CEL Care Services Limited

Felix Holme RCH

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

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

Felix Holme is situated in Eastbourne and provides accommodation and personal care for up to twenty older people. Some people lived at the home whilst others were there for short stays, otherwise known as respite. There were 14 people using the service at the time of inspection; 12 living there and two staying for respite. This is the first rating under the new provider, however the management structure remains the same in the service.

Bedrooms are located over three floors and can be accessed via stairs. Communal bathrooms and toilet facilities are available throughout. There are several communal areas; a dining room, main lounge and quiet lounge. A front garden contains a seating area which we observed people sitting in during inspection.

The service had a registered manager. '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.' There was also a Head of Care who is being trained to be the registered manager and was therefore an integral part of the inspection. For the purposes of this report, the head of care will be referred to as the trainee manager.

The provider did not demonstrate safe practises with regard to fire safety. There were no clear protocols or evacuation plans for supporting people in an emergency and actions identified in a previous Fire Safety report had not been completed. The information on the main handover form regarding support that people required in a fire was also inaccurate. We saw that weekly fire tests were carried out however the service was not completing fire drills. On the second day of inspection, these concerns had already been addressed and fire protocols were much clearer.

Overall medicines were managed safely and staff observed to be professional when supporting people. However there were aspects of giving people 'as required' medication that needed further clarification to ensure they were effective for people. Staff were also not consistently receiving medication competencies to ensure that they were giving people their medicines safely. On the second day of inspection, the trainee manager had sought guidance for what was required and documentation had been improved. The provider also had an action plan for ensuring medicine competencies would be completed in a timely manner.

Staff told us that they received a wide variety of training and people and their relatives were equally confident that staff had the right skills and knowledge to support people effectively. However, records for staff failed to identify whether they had received training and when it was due for renewal. Certificates used to inform this process were either missing or lacked dates for completion which made it difficult for the

registered manager to have clear over sight on whether staff have the skills and knowledge to support people. Since the inspection, we have seen some improvements to the training records.

Staff had the opportunity to meet with their manager's for supervision and had regular staff meetings where they could discuss any concerns.

People were not consistently given opportunities to engage in a variety of social activities. There were limited activities on offer during our visits. Some people were independent in going out or happy to partake in their own activities, however other people and relatives felt more could be on offer. The registered manager acknowledged that activities offered could be better and has since identified actions to improve this.

The registered manager and trainee manager told us that they regularly assess the quality of the service by auditing and reviewing. However areas where records were inaccurate or issues identified during inspection were missed, suggests the auditing process was not always effective. Quality audits that we did see were detailed and in-depth however the trainee manager was not always able to complete them. It was acknowledged that delegation of tasks was important to ensure responsibility did not fall on one person. The provider also has plans to 'up-skill' staff so that they can take responsibility for people's support plans.

Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People and their relatives spoke highly of the staff team who demonstrated their understanding of people's preferences dislikes and support needs. Staff also felt supported and cared for by their manager's and employer's. However encouraging people's independence and setting personal goals was not always identified, particularly for those people on respite.

Staff had a clear understanding on how to safeguard people and protect their health and well-being. Risk's for people were identified in their support plans and actions taken to minimalize this risk. There were sufficient numbers of suitable staff to ensure peoples safety.

We saw that staff had access to Personal Protective Equipment (PPE) to minimalize the risk of cross infection. We observed staff using PPE regularly throughout inspection.

The registered manager, trainee manager and staff had a good understanding of the Mental Capacity Act and how to promote choice in decision making. People at Felix Holme were mostly independent and able to make decisions about their care and safety. Regardless of this, the registered manager and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

People's nutritional needs were met. People told us that they enjoyed the food and that there was a lot of choice with meals. Any risks that were identified for eating and drinking were highlighted in care plans and also displayed in the kitchen.

Records showed that the provider sought guidance from health professionals where additional support needs were identified. A health professional spoke highly of the service and felt they were responsive to people's changing needs. Care plans were tailored to individual's and highlighted areas where additional support was required.

People, their relatives and staff spoke highly of the management team and felt that an open, transparent and supportive culture was promoted. Staff felt that good practise was recognised and celebrated, which

meant they felt valued by the provider.

Further information is in the detailed findings below

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

There was not a clear fire protocol in place and people did not have Personal Emergency Evacuation Plans to ensure their safe evacuation in the event of a fire.

More detailed information was required to ensure that 'as required' medicines were administered efficiently.

