Downing (Green Gables) Limited

Greengables Nursing Home

Inspection report

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Ratings

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

Overall summary

This unannounced inspection took place on 3 and 4 June 2015. Green Gables provides accommodation and nursing care for up to 38 people who have nursing needs. At the time of our inspection there were 34 people living at the service. The home consisted of three floors, with bedrooms and bathrooms on each floor, and a communal lounge on the ground floor. Stairs and a lift provided access between floors.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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.

We last inspected Green Gables Care Home on 20 and 21 August 2014 and judged the provider to be in breach of regulations relating to staffing levels, assessing and monitoring the service and records. The provider sent us an action plan detailing how they would make improvements to address these concerns. At this inspection we found the provider had made the necessary improvements in all areas where there had previously been breaches in legal requirements.

Summary of findings

Since our last inspection in August 2014 the provider had embedded their recruitment process, had increased night time staffing levels and employed contract cleaners on the week end, which allowed care staff more time to deliver person centred care. Care staff told us people were safe but felt they were often stretched, which did not allow them to stop and talk with people as much as they would like.

Robust recruitment procedures ensured people were supported by care staff with appropriate experience and suitable character. Care staff had undergone relevant recruitment checks as part of their application and these were documented.

The provider had implemented effective systems for identifying and recording incidents and accidents. The registered manager had analysed learning from individual incidents to reduce the risk of recurrence but had not always analysed them as a whole to identify trends that may affect other people. We reviewed the incidents since our last inspection and found no trends were apparent.

People told us they trusted the care staff who made them feel safe. Care staff had completed safeguarding training and had access to relevant guidance. They were able to recognise if people were at risk of abuse and knew what action they should take if required. Since the last inspection the provider had reported one safeguarding incident which had been investigated by the registered manager. We noted that the required learning and appropriate care staff supervision had been implemented as a result of this incident.

We observed medicines administered safely in a way people preferred, by trained care staff who had their competencies assessed by the registered manager.

People's needs had been appropriately assessed and reviewed regularly. Their safety was promoted through individualised risk assessments. Where risks to people had been identified there were plans in place to manage them effectively. These plans were responsive to people's specific needs and tailored the care delivered for each individual. Care staff understood the risks to people and followed guidance to safely manage these risks.

People's health needs were looked after and any concerns were promptly escalated to health care professionals for advice and guidance, which was then followed by care staff. Care staff were trained to deliver effective care, and where required, followed advice from specialists. This included training in caring for people with specific health conditions.

Care staff had completed training on the Mental Capacity Act (MCA) 2005 and understood their responsibilities to protect people's rights. The MCA 2005 legislation provides a legal framework that sets out how to support people who do not have capacity to make a specific decision. Where people lacked the capacity to consent to their care, legal requirements had been followed by care staff when decisions were made on their behalf.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide a lawful way to deprive someone of their liberty, where it is in their best interests or is necessary to protect them from harm. They were aware of a Supreme Court judgement which clarified the definition of a deprivation of liberty. The registered manager had taken the necessary action to ensure care staff recognised and maintained people's rights.

People's needs in relation to nutrition and hydration were documented in their support plans. People were supported appropriately by care staff to ensure they received sufficient to eat and drink. Meals reflected people's dietary needs and preferences. When necessary people had been referred to appropriate health professionals for dietary advice, which was then implemented by care staff.

The provider aimed to enable people to maintain their independence and socialise as much as possible. People's dignity and privacy were respected and supported by care staff who were skilled in using individual's unique communication methods.

When complaints were made they were investigated and action was taken by the provider in response. Complaints were analysed by the provider for themes and where these had been identified action had been taken.

The registered manager was highly visible, and promoted a culture of openness where people and staff were encouraged to provide feedback. During our inspection care staff demonstrated the values of the provider through their behaviours. Care staff were observed to treat people as individuals, with kindness and respect.

