Fulford Care Home Limited

Fulford Care & Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 9 October 2018 and was unannounced.

The inspection was brought forward as we had been made aware of safeguarding issues communicated to us directly and received from the local safeguarding authority. Our inspection does not examine specific incidents and safeguarding allegations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection.

At our last comprehensive inspection on 5 and 6 October 2017 the overall rating of the service was, 'Requires Improvement'. This summary rating was the result of us rating the key question's 'safe', 'effective', 'caring', 'responsive' and well-led as, 'Requires Improvement'. At our last inspection we found breaches of five regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that care and treatment was provided safely. Staff were not always deployed to meet people's care and support needs. Staff did not receive supervision and appraisal necessary to enable them to carry out their duties. Consent to treatment was not always obtained from people. Where people were unable to give consent because they lacked capacity, staff did not act in accordance with the Mental Capacity 2005 Act. People were not involved in the assessment of their needs and preferences. Care and treatment was not designed to make sure it met peoples' needs. Systems were not effective in monitoring and managing risks. Records relating to the care and treatment of people were not kept securely.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good. At this inspection we found significant improvements had been made and maintained, resulting in the overall rating of the service changed to, 'Good'.

At this inspection we have rated the key question 'well led' as 'Requires Improvement'. We found although there were significant improvements in the care planning, further work was still needed to ensure they were accurate and fully completed. We also found that the new systems introduced since the last inspection required more time to be embedded and sustained. Although necessary provision had been made to ensure that medicines were managed safely, we found due to the technology being used, medication was delayed. The provider had identified this themselves through their quality monitoring processes. This had impacted how relatives felt their loved one's needs were being met. We have recommended the registered provider ensures care records and information relating to people's care is contemporaneous.

Fulford Care and Nursing Home is registered to provide nursing care and residential care for up to 74 people with a range of care needs, including frailty of old age, specific health conditions and people living in the early stages of dementia. At the time of our inspection, 67 people were accommodated at the home. Fulford Care and Nursing Home is divided into five areas, over three floors. The five areas are called Magnus and Harold, on the ground floor. First floor: Godwin and Edmund. Second floor: William. The floors are accessible

by a lift and stairway.

Fulford Care and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Since the last inspection, the registered manager had left employment and another registered manager was in post. A registered manager is a person who has registered with the CQC 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 were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff had been appointed. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. Care staff had been supported to deliver care in line with current best practice guidance. People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet. In addition, people had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They were also supported to express their views and be actively involved in making decisions about their care as far as possible. Confidential information was kept private.

People received personalised care that was responsive to their needs. People's concerns and complaints were listened and responded to in order to improve the quality of care. Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met. The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Quality checks had been completed to ensure people benefited from the service being able to quickly put problems right and to innovate so that people consistently received safe care. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. The management team worked in partnership with other agencies to support the development of joined-up care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified, assessed and managed safely.

Sufficient numbers of suitable staff were employed and deployed to support people.

Medicines were safely managed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the necessary skills and knowledge to meet their needs.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

People's care was provided in line with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

People had access to activities that were important and relevant to them.

People's concerns and complaints were listened and responded to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well led.

The electronic care plan and medication system needed further time to be embedded and sustained.

Communication between 'management' to people and relatives needed improving to promote trust.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Fulford Care & Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 9 October and was unannounced. The inspection team consisted of one inspector, one medicines inspector and two specialist nurse advisors. There were two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was older person services and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the lunchtime meal, medicines administration and activities.

We spoke with 19 people who lived in the service and with five visiting relatives. We spoke with the operational director, operational manager and registered manager. We also spoke with the deputy

manager, the clinical lead, two registered nurses, one senior carer, five care staff and three activity co-ordinators.

We looked at the care plans and associated records for 10 people. We looked at 11 people's medication records. We reviewed other records, including staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, complaint records, policies and procedures and external and internal audits. Records for five staff were reviewed, which included checks on newly appointed staff and staff supervision records.