Recruitment practises were safe.

Staff demonstrated good understanding of safeguarding processes and knew the procedure to follow for suspected abuse.

People had risk assessments that were task specific and reviewed regularly.

Is the service effective?

Good

The service was effective.

People and their relatives were confident that staff had the skills and knowledge to support their needs.

Staff felt that the service provided a good induction and training programme which gave them the right skills and knowledge to support people.

People were supported to have good nutrition and were involved in choosing what they wanted to eat and drink.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).People are supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible

Is the service caring?

Good

The service was caring.

People and their relatives were confident that staff knew them and their support needs.

Staff were kind and considerate in their interactions with people.

People had their privacy and dignity respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always provided with a range of activities to ensure their social stimulation and well-being.

Each person had a care plan tailored to their individual needs, wishes and preferences.

The provider sought support from healthcare and other professionals in response to any changes in People's support.

Staff, People and their relatives were knowledgeable about the complaints process and felt comfortable raising any issues.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality audits were not consistently completed and incomplete or poor records were not identified.

Roles and responsibilities were not fairly distributed and therefore work was not always being completed.

The training plan and staff certificates failed to identify if staff had received up to date training.

People, staff and relatives spoke positively about the management team and felt well supported.

Felix Holme RCH

Detailed findings

Background to this inspection

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

The inspection took place on the 2 November 2017 and was undertaken by 2 inspectors. This visit was unannounced. A 2nd inspection day took place on the 8 November 2017 and was announced to the Provider.

Before the inspection, we checked the information we held about the service and provider. This included previous inspection reports and any statutory notifications sent to us by the registered manager. A notification is information about important events which the service is required to send to us by law. We also viewed online care home review sites and comments made on social media about the service.

As the provider's legal entity had changed since their last inspection, they were not asked to complete a Provider Information Return (PIR) on this occasion. 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.

On the days of inspection we observed people in their day to day activities. We also walked around the building to ensure that it was a clean and safe place to live. We spoke with eight people, four staff and five relatives about their experiences. We spent time reviewing records, which included six care plans, five staff files and medicine administration records, staff rotas and training records. Other documentation that related to the management of the service such as policies and procedures, complaints, compliments, accidents and incidents were viewed. We also 'pathway tracked' the care for some people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care.

Following inspection we talked to a health professional that has had reoccurring involvement in supporting people who lived at Felix Holme. We also sought feedback about the service from the Quality Monitoring Team who work with the Local Authority.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at Felix Holme. One person said, "I feel safe and I know I can talk to staff if I have a problem" and another, "I came here because I was not safe at home, now I'm safe and well looked after." People confirmed that call bells are always answered and that helps them feel safe. "I ring and staff come. I'm safe here." Relatives also told us that they felt confident that the service provided a safe environment for their family. One relative said, "There is really good care here, I know mum is safe."

Despite this positive feedback we found some practice that was not safe.

The service had a fire risk assessment which was completed in January 2016 and reviewed in July 2017 by the Director of the company. There were various actions to be completed following the risk assessment; this included identifying Personal Emergency Evacuation Plans (PEEPS), ensuring staffing levels were sufficient to facilitate the movement of people to safety and that an evacuation strategy was fully detailed in the emergency plan. On the first day of inspection, we could see that these actions had not been completed, despite being signed off as so.

People did not have PEEPS which meant that staff and emergency services did not have detailed information on how to support people in the event of a fire. A key on the handover sheet highlighted how many staff were required to support each person if they needed to be evacuated. Several people required more than one staff member to evacuate the building, however at night, there is only one staff member working. The trainee manager said this information was incorrect and that most people did not require 2 staff members for support. The provider did not have a clear fire evacuation procedure nor a clear risk assessment of how people in the service would remain safe in a fire. Although fire alarm tests and equipment were checked regularly, no fire drills had been completed. Five staff did not have up to date fire training; this was particularly concerning for one staff member who lone works at night.

On the second day of inspection, we could see that improvements had been made. The trainee Manager had liaised with the fire service and produced a day and night time fire protocol. Although only one staff member was present at night, there were procedures for contacting other managers who lived locally and could be at the service within 5 minutes. The handover sheet had been amended so that information was correct and it was confirmed that no person required two staff to support them in an emergency. A PEEP evacuation plan was developed for every person who lived in the service; this included information of where each person in the home was located and what support they needed. The trainee Manager had also implemented a 'grab bag'; this is a bag that staff can 'grab' in an emergency and contained all fire protocols, the PEEP evacuation plan and a contacts list. The trainee Manager advised that she was planning fire drills for day and night and these would initially be every two weeks so that all staff could experience it. Additional fire training had also been booked and the trainee manager had made sure that night staff missing their training were on this before they were due to work again. Although clear improvements have been made, these had not been identified before our inspection and needed to be embedded further to ensure that people remain safe.