Summary of findings

The registered manager had not always demonstrated good leadership. For example, care staff raised concerns during supervisions regarding staffing levels, particularly in the afternoon. The registered manager investigated the issues raised and conducted a staffing needs analysis to ensure staffing levels were sufficient, but had not communicated the outcome to care staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

When there was a need for additional care staff to cover sickness or annual leave, temporary care staff who were not always familiar with people's needs were used. The registered manager reduced the risk to people's safety by personally briefing the temporary care staff and ensuring they shadowed an experienced member of the regular care staff.

The provider operated systems to effectively identify and manage risks from accidents and incidents. However, they had not always analysed incidents to identify themes and trends so action could be taken to prevent a re-occurrence.

People told us they trusted the care staff who made them feel safe. Care staff had completed safeguarding training and had access to relevant guidance.

Is the service effective?

Good

The service was effective.

Care staff received appropriate training and supervision to support people effectively with their general and specific care needs.

Care staff were aware of changes in people's needs. The provider ensured people accessed health care services promptly when required.

People were supported to make their own decisions and choices. People's consent had been sought. Care staff demonstrated an understanding of consent, mental capacity and deprivation of liberty issues.

People were provided with nutritious food and drink of their choice, which met their dietary requirements. People were supported to eat a healthy diet.

Is the service caring?

Good

The service was caring.

People were satisfied with the care and support they received. They felt their individual needs were met and understood by care staff. They told us that they felt they were listened to and that they mattered.

People had opportunities to express their views about their support and the running of the home.

Care staff encouraged people to make choices about their own care and how they wished to spend their time.

Care staff had developed positive and caring relationships with people who were treated with dignity and respect.

Summary of findings

Is the service responsive?

Good 

The service was responsive.

People's care was personalised and based on their wishes and preferences. Care staff understood people's specific needs and provided care in accordance with their wishes.

The provider had taken action to ensure people were supported to pursue social activities to protect them from social isolation.

People's views were sought through surveys, residents meetings and comments. Complaints were listened to, investigated and acted upon promptly by the registered manager.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Quality assurance and clinical governance systems were not always used effectively to drive continuous improvement of the service.

There was an open and transparent culture in the service and people felt able to express their views freely.

Greengables Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 of Green Gables Nursing Home took place on 3 and 4 June 2015 and was unannounced. The inspection team consisted of one CQC inspector.

Before the inspection we looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law.

The provider had completed a Provider Information Return (PIR) before our inspection. A PIR is a form we sometimes ask providers to complete, which includes key information about the service, what the service does well and any improvements they plan to make.

Prior to our inspection we spoke with local authority commissioners and a healthcare professional who were involved in the support of people living at the home. During our inspection we spoke with 12 people, seven of their relatives and two friends, to obtain their views on the quality of care provided at Green Gables Nursing Home.

We used a number of different methods to help us understand the experiences of people using the service who had limited verbal communication and were not always able to tell us about them.

During our inspection we observed how staff interacted with people and used the Short Observational Framework for Inspection (SOFI) during lunch. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We also observed how care staff cared for people across the course of the day, including activities and when medicines were administered. We pathway tracked the care of four people. Pathway tracking is a process which enables us to look in detail at the care received by each person at the home.

In addition, we spoke with the registered manager, four nurses, including the deputy manager, 12 care staff, the activities coordinator, the home administrator and the maintenance officer. We also spoke with the provider's operations manager and a visiting mental health professional. We reviewed eight people's care records including their daily notes, care plans and medicine administration records (MARs). We looked at recruitment files of 14 staff. We also examined records relating to the management of the home. These included maintenance reports, audits and minutes of meetings.

Following the inspection we spoke with two staff, four other relatives, a person's Lasting Power of Attorney and four health professionals who were involved in the support of people living at the home.

Requires Improvement

Is the service safe?

Our findings

During the last inspection in August 2014 the provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced care staff to safeguard the health, safety and welfare of people. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At this inspection we found the provider had followed their action plan and had made necessary improvements to meet the legal requirements. The provider completed a monthly evaluation to ensure safe staffing levels were maintained. As a result the number of care staff on duty during the night had increased from three to four. The provider had also employed a contract cleaner on the weekend to allow care staff to focus on people's care needs. The registered manager told us they conducted a weekly staffing needs analysis which identified any increase in people's dependency, which they discussed with the provider. The registered manager was not able to provide records of these discussions. Rotas confirmed that when people's dependency had increased, where required, staffing levels had been addressed to support their changing needs.