After our visit, we contacted a commissioner for their views on the quality of services provided. They gave us permission to include their feedback in this report.

Good

Is the service safe?

Our findings

At our last inspection in October 2017 for the key question, 'is the service safe?' we found two breaches of Regulation. The provider had failed to ensure that care and treatment was provided in a safe way. Staff were not always deployed in such a way to meet people's care and support needs. We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and these regulations were now met.

Without exception people we spoke with, who were able to told us they felt safe. Our observations confirmed people who were unable to initiate communication were asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed.

One person said, "I feel very safe here, the staff are wonderful." Another person said, "I feel safe and content here." A third person told us, "Well, I've only been here a very short time but I can tell you I do feel very safe here because strangers can't get in. I sometimes go out into the garden for a smoke about 9pm or 10pm and I feel very safe." A relative told us, "I would say [person] is safe here. They [staff] look after her, which eases a lot of the worry from me." Another relative told us, "I'm happy that [person] is safe."

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls. We viewed 10 peoples care records which included risk assessments regarding nutrition, possible falls, diabetes, choking and the risk of skin damage. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff. Where assessed as needed, people had a record to show they were repositioned at regular intervals to relieve the pressure on their skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place. Moving and handling assessments gave staff clear guidance on how to support people when moving them. We observed staff communicating with people during transfers to check people felt safe and comfortable. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

Records were kept electronically on a care system. This system used wireless handsets to allow care staff and nurses to update information about people in real time. The system recorded care activities against a timeline, for example, four hourly turns would generate a warning if they were overdue to help care staff deliver and record time sensitive care activities. Activities that had not been completed were reviewed by the registered manager or deputy the following day, and followed up with the nurses on duty. We saw evidence of this during a handover.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation

Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

We found suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. However, most of the people we spoke to including relatives raised concerns about there not being enough care staff on duty. For example, one person told us, "I would say at weekends they are a little bit short." A relative told us, "There's never enough staff at any of these places. The staff here are worked off their feet." We fed this back to the registered manager. We saw that the registered manager had established how many care staff needed to be on duty at each time of day based upon an assessment of the care each person required. This was reviewed as a minimum monthly or as and when individual needs changed. At the time of our visit, there was 12 carers in the building from 8am to 8pm. With two registered nurses on site, a clinical lead and one senior carer in this time to oversee the clinical needs of individuals. The registered manager was a registered nurse who also supported the clinical needs of the service.

The management team told us, they have listened to the concerns of people and their relatives. Consequently, since the last inspection, the registered manager told us, they are working at 20% above, what staffing levels have been assessed as needed. Rotas we sampled reflected what we had been told. Records showed that the planned deployment of care staff had always been met. They also showed that on most days the number of care staff on duty had met the minimum level that the registered manager considered to be necessary. We concluded that in practice there had been enough care staff on duty to provide people with the assistance they needed. This was because we were assured that when care shifts had not been filled members of the management team and other members of staff worked flexibly either to provide care themselves or to relieve care staff from having to undertake non-essential duties.

The registered manager told us if agency staff were needed, they were allocated from an approved list. To ensure people were supported safely, we were told, they requested specific agency staff who knew the home to cover shifts and records confirmed this. Records confirmed that agency staff received an induction when first working at the home and given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking. In addition to the care staff, the service had a team of housekeeping staff, two chefs and three activity assistants on each day. The three activity assistants also supported the care staff with the dining experience of people. This enabled the care staff to attend to people and their needs. During our visit we observed people receive care and support in a timely fashion and call bells were responded to promptly. We observed staff having time to interact with people positively.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC). There were records to show staff were interviewed to check their suitability to work in a care setting.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they

had not seen anyone being placed at risk of harm.

The necessary arrangements had been made to ensure the proper and safe use of medicines. There were reliable arrangements for ordering, administering and disposing of medicines. However, we found due to the technology being used, there were long delays in the administrating of medication. We found this had not impacted people's safety or on people receiving time sensitive medicine and no one complained to us of the time it took for them to receive their prescribed medication. Therefore, we have covered this in the well-led section of this report.