People's medicines were not consistently managed so that they received them safely. Some people took medicines on an 'as and when required' basis (PRN). The protocols for PRN medicines gave staff some guidelines as to when they may be required. However more detailed information was needed about the person, why they required the medicine and whether it should be described as PRN if the person was taking it daily. Staff needed to be consistent in recording whether the medicine given was effective. It was also discussed that in some cases, staff were only offering PRN medicines at certain times as prompted by the pharmacy provider and therefore was not considered to be offered outside of these times. An example of this was for a person who was only offered pain relief at times when they were given their other medicines. The provider was aware that the person would not always verbally tell staff that they are in pain. Therefore there was a risk that the person would be in pain and not be offered pain relief outside of medicine support times. This was taken forward by the trainee manager and addressed by the second day of inspection. PRN documentation had been expanded to include the medicine, dose, what it is for, actions to take prior to administering, expected outcomes and when to seek GP advice. Personalised information had been added, such as how the person will indicate they are in pain; for the person who would not always tell staff they are in pain, protocols had been implemented for offering pain relief throughout the day. Another detailed that a person required their PRN medicine before they took part in physiotherapy sessions so they wouldn't be in pain.

Medication Administration Records (MAR) charts showed when people had received their medicines and staff had signed the MAR to confirm this. Records were up to date with just one omission noted. We observed a member of staff administering medicines at lunch time and this was done professionally. Staff remained with the person to ensure the medicine had been taken before signing the MAR. Staff supported people to take their medicines which were ordered, received, administered and disposed of safely. Storage arrangements for medicines were secure and temperatures of storage areas were monitored to ensure medicines were stored at the correct temperature. Staff had completed training in the safe administration of medicines and records showed that this was up to date. The trainee manager had started using medication competency checks as a way of ensuring that staff can administer medicines safely. However records showed that these had only been completed for one staff member and therefore needed to be further embedded. We spoke to the staff member who said that although competencies were new, in supervision they talked about medicine practise and this was another way of assessing their knowledge.

Assessments of risks, both personal and environmentally were undertaken for people who lived at the home. This included risks related to mobility, falls, nutrition, oral health and going into the community. For any people that declined support with personal care, risks of self-neglect had been considered. There were also assessments for people that took their own medicine without staff support. However, the documentation for those people who were at Felix Holme for a short stay (known as respite care) needed to be developed to ensure that support was provided to meet their individual needs and promote their safety and well-being. For example, one person lived with diabetes and there was no guidance for staff as to how this was managed and what triggers to be aware of, if any, such as high or low blood sugars. This is something that the trainee manager was taking forward.

There were processes for recording accidents and incidents, however care plans did not always reflect them as they happened. An example of this was a person who had a skin tear as a result of scrapping her hand on the door frame. The person told them that they did this frequently when they used their walking aid yet this had not been addressed in their care plan. The trainee manager agreed that this was an area for improvement and would be taking this forward.

There were sufficient levels of staff to support the needs of people who lived at the service and call bells were answered quickly and efficiently.

The provider had completed background checks as part of the recruitment process. This included applications to the Disclosure and Barring Service, which checked for any convictions, cautions or warnings. References from previous employers were also sought with regard to their work conduct and character and these were evidenced in staff files. This process ensured as far as possible that staff had the right skills and values required to support the people who lived at Felix Holme.

People were supported by staff who knew how to recognise and respond to abuse. One staff member told us, "The staff are constantly reminded how to recognise and deal with abuse. I know that if I had concerns I would document this and speak to my manager. I also know that I can contact the Care Quality Commission if I felt that this wasn't being handled properly." We saw that contact numbers for CQC and the Local authority Safeguarding team were clearly displayed for staff to use. The trainee manager also had clear understanding of safeguarding procedures. We found that all potential safeguarding concerns were reported appropriately and advice sought where needed.