Since our last inspection the provider had implemented a new recruitment programme, which employed care staff on temporary contracts with a view offering permanent contracts after 12 months, subject to suitability and performance. We reviewed staffing rotas for April, May and June 2015. These demonstrated that people mainly received consistent care from care staff they knew, who were aware of their individual needs. Most care staff told us they had volunteered to work extra shifts when required to ensure short notice absences did not affect the quality of people's support. The rotas for April 2015 demonstrated that on three days one temporary care staff had been deployed, which rose to one temporary care staff being deployed on 21 days during May 2015, due to staff annual leave.

However, when there was a need for additional staff to cover sickness or annual leave, temporary staff who were not always familiar with people's needs were used. On the second day of our inspection we spoke with a temporary member of care staff who told us they had not worked at the home before. We observed they were present at the morning handover from the night shift. They told us they had also had a briefing from the registered manager regarding people's individual needs, which were also detailed on an information sheet. This information sheet briefly identified people's needs and the support they required. This member of care staff did not know people's needs without reference to the information sheet or speaking with other care staff. The risk to people had been minimised by the temporary care staff shadowing another experienced regular member of care staff.

People and relatives told us they felt people were safe at Green Gables, although during busy periods care staff were stretched to the limit, which limited their time to engage with people. One person said, "The staff are so caring but sometimes they are rushed off their feet and you don't want to bother them." Rotas demonstrated there were six care staff during the morning shift and five during the afternoon shift. All care staff told us they thought the staffing levels during the afternoon were insufficient. They told us that whilst they felt people were safe, care staff were always under pressure, had to rush when completing records and did not have time to talk with people. Care staff told us there were periods of understaffing, such as times when care staff had to support people when they had hospital appointments. Care provision we observed during the two days of our inspection confirmed that people received safe appropriate care and support in a calm, unhurried manner.

Robust recruitment procedures ensured people were supported by care staff with appropriate experience and suitable character. Care staff had undergone relevant recruitment checks as part of their application and these were documented. These included the provision of suitable references and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with people who use care and support services. Suitable references confirmed the details care staff had provided and proof of their satisfactory conduct in previous health and social care employment. Recruitment files showed that a thorough system was in place for pre-employment checks and the required records were available to confirm these had taken place.

During the last inspection people were not protected from the risks of unsafe or inappropriate care and treatment

Is the service safe?

because accurate and appropriate records were not maintained. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During this inspection we found the provider had followed their action plan and had made necessary improvements to meet the legal requirements. Care staff supported people to keep safe by carrying out risk assessments and taking steps to minimise risks effectively. These were accurately recorded in people's care plans. People's needs were assessed before they moved into the home, using information from the person themselves, relatives and health professionals involved in their care. These assessments were used to ensure people came to Green Gables only if their needs could be met safely. The care plans we reviewed had not been signed or dated to demonstrate who had been involved in creating them or when. The registered manager told us they had written all of the care plans together with the person or where required their family. We spoke with people and their relatives who confirmed they had been fully involved in this process. Monthly reviews by nurses of the needs and risk assessments had been signed and dated.

Care staff were able to demonstrate their knowledge of people's needs and risk assessments, which was consistent with the guidance contained within their support plans. Assessments included risks relating to moving, falling, skin breakdown, choking and malnutrition. When risks were identified, staff developed and followed risk management plans to help keep people safe from harm.

When people required equipment to support their independence or safety, such as walking aids, specialist chairs or bed sides, these were risk assessed appropriately. We observed care staff using equipment correctly and considering risks to people's health and safely. We saw people being repositioned before they ate and during their meals, to reduce their risk of choking. Where people were identified to be at risk of pressure ulcers we noted these were monitored and where necessary people were repositioned in accordance with their pressure area management plans.

