection we made a recommendation that the provider follow their complaints procedure and ensure all complaints were recorded and responded to appropriately. At this inspection we found that action had been taken and the complaints had been recorded, responded to and used as a means of improving the service.

There was a complaint handling policy that allocated tasks to be completed based on a risk assessed traffic light system. The registered manager told us that they managed all complaints in the first instance, but that some higher rated items had to be signed off by a nominated senior manager. All complaints, incidents and safeguarding alerts had to be entered onto the provider's electronic recording system. There was also a paper tracker kept by the registered manager that listed the status of the investigation of each complaint. Each complaint then had all of its papers collected in a wallet that sat behind the tracker. The system was

organised and well recorded. The entries showed that suitable steps had been taken to investigate individual complaints including reviewing written care records, observations and interviews with staff. The registered manager was sharing information appropriately with the local authority safeguarding adults team: a safeguarding referral had been made for the most recent complaint that concerned unexplained bruising. In each complaint there was evidence that the 28 day timescale for any initial response had been met and that each complaint had been concluded with a polite letter from the provider to the complainants.

People were supported to have a pain free, comfortable and dignified death. We reviewed the care plan for one person who was receiving palliative care near the end of their life. Palliative care is any care or treatment to relieve pain without dealing with the cause of the condition. The person had a do not attempt resuscitation (DNAR) notice in place that had been completed by their GP. DNAR stands for Do Not Attempt Resuscitation. A DNAR form is a document issued and signed by a doctor, which instructs medical teams not to attempt cardiopulmonary resuscitation (resuscitation after a heart attack). They had been seen by a wide range of medical professionals including the hospice team and a palliative care nurse who attended with the GP. The person was being nursed in bed but staff asked regularly if the person would like to sit in their chair when feeling up to it. Most recently, daily notes said, "[Name] was bright and cheerful, putting their legs out of the bed. Asked if they would like to sit in chair. Big smile and said yes." The care plan had been reviewed regularly and had noted the need for repositioning every three hours to protect their skin, which had been done.

People's preferences and choices for their end of life care and where they wished to die, were clearly recorded, kept under review and acted on. People were able to record their future wishes and plans in a future decisions booklet. This booklet set out a person's next of kin, whether anyone held a lasting power of attorney, whether there was an advance decision or living will in place, whether there were any other relatives or friends that the person wanted involved in their care, anyone the person did not want involved in their care and whether any advocates were involved. The plan also set out if people had any plans in the last year of their lives, such as places or people they would like to see or things they would like to do. There were also plans for where people would like to be cared for when they became unwell and if there were any treatment decisions they would or wouldn't want. People were encouraged to think about their final days and whether they would like a priest or religious minister to visit them, or if there were any important objects they would want to have. Choices were set out for any arrangements after people had died such as whether they wanted to consider organ donation, what type of burial or cremation they would like and what funeral service they had planned, including preferred funeral directors.

Is the service well-led?

Our findings

At our previous inspection in June 2017 the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. We found that the provider and registered manager had failed to establish and operate systems to assess, monitor and improve the quality and safety of the services provided, had failed to maintain accurate and complete records, did not provide adequate support to staff, and not all risks had been assessed and mitigated. We served a warning notice on the provider and registered manager which told them what needed to improve and gave a date by which to make the improvements. At this inspection we found that systems to monitor and improve the quality of service had been implemented; records were complete and contemporaneous; staff were well supported, and risks had been assessed and mitigated, and the breach had been met. However, we need to see evidence that the improvement has been embedded and sustained.

Staff were being supported well by the registered manager and no longer found that high agency usage was making it difficult to provide good quality care. One staff member told us, "At the last inspection things were dire. There were vacant posts, people were off sick, and agency were brought in who didn't know the home. Since then it's much better; there is a more settled staff team, much less agency use and [managers] are just lovely. Morale is one hundred per cent better." One relative told us, "[Manager] has done an amazing job of motivating the staff team following the last inspection." Staff were reporting concerns and issues promptly to the registered manager and this was being reviewed in daily and weekly audit checks.

Risks were being managed safely through sensible control measures and there was now an effective falls analysis in place. The falls analysis toolkit had identified where a person had three falls and implemented an individual toolkit for that person. This tries to find out the reason for the falls and looks at the location, time and whether the fall was witnessed amongst other criteria. The falls analysis had identified a high number of falls in corridors so the registered manager trialled different lighting on one floor and saw a significant reduction in falls and rolled the new lighting out across the building. Other risks had been similarly well managed.

There was a comprehensive system of audits checks on a daily, weekly, monthly and three monthly basis. An example of a daily audit was the clinical daily walk around forms. These forms were completed by care staff to capture a picture of how each person was and any changing or new needs people may have had. The forms were given to the unit manager or care services manager to check before being audited and sample checked by the registered manager as part of the daily morning meeting at 10 am. Weekly audits, such as the audit carried out after the clinical risk meeting, were part of the heads of department meeting where all senior staff discussed the entire service, covering areas like, pre-admissions assessments, recent admissions, wound management and any trends developing i.e. infections. The audit generated from this meeting was spot checked by the registered manager to ensure the information was up to date and relevant. We noted positive actions and outcomes from the weekly clinical risk meeting audit. For example, it had been noted that for people not eating enough, yellow plates had been trialled and proven to be successful in increasing people's food intake. This was because staff knew that if someone was eating from a yellow plate they need extra help and encouragement to eat their meal. This scheme resulted in people who

were at risk of malnourishment putting on weight. Monthly audits, such as care plans reviews ensured that 10% of care plans were reviewed every month as a minimum target. The management team carried out these audits and then cross checked each other's work to make sure care plans were accurate and up to date. Senior staff had been given extra time off the rota to complete the review and audit of care plans and sections that were out of date, such as medical histories, had all been updated.