We observed good practise in infection control. The environment was clean, warm and well maintained and people and relatives confirmed that 'it is always like that now'. This was following a cleaning audit completed by the trainee manager that identified several areas for improvement. Staff had access to and wore personal protective equipment (PPE). Soap, gloves and aprons were readily available and used frequently. The laundry area had been adapted to provide more room for staff; this also meant that the area was free from clutter and trip hazards. Any substances that could be harmful to a person's health were stored safely and the laundry system was well organised with sluice facility and tumble drier.

People lived in a safe environment. Maintenance records evidenced that equipment was well maintained. This included stair lifts, hoists and fire lights and doors. The service held an up to date Legionella certificate and the call system was regularly checked and maintained. Weekly environmental checks and monthly maintenance audits were completed by maintenance staff. This included areas for improvement as well as long term plans for repair and renewal of the building.

Good

Is the service effective?

Our findings

People and relatives told us that they felt the service was effective. People in the service had low to moderate needs and no-one raised any doubts about staff having the skills to support them. One relative told us, "The staff are trained and qualified to look after people here – they know exactly what they're doing." Staff informed us that training gave them the skills and knowledge they needed to support people. There were also opportunities to complete National Vocational Qualifications (NVQ) in Social Care for those who wished to develop personally and several staff had participated in this.

The trainee manager and training co-ordinator advised that staff receive an in-depth training programme which included Health and safety, safeguarding of adults, medication, moving and handling and mental capacity. Staff told us that training was, 'Excellent', and could tell us what training they had received. Physical evidence, such as training certificates, were missing, however this was considered to be a low impact on people as they did not have high needs or require high levels of support. Staff did confirm that they had not received Equality and Diversity training, however demonstrated that they had knowledge of current legislation and practise.

Staff told us that they received a thorough induction programme where they learned about their roles and responsibilities and shadowed an experienced member of staff. Records showed that staff were given guidance on health and safety, policies and procedures around the home. We were told that new staff also completed the Care Certificate as part of their induction. This qualification sets out the standards expected of staff and guides them in providing safe and guaranteed care.

The trainee manager told us that staff were offered supervisions every three months however these were sometimes declined if the staff member didn't feel that they needed one. One staff member told us, "I get asked if I would like supervision, but if I am happy and do not have concerns to discuss then we might just have a quick chat instead." The trainee manager had developed a supervision plan to help her remember when they were due. Staff that did have supervisions confirmed that they found them helpful as, "we can talk about issues and discuss what could be done better." Although supervisions were not always consistent, there were three monthly staff meetings where staff could express their opinions and raise any concerns. Staff also described an 'open door' work atmosphere, where they always felt able to discuss anything with the trainee manager. Staff confirmed that this meant that they never felt like there were unresolved issues or concerns and that they were well supported by management. The trainee manager told us she also planned to introduce Appraisals for staff once a year where they can discuss any training needs and personal goals; however this has not been implemented yet.

Staff demonstrated understanding of involving people in decisions and asking their consent before providing care and support. We saw this when staff talked to people and was also reflected within people's care plans.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Although people had capacity and therefore did not require DoLs documentation, staff were able to discuss restrictions and their knowledge of best interest meetings. The trainee manager knew how to submit a DoLS referral if needed for the future.

People's nutritional needs were met. Although no one was in need of a specialised cultural diet, the cook was aware of religious cultures. One person was receiving a fortified diet; this means that additional nutrients were added to meals without increasing the portion size to aid the person to gain weight. The provider had used a Malnutrition Universal Screening Tool (MUST) to assess whether the person was at risk from being underweight and although only a low risk was identified, this was reviewed monthly. The care plan listed foods that the person liked to eat and also what could be used to fortify their diet. The person had their own personal menu in their room and in the kitchen to support them to choose foods they enjoyed when they could not decide what to eat. This information was also displayed on a white board in the kitchen which specified dietary requirements, preferred portion sizes and preferences for each person.

People told us that they enjoyed the food at Felix Holme and through observations at lunch-time, enjoyed their meals. We were told, "The food is very nice" and "I can have whatever I want". People in their room received their meals in a timely manner and had easy access to their meals. People were offered choice with their meals and involved with decision making regarding menus. There were menus on each table and meals were well presented and nutritious. There were two main meal options and then five alternatives if these were not wanted. People could also have a choice of smaller meals such as soup or sandwiches if they wished. We saw the resident meetings regularly discussed menus with people and that suggestions for meal choices were added. The cook also told us that once every four weeks they had a 'surprise pudding'. This was suggested when people could not decide what they wanted. The cook prepares a surprise dessert and then people let them know whether they enjoyed it and if they would like it added to the menu.