People were kept safe as care staff understood their role in relation to safeguarding procedures. Records showed safeguarding incidents had been reported, recorded and investigated in accordance with the provider's safeguarding policies and local authority guidance. All of the care staff had received safeguarding training and knew how to recognise and report potential signs of abuse. They described how they would deal with a safeguarding concern, including reporting issues outside of the provider's organisation if necessary. Care staff told us they had access to safeguarding polices and relevant telephone numbers to enable them to report any safeguarding concerns. Care staff told us they would have no hesitation in reporting abuse and were confident the home manager would act on their concerns. Care staff knew about the provider's whistle blowing policy and said they would use it to keep people safe if they needed to.

People had their medicines at the times they needed them, in the correct dose and in a safe way, administered by care staff who had the required competency and skills. The provider ensured care staff followed policies and procedures about managing medicines, which were in accordance with current legislation and guidance. Records confirmed that nurses had received medicines management training which was up to date, in accordance with the provider's policy. Their competence to administer medicines was also assessed by the registered manager.

The provider had systems for ordering, receiving, storing and disposing of all medicines safely. All medicines were kept safely in a secure environment. Our observations confirmed that access to medicines was restricted only to appropriate care staff involved in the management of medicines. The provider operated a system which ensured medicines required to be stored within recommended temperature ranges to remain effective were safe to administer to people.

Appropriate information was recorded to ensure the safe administration of medicines. During our visit we reviewed the Medicines Administration Records (MAR) for ten people living in the home. MARs contained consistent information regarding people's allergies and preferences regarding how they took their medicines. Appropriate arrangements were in place for the recording of medicines administration. MARs accurately identified which medicines had been administered, when and by whom. Nurses were able to demonstrate the procedure to follow if people declined their medicines, which we saw recorded in the MARs.

The provider had a policy and procedure in relation to homely remedies and medicines prescribed to be taken as required (PRN), which care staff followed in practice. Homely remedies are medicines the public can buy to treat

Requires Improvement

Is the service safe?

minor illnesses like headaches and colds. PRN medicines are those prescribed to be taken when the person requires them. Homely remedies and PRN medicines were managed safely. There had been no medicines errors recorded in the home since the previous inspection. People were protected from the misuse of medicines, as procedures were in place for the safe management of medicines.

The provider had an emergency business and continuity plan for the home. Fire safety precautions and equipment were checked regularly. Evacuation procedures had been practiced to ensure they were safe and effective. Utilities, such as gas and electricity were routinely checked under contract and the maintenance staff ensured that repairs were completed promptly. All equipment used to support people had been serviced regularly in accordance with the manufacturer's guidance, to ensure it was safe, clean and fit for purpose. People lived in a safe environment because premises and equipment were checked and maintained effectively.

Good

Is the service effective?

Our findings

People and relatives made positive comments about the effectiveness of the service. One person told us "The carers are really good because they always make sure I see the nurse or a doctor if I'm poorly." A relative told us, "I have every confidence in the carers because they know the people here and communicate with them and their families really well."

Care staff had completed an induction process recognised by the care sector. This ensured they had the appropriate knowledge and skills to support people effectively and could work safely unsupervised. Care staff told us they had received a thorough induction which gave them the skills and confidence to carry out their role. This was followed by a period where they shadowed an experienced colleague until they were confident to work alone.

People told us that care staff were well trained, and they had seen new care staff shadowing the experienced care staff, which they thought was good. We spoke with two new nurses who told us they had shadowed a colleague for two weeks before they were allowed to work unsupervised. They told us the registered manager had provided clear guidance regarding what they could and could not do during this period, although there was no record of this guidance.

People said the care staff were attentive, and a visiting health professional confirmed that care staff followed any guidance they had provided. People were cared for by care staff who understood and responded to their needs. Care staff were knowledgeable about individual's needs and provided care in a calm and relaxed manner, which reassured people. Records showed that the required staff training was up to date, which included moving and handling, safeguarding, infection control, basic food hygiene, fire safety and first aid awareness. Care staff had received further training specific to the needs of the people they supported, such as diabetes.