There was a sufficient supply of medicines, nurses and senior care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

There were suitable systems to protect people by the prevention and control of infection. One person told us, "I think it's fairly clean. The cleaners clean in the room every day and I think outside is kept fairly tidy. I haven't noticed any bad odours." Another person told us, "I think it's fine [cleanliness of the home]. I've not really been aware of any odours." A relative told us, "I've no complaints about the cleanliness. They've recently had new carpets and some painting done. I don't think I've smelt any odours." Records showed that the management team had assessed, reviewed and monitored what provision needed to be made to ensure that good standards of hygiene were maintained in the service. We found that the accommodation was clean and had a fresh atmosphere. We also noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean. In addition, we noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. We observed that care staff recognised the importance of preventing cross infection. They were wearing clean uniforms, had access to antibacterial soap and regularly washed their hands.

We found that the registered manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the need to refer people to specialist healthcare professionals who focus on helping people to avoid falls. They also included practical measures such as when using agency staff, they are always paired with an experienced carer or registered nurse who is employed by the service.

Good

Is the service effective?

Our findings

At our last inspection in October 2017 for the key question, 'is the service effective?' we found two breaches of Regulation. Staff did not receive supervision and appraisal necessary to enable them to carry out their duties. Consent to treatment was not always obtained from people. Where people were unable to give consent because they lacked capacity, staff did not act in accordance with the Mental Capacity Act (2005). We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and these regulations were now met.

Staff received appropriate support to enable them to carry out their duties and to promote their professional development. Staff told us they had regular meetings with their line manager to discuss their work and performance. The registered manager confirmed that three supervisions and annual appraisal took place. The registered provider's records reflected what we had been told. We found records demonstrating other ways staff were supported. This was through staff monthly team meetings. Minutes of these discussions demonstrated staff discussed people's needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the management team had an open-door policy where they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

People's rights under the Mental Capacity Act 2005 (MCA) were respected. 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 MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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 staff were working within the principles of the MCA and whether any conditions or authorisations to deprive a person of their liberty were being met and we found they were. We found decision specific mental capacity assessments, best interests decisions and DoLS applications for people.

We found that the management team and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who lived in the service, explained information to them and sought their informed consent. Records showed that when people lacked mental capacity the registered manager had ensured that decisions were taken in people's best interests. The management team had 'flash meetings' once a day with key staff members to ensure essential information was handed over and areas of need were acted on. At the flash meeting we observed a safeguarding referral made to the local authority for a person that was declining personal care, they were assessed to have capacity to make this decision, but due to the impact this was having on the persons wellbeing, the

registered manager felt additional support should be explored so that the person could make a better-informed decision. There was also a referral to the community falls team after a person had a second fall and from a best interest meeting it was also agreed to involve an occupational therapist.

We found that robust arrangements were in place to assess people's needs and choices so that personal care was provided to achieve effective outcomes. Records showed that the registered manager had carefully established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the providers assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they can carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Induction training was followed by a minimum of three shadow shifts.

The provider maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people, record keeping and the Mental Capacity Act (MCA). Additional training was available to staff in specific conditions such as nutrition, person centred care, diabetes, epilepsy and dementia. The senior carer demonstrated a thorough awareness of consent and capacity issues following recent dementia care training. In addition, staff had received on-going refresher training to keep their knowledge and skills up to date.

Our observations showed staff were confident and knew how to support people in the right way. An example of this was care staff knowing how to provide clinical care for people who lived with medical conditions. Other examples were care staff knowing how to correctly assist people who experienced reduced mobility or who needed help to promote their continence. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

People told us that they enjoyed their meals. One person told us, "I think the food is excellent, there's always plenty and if you want more you can have it." Another person told us, "I've enjoyed my meal very much." A third person told us, "The food is lovely. I have breakfast in bed, main meal in the dining room and the evening meal is served on a tray in the lounge or my room (person confirmed this was their choice). Some people don't talk and I'm not particularly sociable myself. The dining room is the oldest part of this building. It's a very nice room."