The service supported people to maintain good health with input from health professionals on a regular basis. A health professional told us, "I find Felix Holme to be a very good service. They keep me in the loop when it comes to patient's support needs and they have a great rapport with the people they support." Records showed that people were supported to have access to health professionals when they were unwell. GP's visited on-site when required and on inspection, we saw people receiving support from community nurses.

Good

Is the service caring?

Our findings

People were positive about the caring nature of the staff at Felix Holme. We were told, "staff are very kind and caring", that they are "nice and always very attentive" and "the best staff in the world". Relatives were also complimentary and said, "The service is brilliant." Another described Felix Holme as, "small and intimate which makes it feel like a family." We observed that people were comfortable in the company of staff and there was a calm, relaxed atmosphere in the home.

Staff emphasised that, "Care is what we do best here" and observations of interactions between people and staff found them to be caring and dignified in their approach. Staff were friendly and smiling when talking to people. One person became anxious and tearful; staff demonstrated warmth and kindness in their response. They sat with the person, held their hand and gave them a hug to reassure them. Staff demonstrated good active listening skills by maintaining eye contact, asking questions about how they could support and responding with empathy to concerns. Once resolved, staff joked with the person which made them laugh and they left the encounter smiling. The person later told us, "I love being here and never want to leave." Relatives also felt that people were welcomed into the home in such a way that they felt at ease instantly. "My relative was afraid of going into a care home. Now they are happy and really like it here. I believe that the staff are the reason for that."

Staff had a good understanding of people`s likes, dislikes and preferences and this was reflected by comments from people and their relatives. One person told us, "Yes, they take time to get to know me" while a relative said, "The staff know my relative well and genuinely seem to love her". People's documentation detailed how they wished to be addressed and we observed staff calling them by their preferred names. Documentation also showed that staff responsible for care planning had gathered views from people about their lives and preferences. A, "My life before you knew me" section in care plans included information about the person's family, their early years, their working life, their hobbies and interests and how they like to spend their time. The trainee manager informed us that this was designed so that staff could 'really get to know the person, their history and what was most important to them'. This was confirmed by staff. One told us, "It is about getting to know people and taking time to appreciate their wants and needs. Care plan are also extremely useful, particularly when a person is new to the home."

Staff told us that promoting independence was important to them and the people they support. Care plan documentation for people living at Felix Holme considered aspects of support required, what the person could do independently and what they may need support with. We observed staff encouraging people to be independent particularly when moving around the home with walking aids; staff walked beside the person and offered encouragement but did not assume support was required.

People had their privacy and dignity respected. People had their own bedrooms where they could go for privacy if they wished and these were decorated with photographs and other personal belongings to make it feel more homely. Staff were polite and knocked on people's doors to ask permission before entering. Confidential information was handled appropriately by staff and this included the use of any electronic information. There was a policy on confidentiality; confidential records were held in the office and were

locked in filing cabinets. Staff had a good understanding of what confidentiality means and we observed that conversations about people were held in privacy. We also saw that staff meeting minutes reminded staff about the importance of confidentiality and to read policies.

Most people were independent with their personal care; however those that were supported by staff were well presented with clean clothing, manicured nails and hair brushed and set. We observed staff providing manicures for people in the living area during both days of inspection.

People were encouraged to maintain relationships with those that were important to them. People went out with family members and we were told, "I feel the home is welcoming, my family visit regularly, staff always pop in and chat to them and offer them a drink." Relatives confirmed that staff made them feel welcome when they visited. One relative told us, "I was told from the word go that I could visit whenever I like. I visit most days and each time, I am made to feel welcome."

The caring principles of the service included the well-being of their staff, who told us they felt well supported and valued as a team member and individual. One staff member said, "I have worked in other care homes and it is so different here. Everyone is friendly and supportive of each other – it feels like a family." Management demonstrated that they took time to get to know their staff and support them with developing skills. One example of this was a staff member with dyslexia who found on-line training difficult. They were offered additional support with completing any online training and also booked onto practical training courses as an alternative to increasing their skills and knowledge. Another staff member told us how the management supported their mental health well-being, "Sometimes if I am anxious, they sit down with me for a chat and a cup of tea and that is all I need to feel better. I feel listened to".

Requires Improvement

Is the service responsive?