We accompanied the night nurse early in the morning, whilst they were administering medicines to people with diabetes. During this medicine administration round the nurse took immediate action to support a person with breathing difficulties, offering reassurance whilst repositioning them, and completing appropriate respiratory tests. Although these tests proved negative the nurse ensured all care staff were made aware of the person's condition and arranged for regular monitoring to ensure prompt intervention by care staff if required.

Care staff were supported by a system of formal supervisions every eight weeks and had had an annual appraisal during 2015 or had one scheduled. Supervisions provided staff with the opportunity to communicate any problems and suggest ways in which the service could improve. Staff told us they were encouraged to speak with the management team immediately if they had concerns about anything, particularly in relation to people's needs.

Care staff confirmed they had completed training in the Mental Capacity Act (MCA) 2005 on 28 May 2015, which records confirmed. The MCA 2005 provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Where people lacked the capacity to consent to their care, guidance had been followed to make best interest decisions on their behalf. If people lacked the capacity to decide to receive care, where required, their relatives had been consulted about their best interests. Care staff demonstrated an understanding of the principles of the act and described how they supported people to make decisions.

We observed people being asked for their consent before they were given medicines and other support. People told us that their medicines were reviewed regularly and they were involved in discussions with their GP and care staff before decisions were made to change their prescribed medicines or the dose. We noted that the service had policies regarding non-compliance with medicines and a covert administration policy, which care staff followed in practice. This meant that people's rights were protected and their prescribed medicines were always lawfully administered.

The Care Quality Commission (CQC) monitors the operation of the DoLs which applies to care homes The registered manager was aware of a Supreme Court judgement which widened and clarified the definition of a deprivation of liberty. They told us about how they were working with social services and had identified ten applications required to be made. We noted that four had been submitted and six others were in the process of being completed. People's human rights were protected as relevant staff understood the DoLs.

Good

Is the service effective?

People and relatives had mixed views in relation to the food. Most people told us the food was good, whilst some said it could be improved. One person said, "I like the food but if you don't like what's on offer the cook will make something you would like." Another person said, "I don't always like what is on the menu but they are very good at getting what you want. The other day I just fancied having a lamb chop and the cook went to the butchers and got me one."

People's nutritional needs were assessed and there was guidance for care staff on how to support people in the way they needed. The cook followed nutritional guidance based on people's preferences and any professional assessments undertaken by dieticians or speech and language therapists. This guidance was detailed in people's files and the cook was involved in ensuring people received suitable foods of the correct consistency to mitigate against the risk of choking.

Information about people's nutritional needs was displayed on a kitchen whiteboard. However, there was no written documentation in the kitchen to show what modified texture of food people required. We observed catering staff prepared texture modified food and drinks from their experience and knowledge of the person, and that the texture was in accordance with their identified nutritional needs. Recognised descriptions for texture modified foods were not used by catering or care staff to define the correct texture of meals required for each person. People may not receive food of the right texture if catering staff were unfamiliar with people's specific nutritional needs.

We recommend the provider refers to best practice issued by the National Patient Safety Agency in relation to texture modified foods.

Where people were identified at risk of malnutrition or dehydration, care staff monitored their daily intake of food and fluids. One person we pathway tracked was supported by a community mental health team and had been receiving support to improve their nutritional intake. During our SOFI observation we saw this person eat the main course and pudding, whilst consuming two drinks. A visiting health professional told us the person's mobility had greatly improved whilst living at Green Gables, which was due to improved nutrition and being supported to walk as far as they could, in accordance with their mobility plan. People were supported to have sufficient to eat and drink.

We conducted a SOFI observation during lunch between 12.45 pm and 2.15 pm on 4 June 2015.

We saw that care staff discreetly offered support to people to make food and drink choices and checked when they had finished their meals. Positive friendly interactions between staff and people were observed and support was provided at people's own pace. Care staff were attentive throughout the meal and offered gentle encouragement particularly to people who had been identified at increased risk of malnutrition. Care staff provided appropriate support with people's mobility when they decided to leave. People were supported to maintain a healthy, balanced diet.