During our inspection we had noted a significant improvement in the governance of the service and we discussed sustainability of quality systems with the registered manager. The registered manager told us, "I have been careful to make changes in a sustainable way. When we fixed the care plans it wasn't a specialist BUPA team or senior managers, it was our staff learning, writing and re-writing the plans so we know what we're doing." We discussed the staffing levels and whether increasing the occupancy rate in the service would lead to a drop in quality and were told by the registered manager, "I staff the home safely and with the unit manager and care services manager we decide if we can manage another admission. If occupancy levels increase staffing levels will increase. I have been granted the budget for care staff to increase as we change occupancy and the increase will be in permanent staff."

We recommend that the registered manager keeps the staffing levels under review.

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that all incidents that had met the threshold for Duty of Candour had been reported to people's relatives. The registered manager was given good support from their line manager who supervised and appraised their performance and oversaw quality monitoring with the registered manager. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be informed of our judgements. The provider had displayed the rating conspicuously in the service.

There was an open and inclusive culture in the service. The registered manager kept under review the day-to-day culture in the service, including the attitudes and behaviour of staff. The registered manager was a visible presence in the service and role modelled positive support to staff. One relative commented, "[Manager] does look for staff that care. They have handpicked staff for their values." The registered manager attended every induction training to get to know new staff and to ensure that they got to know and were confident speaking to the manager. The registered manager described the culture in the service as, "It is homely and we try to make it a bright energetic home. Where it is appropriate we encourage physical contact with people to show we care." The registered manager had enacted a culture change in the service and had challenged staff on a number of areas such as wearing correct uniforms and not wearing jewellery. The management team had used performance management and the disciplinary procedure to change staff attitude as well as extra supervisions and listening more to staff.

The registered manager understood their responsibilities and was well supported by the provider and the senior management team. The provider had made available resources through their service improvement team. The registered manager was given support with recruitment and all salaries were increased which resulted in better staff retention. The registered manager also introduced care bandings so that staff could progress depending on their experience. The staff team understood their responsibilities and what was expected of them. The registered manager commented, "The staff have been trained that filling in a form is

not the end of reporting. They understand that if someone falls they fill a form but action happens as well. We are getting staff to think about what they are doing, and where they belong in our quality delivery, and the staff have been really positive."

People, their families and staff members were involved in the service and regular feedback was sought through meetings and questionnaires. The registered provider had sent out quality questionnaires to people, their relatives and to staff and the feedback was very positive. Staff reported feeling positive about the service. Staff were actively involved in running the service and were encouraged to suggest new ways of working. Staff meetings had resulted in suggestions, such as not organising big days out for people and instead doing smaller trips and these had been trialled and implemented as they had proven successful. Staff had also raised that personal care was being rushed in order to get people to the dining room for breakfast so suggested a breakfast in bed trial, for people who wanted it. This was implemented after proving popular with some people and reducing the amount of people who requested personal care at peak times leaving people who wanted to go to the dining room for breakfast to have more time for their personal care. The service had developed strong links with the local community including a local garden centre and a pub. The staff at the pub had shown consideration to people with support needs and staff who supported people to the pub did not wear a uniform so that there was no visible barrier between people and care workers. Staff were supported to question their and others' practice and any staff that raised concerns were supported and protected. The whistle blowing policy was on display in several places around the service. One staff member had reported an issue via whistle blowing and the providers' procedure was followed and the matter investigated fully and transparently.

The service was continuously learning and improving and learning was shared with staff members. Information from incidents, investigations and complaints were used by the registered manager to improve learning and to drive up quality. We reviewed several incidents with the registered manager and discussed how learning had been identified, shared with staff and improved services. Following a series of incidents the registered manager had identified that the service was not set up to safely deal with violent conduct and had identified that people whose needs changed would not automatically be moved from the ground floor to the top floor, but would be individually assessed and if necessary referred to other specialist services. There had been a recent number of cases where people had been transferred from hospital stays with pressure wounds to their skin. Following a review of these incidents it was decided that anyone who had been in hospital for five days or more would be body mapped and weighed upon their return to promptly identify any issues with skin integrity or malnourishment. This learning was escalated to staff through staff meetings and the daily 10 at 10 meetings. Information technology systems were used to effectively monitor and improve the quality of care. For example, call bell logs were audited by the registered manager to identify any calls that were not answered within four minutes. Where these longer response times had been noted staff involved had been asked to debrief with their line manager to find out what caused the delay and to let staff know their response times were being monitored.

The registered manager had a good working relationship with the local services and was working effectively in partnership with key organisations. The registered manager described a close working relationship with the local authority safeguarding adults team and told us that they had received good support and advice from the team. Relationships with local GP surgeries were now positive and staff at the service were communicating well and reporting concerns appropriately. There was a monthly meeting between the management team and GP's and the registered manager told us, "It is now a positive working relationship. The GP surgery has taken on a pharmacist and they will be coming to review people and review a medicines round." The local NHS commissioning team were visiting to review people and the service was working in partnership with them to meet people's needs. There were close links to local health teams such as physiotherapy, occupational therapy and dieticians. The service had been sharing appropriate information

and assessments with other relevant agencies. The registered manager and provider were aware of the changes to data protection coming in to force and there was a strategy in place to ensure compliance with the changes.