Our findings

People felt that the service responded efficiently to them. Relatives agreed that they felt the service was responsive to changing needs and they were always updated with information. One told us, "They are very responsive if my relative or I need anything." While another confirmed, "they respond brilliantly and are always in contact, particularly when my relative first arrived."

We looked at how activities were provided to ensure social stimulation and wellbeing. There was no activity coordinator due to ill health and there had not been an extra care staff member introduced to cover the shortfall. We were told that activities were provided by the care staff. However, staff told us it depended on the people on the day and we saw limited activities offered during the inspection. The trainee manager informed us that people were offered one to one time with staff in their rooms and the activities they took part in were documented as part of their daily notes. However, staff had not specified what the activity was nor how long they were engaged.

Views about activities were mixed. We talked to people who went out regularly to hair dressers and shops. Other people were happy to pursue friendships and their own past times such as reading, watching films and seeing family .One person told us, "More trips out would be my choice but other people might not want it." A relative also commented that more activities could be provided; "Overall I can't grumble as everything is good; however there could be more activities. That being said I am not sure my relative would enjoy this as they like their own company and we visit every day." The registered manager agreed that activities were an area that could be improved, particularly in making them more tailored to individual's preferences. They also said they would seek an alternative activities co-ordinator to cover absence.

We viewed an Activities board that people and staff had created together with photos of activities such as birthday celebrations and arts and crafts sessions. There was a remembrance board for people that had passed away with poems and quotes chosen by people to remember them by. There were also posters about future meetings and activities such as a Christmas Carol Service. We were told by staff about external activities such as musicians, theatre companies and 'Pet Pals'; a service which brings animals to the home for people to interact with. These were booked as a monthly activity.

People told us that they received care that was specific to their individual needs. Before moving into the home, pre-assessments were completed with each person to identify their support needs, preferences and wishes. Relatives confirmed that they were also involved in this process and that it was "both professional and efficient." We saw that information in the assessment documents helped develop care plans and ensured that they responded to and met people's needs. An example of this was shown in documentation for a person who was registered blind. The service had sought support from the blind society who provided audio books and headphones. They highlighted specific information regarding the impairment in the care plan, so that it stood out to staff reading it. Detailed guidelines for how to support the person were in the care-plan and also displayed on their bedroom door.

We spoke with a health professional that was involved with the service due to the support needs of people.

They told us, "I feel that Felix Holme are responsive to the changing needs of the people and they keep me involved. I've also noticed that they are responsive to people in other ways, for example, when a call bell rings, it is answered straight away."

The provider had a complaints policy. Although they had not received any formal complaints, there was evidence to show that the trainee and registered manager regularly sought constructive feedback through one to one discussions and meetings. People told us they had never had reason to complain but felt confident that any issues would be dealt with appropriately. One person informed us that, "I know how to make a complaint if I needed to". Relatives confirmed this, one telling us, "I've never had to raise any complaints but I would not have any issues doing so."

When feedback was received, views were listened to and actions taken to improve. Resident's had monthly meetings and part of this was a, "You said, we did" section. This identified issues or suggestions made by residents in meetings that were then addressed by the provider immediately. An example of this included feedback given by people and relatives that they felt a shower room would be beneficial to the home. This feedback was also highlighted in resident's meetings. The registered manager was aware of this issue and had already gathered quotes to have a wet room built on the ground floor. Another example was feedback received from people that they did not enjoy an externally provided activity as much as others and requested a change. The management immediately advised the visiting activities co-ordinator of the people's views. The trainee manager told us, "It was not a pleasant conversation as the person involved had been coming to the service for years and was upset. However I needed to respond to the people's wishes and respect their choice." A staff member also told us, "I feel that the service is very responsive – recently a person was unhappy with the lay-out of their bedroom and we immediately discussed with her how to improve this and made changes."

Requires Improvement

Is the service well-led?

Our findings

The management structure consisted of a registered manager, a head of care and two senior support staff. The head of care was in training to be a registered manager and was referred to as the trainee manager by staff and people.

People told us that Senior's and the trainee manager were 'approachable' and 'supportive'. Relatives confirmed that they have regular contact with the trainee manager and that, "Communication is brilliant." Another relative said, "Communication is excellent, particularly with the trainee manager – they communicate regularly and keep me up to date with any changes."