People were supported to stay healthy. Records showed that people had regular access to healthcare professionals such as GP's, district nurses, dieticians, occupational therapists, physiotherapists, opticians and dentists.

Good

Is the service caring?

Our findings

People were supported by care staff who were kind and attentive. People were satisfied with the care and support they received. They felt their individual needs were met and understood by staff who listened to them. One person said, "It's lovely here, I didn't want to come but now it's like my home from home." Another person said, "The carers are so kind and patient." We observed a warm atmosphere in the home with people engaging care staff and each other in conversation. Care staff always spoke in an inclusive manner, enquiring about people's welfare and feelings. Care staff treated people in a gentle supportive way and took their time whilst delivering support so people did not feel rushed. A relative with experience of other care homes told us, "This is better than other homes because the carers treat people like their own family and it's not just a job to them."

Care staff were very knowledgeable about people's needs and had developed caring relationships with them. Health professionals told us that relationships between people and care staff were 'caring and compassionate'. During our inspection we observed a group activity where we saw a person become confused and distressed. Care staff immediately provided kind reassurance, in accordance with that person's care plan. During lunch one person, concerned about the wellbeing of another who was their friend, asked for a particular nurse who their friend preferred to come and see them. We observed this nurse engage with the person who was worried about their friend, which reassured them. The nurse also spoke with the person's friend in an inclusive manner and had a meaningful conversation with them, which made them smile. Another nurse knelt next to a person with a hearing impairment so they could engage with them in a meaningful conversation. After the conversation the person told us, "She is very kind and always talks to me even though I can't hear very well."

Throughout the inspection we observed and heard care staff continually providing reassuring information and explanations to people whilst providing care, particularly when supporting them to move. One person became worried and disorientated whilst being transferred from an armchair into their wheelchair. Care staff provided gentle reassurance which eased their anxieties.

Care staff ensured they used language the person understood and continually encouraged and reminded them of their positive achievements whilst providing support. People and care staff had general conversations that did not just focus on the person's support needs. Some people had limited verbal communication, whilst others had sensory impairments. Care staff understood how people showed dislike, displeasure, and discomfort, and addressed identified issues in a sensitive manner.

Care staff understood their obligation to support people's freedom and independence. People had access to all parts of the home, and chose how they spent their time. When care staff offered people options, for example, in relation to activities, meals, drinks or clothing, they gave people time to decide and respected their decisions.

We observed people's privacy and dignity were promoted by care staff who respected people's diversity. Care staff told us they had completed training in relation to 'equality and diversity' and 'dignity and person centred care', which was confirmed by records. We observed care staff knocked and asked for permission before entering their rooms and spoke courteously with people. We heard conversations between care staff and people which demonstrated care staff knew people's personal histories. People said care staff were polite and respectful when providing personal care and they were given a choice of male or female carers. Care staff gave examples of how they supported people in a dignified way with their personal care, by ensuring doors were closed and curtains drawn when necessary.

People's rooms were personalised with their belongings, furniture and photographs. One person told us, "I like my room because I have my personal things around me and lots of happy memories about my family."

Some people had expressed their wishes for end of life care and these were noted in people's records. Where appropriate, people were given support when making decisions about their preferences for end of life care. We reviewed people's end of life care plans and noted people's faith, culture and advanced decisions had been considered. We spoke with relatives of a person who was being supported with palliative care who praised the registered manager and care staff for the "kind and compassionate care" provided to their loved one and their family. When people were nearing the end of their life we observed they received appropriate care from care staff who were supported by palliative care specialists where

Good

Is the service caring?

required. Palliative care is the active holistic care of patients with advanced progressive illness. Care staff had completed training in relation to the provision of palliative care and demonstrated clear understanding of the principles of palliative care through their care practice.

All care records were kept securely in the nurse's office, which was locked when not in use by nursing staff. Care staff had completed training and demonstrated knowledge in relation to their responsibility to maintain the confidentiality of people's care records in order to protect their privacy.

Good

Is the service responsive?