Seven people who had requested to eat meals in their bedroom, told us, the food was often cold. Records confirmed people who were experiencing cold food, were independent in this area and were not eating the food when it was served. Our observations also confirmed when the food was in their bedrooms, people were falling asleep or not eating it when it was brought to them. Consequently, we found food was being left or eaten cold. We fed our observations back to the management team, who offered assurances people

would be spoken with to see if they wanted to change the time of their meal being provided.

People were supported to eat and drink enough to maintain a balanced diet. This included assisting some people to eat their meals and gently encouraging others to have plenty of drinks. We were present at lunch time and we noted that the meal time was a relaxed and pleasant occasion. The dining tables were neatly laid, people were offered a choice of dishes and the meals were attractively presented. People were offered sherry, wine or beer. One person was presented with a hot meal but requested that they had a sandwich instead and another person requested an omelette instead of the menu choice, the chef accommodated these requests. We observed a carer provide a person with a plate guard to enable them to be independent with eating. We also observed that some people had adapted cutlery to maintain their independence. Hot drinks were offered after the meal on an individual basis. A small group of people requested that they had their hot drinks in the garden area, this was a significant social focus, that we were told occurred each day. The home offered several pleasant outside areas for people to use.

The chef explained to us the importance of how food played a role in persons day and in their health. They spoke passionately about being able to provide home cooked food. Making soups we were told was a favourite. The chef told us, "I love making them and nearly all residents can eat them." The chef was aware that some people needed to increase their fluid intake and cited jelly as a way of doing this without a large volume. The chef spoke enthusiastically about a new initiative she had introduced, using moulds to set pureed food to make it look more appetizing. People told us, they liked this and it encouraged them to eat food that might usually decline.

People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The registered manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example being, people had 'grab packs' that contained essential information, should this be needed quickly, for example if a person needed to be taken to hospital by the ambulance service. The grab packs contained information about family contacts medicines, details of medical history and do not attempt cardiopulmonary resuscitation (DNACPR) if this was in place.

Nurses and senior staff had completed an awareness course on the National Early Warning Score (NEWS) to support nursing staff pick up early warning signs of deterioration in health. A nurse told us how the NEWS chart was used for people and the positive impact this had had, in preventing unnecessary hospital admissions. The staff were aware that observations were only beneficial if there was going to be clinical intervention because of them. For example, two people had regular observations made on their end of life care, but these were limited to checks on their wellbeing and comfort.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

At the last inspection we recommended that the provider looked at ways to improve the environment to

make it more dementia friendly. At this inspection we found the needs of people with dementia had changed. There was no one in need of additional signage to help them navigate themselves around the service. However, since the last inspection the provider had personalised people's bedroom doors to make them more recognisable. They were painted different colours, some doors had photos of the person if they had agreed and other people had their names. Some doors had letter boxes and door knockers while others had their own key entry.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. People could move about their home safely because there were no internal steps and there was a passenger lift between the floors. There was sufficient communal space in the dining room and in the lounges. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Good

Is the service caring?

Our findings

At our last inspection in October 2017 for the key question, 'is the service caring?' we found some staff lacked a caring approach when addressing people and did not always take account of people's care needs in a sensitive way. This was an area of practice that needed to improve. At this inspection we found improvements had been made and was now awarded the rating of 'Good.'

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. Interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

One person told us, "The staff are really kind, they will share a joke with you and give you a bit of a hug if you are feeling down." Another said, "They are a nice bunch of girls [staff] and some of the lads [staff] are really pleasant and friendly." Another person told us, "They're [staff] definitely kind and caring. It makes me feel satisfied because it's nice to know you're under the care of people who are kind and do their job efficiently." A relative told us, "[Person] has only been here a little while but whenever I've come everyone has been very friendly and kind." Another relative told us, "The staff seem very pleasant and [person] has certainly never complained that anyone has been rude or unkind to them, and [person] would speak up pretty quickly if they were."