Staff informed us that they felt the home held an open and empowering culture. One staff said, "When we changed to a new provider, we all sat down together and talked about it – it was nice to be involved." Staff highlighted that what stands out for them most is a sense of teamwork and that there is someone to support them. They felt that the registered manager and trainee manager were both very supportive. One staff member said, "Management listen and involve us – they are very approachable" while another said, "They encourage us and praise good practise – this makes us feel appreciated." Staff gave an example of how the trainee manager had nominated staff for the 'Great British Care Awards' in recognition of their hard work. Directors of the service had also been nominated for Care Employer of the year. The trainee manager told us, "the staff I nominated are so caring; they go above and beyond what is expected and are a good influence on new staff." Management also felt supported by the Director's.

Despite this positive feedback, there were some areas that we found were not well-led.

Lines of responsibility within the management structure were unclear. We were advised that this is sometimes due to staffing pressures, particularly when several staff were on long term absence. The trainee manager told us they were mainly responsible for completing tasks such as auditing, maintaining oversight and managing the building with support from the registered manager. However due to additional work pressures, some tasks were not being completed consistently. We were told that staff were to be trained by the trainee manager in how to be keyworker's; this would entail managing people's support plans, organising appointments and being involved with reviews. However, in the interim this was being solely managed by the trainee manager. Management were also hoping to introduce lead roles for staff in areas such as Infection control, Medicines, Equality and Diversity and Record keeping. This would give additional responsibility and an area of expertise to guide other staff with. We discussed with the trainee and registered manager the importance of sharing and delegating tasks so that more than one person is responsible. It is also important to remember that although the head of care was in a trainee manager position, accountability for the service is still held by the registered manager. Therefore the trainee manager should still receive support in completing documentation and having oversight of the service.

Systems and processes were not always in place to monitor and assess the quality of service that people received. Audits that we did see were completed by the trainee manager. They were detailed and looked in-depth at areas for improvement. An example of this was a cleaning audit that had highlighted several areas

of concern with regards to standards of cleanliness – the trainee manager had taken this forward and standards had vastly improved. People and staff file audits were not being completed consistently; this is because the trainee manager was also managing these systems and auditing their own work would not be effective. As a result, the registered manager did not have complete oversight of the service and the people living there.

Although we saw that staff promoted independence, documentation for people staying on respite lacked evidence that staff had developed personal goals with people in how to promote and maintain their independence before going home. Examples of this included people managing their own medication and improving their mobility. This was recognised as an area of improvement and was being taken forward by the trainee manager.

Although people, staff and relatives felt that training was effective, there was a lack of evidence to show this. We saw a training plan that was designed to identify when staff training has been attended or was due. This information was gathered from training certificates. However from this plan it was difficult to determine if staff had received training and when it needed to be reviewed. Statements such as 'Due' or 'Booked' were used without dates of when their previous training occurred or when the next training was booked for. This made it difficult to determine how out of date staff were with their training. There were discrepancies between staff training certificates and the plan, with a lot of certificates missing and others with no date on. The staffing list on the plan was also out of date, with new staff missing and previous employees still listed. The registered manager told us that they would differentiate between fire safety courses as one was for using the fire panel and the other for using fire equipment. We also discussed adding medicine competencies to this so they would have full oversight of when all training was due.

There was evidence to show that the registered manager had tried to seek feedback from residents, staff and relatives in the form of questionnaires that were sent out six monthly. However, these forms were not consistently completed, in some circumstances only one form being returned. We discussed with the trainee and registered manager about how they could seek more rounded feedback. Despite the lack of questionnaires received, those that were, were positive; one relative wrote, "Having worked for many years in care, this home is one of the best. The service is satisfactory in all areas, I am deeply impressed by all the staff." The service has also received praise in online forums such as care home review sites and social media which could be included as part of feedback.

During inspection we found the registered and trainee managers to be open and responsive to feedback. Any constructive comments made were dealt with immediately and by the second day of inspection, improvements had been made to manage issues identified. This demonstrated the provider's willingness to improve.

Staff told us that they attended regular staff meetings and minutes showed that meetings occurred every three months. Staff meeting minutes demonstrated that staff were kept informed of and involved with any changes and we were told, "They ask our opinions, it is so nice to feel involved in everything." Staff were also asked to complete feedback forms after their meetings so that management could gain insight into where meetings could improve.

Records showed that the registered and trainee managers attended regular training to increase their skills and knowledge. The registered manager had completed their NVQ 5 in management and the trainee manager was in the process of this.

The provider had ensured that the rating from the previous inspection was displayed within the home and

also on their website.