Our findings

People were involved in planning their care. People and relatives told us they had visited the home before they moved in, which had reassured them. Initial assessments were completed by the registered manager before people moved into the home to ensure the provider was able to meet their needs. Needs and risk assessments were completed and reviewed with the involvement of the person, their relatives or advocate where required. Care plans captured people's individual preferences and identified how they wished to spend their time and live their lives. People were supported to be involved in decisions about their care.

The registered manager told us people's care plans had been reviewed and there was a greater focus on care documentation being person centred. Care plans highlighted when people preferred care staff of a particular gender and how people liked to be addressed. The registered manager told us that where people's life histories were brief they were in the process, with relative's assistance where required, of describing people's interests, achievements and passions in more detail. People and relatives we spoke with told us the registered manager and activities coordinator had spoken with them to arrange convenient appointments to gain further information about their life histories.

People's care plans were personalised providing guidance for staff about how to support them. The manager told us care staff planned care with people and focused on the person's description of how they wanted their care provided. People's preferences about terms of address, bathing arrangements, times they liked to get up and go to bed were noted. Care staff told us about the preferences and dislikes of the people they were supporting. People's care plans reflected how they wanted their care provided.

Care documentation included information about individual support needs. Information was presented in a personalised way and included details such as how people liked to be supported people when they were distressed or unhappy. The home's cook was dedicated to providing person centred nutrition and hydration. For instance they visited the local butcher and green grocer to obtain particular cuts of meat and vegetables that people specifically requested, if they did not want the meal offered on the menu. People were also offered drinks of their choice.

The provider was committed to listening to people's views and making changes to the home in accordance with people's comments and suggestions. People said they could let care staff know if they were unhappy with something. Feedback was sought by the provider and registered manager from provider surveys and resident's meetings. The registered manager ensured this feedback was acted upon. People commented on changes that had been made as a result of feedback such as the new menus, replacement furniture and activities. One person told us they had asked for less sausages on the menu, whilst another had requested new armchairs. We noted these requests had been recorded in minutes of the quarterly residents meeting on 17 April 2015 and action had been taken by the provider. One person said, "The registered manager is always available and listens to what we say."

People had a copy of the provider's complaints procedure in a format which met their needs. This had been explained to them and, where necessary, their relatives by the registered manager. Care staff knew the complaints procedure but told us they dealt with small concerns as soon as they arose to prevent them escalating. Complaints and concerns formed part of the provider's quality auditing processes so that on-going learning and development of the home was achieved.

The registered manager maintained a record of complaints, but said that most issues were brought to her attention verbally and were addressed swiftly. This open approach was confirmed by people, relatives and care staff. Since the last inspection there had been five complaints. One complaint raised concerns that a person was being transferred in a wheelchair rather than being supported to walk. This complaint had been addressed by the registered manager who had investigated the complaint and ensured care staff were fully aware of the person's mobility plan. During the inspection we observed the person being supported to walk in accordance with their care plan. Records demonstrated that formal complaints since our last inspection had been promptly resolved by the provider.

People's care plans included guidance for care staff on supporting their specific health conditions, such as

Good

Is the service responsive?

diabetes or dementia, and how to support them if they became unwell. Care plans also described how people communicated and any care needs associated with this, such as prompting staff to check people's supportive equipment, such as hearing aids.

The provider responded promptly to people's changing health needs through person centred care planning and review. People's care plans were reviewed monthly or more frequently if their needs changed. People recently discharged from hospital had all aspects of their care re-assessed and reviewed before or upon their return to the home.

People were supported to pursue social activities to protect them from social isolation. The activities programme had been revised and there were a range of social events arranged in the home, which included visiting entertainers, quizzes, arts and crafts, parties and music. People enjoyed the activities on offer and staff enabled people to participate at their own pace. We observed a game of bingo where ten people engaged in humorous banter with the bingo caller. People were very positive about the activities programme and the enthusiasm of the care staff encouraging their involvement. People's participation was monitored by the coordinator to improve the programme and identify if people were becoming socially isolated.

People told us they enjoyed trips outside the home. One person told us, "I like going out and look forward to the church coffee morning where I treat myself to a cake." A relative told us their loved one looked forward to going into the community and said, "I try to come as often as I can to support staff when there is a trip out. They had a lovely time recently visiting the local garden centre, looking at all the plants and flowers."