We observed two staff offering compassionate care to a person who was confused and distressed. Both staff took time to talk to the person calmly and respectfully, listening to what they were saying and responding appropriately. We observed one person having their blood sugar taken and the carer held the persons hand reassuringly and reminisced with them to reduce their anxiety. We observed a staff member holding a person's hand while they were chatting, the staff member was bending down so she was at eye level, not overbearing and patiently listening to what the person was trying to tell her. The staff member did not rush the person or prompt them to get their words but waited until they had finished speaking before she replied. When the staff member did so, she spoke softly to explain that the persons relative would be coming in to see them later that day and she would make sure that they didn't miss them. The person was reassured and content with the response.

People and where appropriate, their families were involved in discussions about developing their care plans, which were centred on the person as an individual. We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Records showed that the management team had encouraged their involvement by liaising with them on a regular basis. Care plans included people's preferences around clothes, when people wanted to get up or go to bed and their choice of how and where to eat and how to spend their day. Preferences were clear on whether people had chosen to have a bath or shower and how often. One visiting relative told us that they

had been involved in their loved one's care plan. No one told us they had any concerns about their care plan or how often it was revised.

People were supported to maintain important relationships. One person told us, "I keep in touch with friends who visit, not much in the way of family. We go to my room for privacy." A relative told us, "I can come when it suits me. I'm made to feel welcome. The staff know me. If the trolley is being brought around with drinks I'm offered one, or I can always make one for myself." Another relative told us, "All the family are made to feel welcome when we come in. We sometimes bring the dog in too and they don't mind that at all. We visit at different times so that [person] gets a regular stream of visitors." Where people required help to maintain relationships, staff were at hand to help with correspondence such as birthday cards, emails, social media or letters. This helped to ensure that people could maintain close links with loved ones.

People were encouraged to be as independent as possible. Many people had previously lived in the local community and were encouraged to carry on routines such as visiting friends or local shops. Staff could provide support to facilitate these visits if required. Where people went out independently, they had agreements in place with staff about where they were going and time of expected return. This helped to ensure that staff had an awareness of people's whereabouts if they did not return as expected. One person was supported to take their mobility scooter test, this was successfully passed in August 2018, which meant the person could independently access their local community with more ease due to their deteriorating mobility.

The provider demonstrated a clear understanding through the planning and delivery of care about the requirements set out in The Equality Act to consider people's needs on the grounds of their protected equality characteristics. The Equality Act is the legal framework that protects people from discrimination on the grounds of nine protected characteristics including age, sex and disability. Staff had all received training in equality and diversity and there were policies in place to help ensure staff were considering people's individualised needs in the delivery of care. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. One relative told us, "I think [person] is treated fairly, if there was any discrimination none of the family would stand by and let it happen." Another relative told us, "I think [person] is treated fairly. There's no discrimination here." The registered manager gave us an example of this regarding one employee's life choices which could lead them to be discriminated against in the service. There were plans in place to ensure the employee could work in a way that protected them from harassment.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

The Accessible Information Standard (AIS) was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. We saw records for some people were provided in a pictorial and written format, which were easy to follow. We saw, where appropriate, people had their medicines described on information sheets that had a photograph of what it looked like, which was an accessible format.

We found that care records were stored securely. Policies and procedures we looked at showed the service placed importance on protecting people's confidential information. Staff handed over information to each other away from communal areas. This helped to ensure that personal or sensitive information about

people was kept private.

Good

Is the service responsive?

Our findings

At our last inspection in October 2017 for the key question, 'is the service responsive?' we found one breach of Regulation. People were not involved in the assessment of their needs and preferences. Care and treatment was not designed to make sure it met peoples' needs. We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and the regulation was now met.

People's care plans recorded their care and support needs in relation to communication, mental health and activities. People's interests, religious needs, sleeping, tissue viability, personal care, eating and drinking, and medical conditions were also recorded. Where people were living with diabetes, records provided staff with guidelines on how to support the person when their blood sugar levels were high or low. Detailed information was recorded about how people wanted their personal hygiene carried out. Staff told us, they found the care plans informative and provided them with enough detail to support people's individualised needs.

People who received nursing had their records and care reviewed by two of our specialist advisors and we found examples of good practices. For example, where people had PEG feeding tubes and catheters best practice techniques and national guidelines were being followed. A PEG feed is a medical procedure used when people may no longer take in food and/or medication orally. Where people required additional care, records were in place to monitor their wellbeing such as fluid, food, weight and bowel charts and body maps. Information contained in these records were up to date. This demonstrated that staff were responsive to people's needs and provided safe and individualised care.

Staff told us they completed a handover sheet after each shift which outlined changes to people's needs. We looked at these sheets and saw that the information related to a change in people's medicine, healthcare appointments and messages to staff. Daily records were also completed to record each person's daily activities, personal care given, what went well and what did not and any action taken.

Records were kept electronically on a care system. This system used wireless handsets to allow care staff and nurses to update information about a person in real time. This information was protected by passwords and each member of staff had an individual login. The system was cloud-based that gave it some resilience against an IT failure (there was unlikely to be a loss of data in this eventuality). The handsets were like mobile phones, but did not have the ability to send data outside the system (as they had no SIM cards). The handsets were also used to document wounds (using the in-built camera facility), new areas of potential skin damage identified by care staff when carrying out personal care. The staff could request that a nurse conduct an assessment or check on any aspect of a person's care using a notification system. This would flag up the requirement to the trained nurse on duty that day. The system allowed observations, fluid and food records and details of personal care and consent to be recorded in real time. This ensured staff were responsive to people's health needs.

People's communication needs were detailed well in care plans and support was provided in accordance

with people's needs. For example, one person's support plan for communication noted they wore a hearing aid and it could be difficult to communicate with the person without it. Staff checked the person was wearing this and we also observed the person wearing the hearing aid during the day.

People confirmed that they took part in the activities in the home and in the local community. The Activities Programme was broken down to regular daily activities, which change according to needs and additional monthly activities and entertainment, which are booked from external sources. One person told us, "Some of the activities include arts and crafts, singers and sometimes a playgroup visiting the home to dance for the residents. That's lovely all the little ones. The activity assistants do a really good job." Another person told us, "I don't have any particular interests. I'm happy with what they put in front of me. I take part in the activities, but not a lot. A lady comes in with a guitar and sings every fortnight. There's a man that comes in once a month with mobile skittles and a couple of singers who have microphones. I like all that. It's enough for me. I can't say I'm particularly bored, certainly no more than I'd be at home. Less probably." Another person told us, "I enjoy taking part in skittles, ball throwing and singing."

For people who enjoyed physical exercise, a group of nine people got together in August 2018 and took part in 'Going the extra mile.' This meant they walked a mile each and obtained an achievement badge. Photos of the event demonstrated people were proud of this accomplishment. Each month children from a local nursery visited the home and joined in with games and ate lunch with people. People told us, this was hugely popular. Photos were kept of the memories being made together and displayed in the home as a reminder.

Where people preferred their own company, this was also respected. One person told us, "A lot of the people here are wheelchair bound. I don't really mix that well. I'm a bit of a loner. I'm happy with my own company." Another person told us, "I tend to keep to myself most of the time. I'll speak if someone approaches me but I'm not one for putting myself on other people." A relative told us, "[Person] stays in their room. They won't come out to join in. The activities people go into see [person]."

Records confirmed that for people who chose to remain in their bedrooms, or for people unable to leave their room for medical reasons, were offered one to one support each day. The activity assistants used the electronic system, to record who had participated or declined activities. Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them. During peoples one to one support they would be offered activities around their known likes. Examples we found were being read a book, given a hand massage, playing a game, helping with a puzzle or sitting with the person and offering company.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to, to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. One person told us, "I've not had cause to complain but I'm quite sure if I had to, I would. I'd speak to whoever was in charge at the time." Another person told us, "I'd speak to the manager if it was serious enough but I'd weigh it up first. I don't see the point of rippling the waters just to make a point." Another person told us, "I'm no wallflower and if I have to make a complaint I will." People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. The home obtained guidance and best practice techniques from professional bodies to assist them in providing good quality end of life care. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We noted that care staff supported relatives at these difficult times by making them welcome so that they could stay with their family member during their last hours or days to provide comfort and reassurance.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in October 2017 for the key question, 'is the service well-led?' we found one breach of Regulation. Systems were not effective in monitoring and managing risks. We made requirements for this to be addressed and the provider sent us an action plan.