The activities coordinator had identified the need to develop 'one to one' time with people. They told us that as well as the group activities they also tried to spend time with people on a one to one basis who just wanted to chat. The care coordinator told us that an activity course they would be attending, would enable them to provide more choice and stimulating activities in the future.

Requires Improvement

Is the service well-led?

Our findings

During our inspection in August 2014 the provider had not protected people against the risk of inappropriate or unsafe care by effectively assessing and monitoring the quality of the service provided. Procedures for monitoring and assessing care quality and service performance had fallen into disuse.

At this inspection we found the provider had taken action to ensure the necessary improvements had been made. The provider was now assessing and monitoring the quality of the service to protect people from the risk of unsafe care.

People's care plans and risk assessments had been reviewed and updated. The registered manager completed monthly audits of people's care records. They reviewed three different people's care records at each audit. This ensured every person's care records were fully reviewed annually by the registered manager. We identified that some of the audit processes completed by the registered manager were duplicated by audits completed by other care staff, such as care records. This was to ensure these processes were embedded and sustained.

The registered manager had implemented a programme of supervision and appraisal where staff were encouraged to discuss all matters relevant to the quality of care people experienced. All supervision records identified that care staff had raised concerns to the registered manager about insufficient staffing levels. The registered manager had investigated these concerns and found staffing levels to be sufficient to meet people's needs. However, they had not told the care staff of the outcome. The provider did not always demonstrate effective communication by providing feedback when care staff had made suggestions to improve the quality of the service.

Since our last inspection care staff turnover had decreased and deployed staffing levels were higher and more consistent. Care staff understood their roles and responsibilities. The registered manager believed they should be highly visible and not sat in their office, which we observed in practice. The registered manager, who was a registered nurse, said they frequently worked alongside care staff which enabled them to speak with people, observe staff practice and interactions with people and to seek staff feedback. This was confirmed during our observations and conversations with people, relatives and care staff.

The registered manager actively encouraged care staff and people to be involved in the running of the home. There was an open and transparent culture in the service and people felt able to express their views freely. We observed people and staff approaching the registered manager and deputy to ask questions or chat. Care staff told us the registered manager was always available if they needed guidance and were regularly involved delivering care. They told us that the personal support provided to people by the registered manager increased during busy periods, which we observed in practice.

Management arrangements for communicating important events and tasks were effective. This was confirmed by visiting health professionals, staff and relatives. There were daily meetings at shift handovers, which were recorded and regular staff meetings. We reviewed the minutes of these meetings which emphasised the person-centred approach to care, areas for development and any issues that needed to be addressed.

Accidents and incidents had been recorded and individual events investigated. However the provider had not completed any root cause analysis to identify any trends and learning to minimise the risks of reoccurrence. For example, the home had recorded 24 falls during 2015 and action had been taken to minimise the risk of the individual experiencing further harm. However, there had been no analysis to identify common themes that could be relevant to other people using the service to minimise the risks to them. The approach to service delivery and improvement was reactive and focused on short term issues.

There was a culture of reporting errors, omissions and concerns. Staff understood the importance of escalating concerns to keep people safe, and they were offered additional support and training when necessary. The registered manager understood their responsibility to report incidents of actual or suspected abuse promptly to the Local Authority and to notify the CQC.

Records were managed to promote effective care. The records were up to date and informative. They were routinely reviewed and kept securely to maintain confidentiality.

Requires Improvement

Is the service well-led?

Even though care staff we spoke with were unable to tell us about the values of the service contained in the provider's mission statement they were able to identify the main values which they demonstrated in their practice. One member of care staff told us, "Looking after people and giving them the best possible care is our main priority", whilst another said, "We treat people with respect and dignity at all times." These comments mirrored the main ethos of the provider's values. We observed staff demonstrating the provider's values when providing support to people. . Care staff treated people as individuals, with kindness and respect. People were cared for by staff who practised the values of the service in the provision of their care.