At this inspection, we found improvements had been made and the regulation was now met. However, some improvement and further work was required. For example, there was a disconnect between the records on the information system and what staff told us they knew about people. For example, of the five care records we reviewed the biography of people was not completed on any of them. There was some inconsistency about how staff recorded people's fluid intake, with some staff recording sips rather than estimating the proportion of a cup or measurement consumed. We found this had not impacted people's safety or on people receiving time sensitive medicine and no one complained to us of the time it took for them to receive their prescribed medication.

We recommend the registered provider ensures care records and information relating to people's care is contemporaneous.

We saw staff members gave medicines prescribed to be given in the morning to some people at 11.45am. This meant for some people who were prescribed medication at lunchtime, they had to wait until the late afternoon for the medication. We found although this was not good practice, peoples safety had not been compromised. This was because the electronic system being used, informed the staff administering the medication of the next appropriate time for the person to receive their medication which ensured there was a sufficient gap between the morning and afternoon medicines. We shared our concerns regarding the time it took to administer people's medication with the registered manager. The management team were fully aware of the time delay and agreed this was not good practice and area of required improvement. The management team told us the delay was caused by the computer system introduced since the last inspection. The management team told us the handsets being used had too much information on them, causing them to be delayed which impacted on the time it took to upload people's medication details. The provider was confident that by having more handsets on site would resolve this issue. Sufficient evidence was given at the time of our visit that an additional handset had been ordered and they were awaiting its delivery. We found that the new electronic system introduced since the last inspection required more time to be embedded and sustained. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

The home had a change of provider in December 2016. Since this time has had two registered managers at different times. People and relatives, we spoke to expressed concerns about the staffing levels, while expressing support for the current registered manager. One person told us, "They [staff] are very kind but they are short staffed I think." A relative told us, "They are often short staffed, particularly at the weekends. They don't have the staff to monitor people properly."

Feedback from people and their relatives felt their view that staffing levels were not adequate was impacting

the quality of care being delivered. Improvements were needed to how information was being communicated around staffing levels. Although we found staffing levels to be at a safe level and at a level to be able to deliver good quality personalised care, there were missed opportunities between the provider, people and relatives regarding what is the expected staffing levels. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

We found one occurrence where staff did not follow correct procedures to give people their medicines. We observed staff give medicines to people in the morning and afternoon. We saw one member of staff hand medicines to another member of staff. The staff member who signed the Medicines Administration Record (MAR) did not witness the medicines taken by the person. The involvement of a second person introduces the risk of error and is unsafe practice. Although we observed the persons safety on this occasion was not compromised, the practice we observed did not follow guidance relating to medicines management outlined in the providers policy. We reported this at the time to the registered manager who took immediate action to remind staff on duty to not do this on any occasion for any reason.

There were systems in place to make sure the service assessed and monitored its delivery of care. We saw there were various audits carried out such as medicines, health and safety, room maintenance and housekeeping. Accident records were kept which contained a description of the accident, time it occurred and if people required hospital treatment. The registered manager conducted an analysis to help identify trends and patterns for example the number of time people used the call bell and the reasons why. The registered manager who was also a registered nurse, conducted care quality audit's. For example, checked peoples wound care progress by redressing and re-evaluating people with wounds to ensure they were being appropriately cared for. The registered manager used this as an assurance exercise to look at staff knowledge and ensure that the wound care information board was up-to-date and people were making appropriate progress in wound care.

People told us they felt the registered manager was approachable and the home was well managed. There was an open-door policy as we saw people, including their relatives, go into the office throughout our inspection.

Staff told us that managers were open and approachable and they could discuss any issues they had with them. A senior member of staff told us, "I feel really positive about the service now. There is light at the end of the tunnel. I can see the potential and where we are going." Staff told us, there had been many improvements over the last year citing that support and benefits from the provider had increased which they felt meant that local people were being employed and were staying longer. The clinical lead told us, "It feels like a local community here." Without exception staff told us, since the new manager had been in post, communication had improved and team meetings and supervisions had been introduced. Staff told us that team meetings were held regularly and that they could raise any concerns they had at these meetings. Staff told us, ideas from staff were listened to by the managers and they encouraged staff to share these.

We found that the registered manager understood and managed risks and complied with regulatory requirements. Records showed that the registered manager had subscribed to professional websites to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all the key questions we ask when assessing the quality of the care people receive. In addition, we noted that the registered manager had correctly told us about significant events that had occurred in the service. These included promptly notifying us about possible safeguarding incidences. Furthermore, we saw that the registered manager had suitably displayed the quality ratings we gave to the service at our last inspection.

Staff were clear about their responsibilities. The home employed a Care Manager whose responsibility it was to ensure that care staff were responding appropriately to people's needs and requests for assistance. There was a system of daily meetings to ensure that all staff knew what was going on. This consisted of a 'Head of Department' (HOD) meeting every morning that involved maintenance, catering, domestic and care staff to ensure that each department had an overview of activities that might affect the smooth running of the home. This meeting was chaired by the registered manager or deputy manager. There was also a meeting known a 'Flash Handover' and was attended by senior care staff from each unit. This gave high level information about people, was rapid and by-exception. We attended both meetings. Handover sheets were updated by the deputy manager and these were given to all staff at the beginning of their shift based on the information shared in these meetings. They contained details of peoples, such as relevant medical history, dietary needs, as well as details of DNARCPRs that were in place. These handover documents did not leave the building after the shift but were disposed of securely by the service to prevent loss of person's personal information.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend monthly joint residents' and relatives' meetings at which they had been supported to suggest ideas about how the service could be improved. We noted examples of these suggested improvements being put into effect. An example of this was introducing a 'suggestion box' in the main entrance for people, relatives and staff to make anonymous suggestions. We saw this had been actioned.

People and their relatives had opportunities to feedback their views about the home. The provider had conducted an annual resident's survey in 2018 and people's feedback was positive. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.

We noted that the registered manager adopted a prudent approach to ensuring the sustainability of the service. This included operating efficient systems to manage vacancies in the service. We saw that the management team carefully anticipated when vacancies may occur and liaised with local commissioning bodies so that new people could quickly be offered the opportunity to receive care in the service. Records showed that these arrangements had been largely successful in that relatively good levels of occupancy had been maintained. This helped to ensure that sufficient income was generated to support the continued operation of the service.

We found that the service worked in partnership with other agencies. There were examples to confirm that the provider recognised the importance of ensuring that people received 'joined-up' care. We asked the registered manager where she went for clinical advice or for a professional conversation, she identified the community matron for the prevention of admission to hospital was this go-to person. The registered manager was also supported by a non-clinical deputy and two clinical leads. Another example of the provider working in partnership with other agencies was their involvement and commitment with a clinical commissioning group (CCG). The home had eight beds that were purchased by the local CCG for 'admit to-assess', this prevented people having to remain in an acute hospital.

A social care professional told us; "We find them to be very proactive with us, since their last inspection, they have come back well and we have been monitoring them since. We have offered clinical support and peer support. The registered manager has been receptive to the support offered and our staff are in there every day. We have a dedicated social worker visiting the home every day in office hours. We have observed good care, resulting in positive outcomes for people. People are encouraged to be fully involved in the process of creating their care plan. They are working jointly with the discharge / enablement team from hospital to

provide care on occasions at short notice, but done so safely, with the person starting to be involved from the point of being in hospital onwards."