Victoria Nursing Group Limited

Victoria Chatsworth

Inspection report

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Date of inspection visit:
10 January 2017

Date of publication:
02 February 2017

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

This inspection took place on 10 January 2017 and was unannounced.

Victoria Chatsworth is a nursing home registered for up to 22 people. It provides nursing care and personal support to older people with nursing care needs usually over sixty-five years of age. There were 19 people living at the service. The service is in a large detached house, arranged over two floors accessed by a passenger lift. The ground and first floor was used to provide people with nursing care, support and treatment. Long term care and respite care was provided. At the time of the inspection a contract was in place to provide six community short term beds (CSTS.) This is where people have been in hospital, or to prevent hospital admission and need a short period of rehabilitation before returning home.

This short-term rehabilitation is a joint partnership between Brighton and Hove City Council and the Sussex Community NHS Trust who work together to provide co-ordinated care. People have the guidance and regular support from the physiotherapists, occupational therapists, consultants for elderly care, GPs and a community mental health nurse. These specialists had worked with people to improve their independence and mobility prior to returning home.

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

Senior staff carried out a range of internal audits, including care planning, checks that people were receiving the care they needed, medication, and infection control. However, regular fire and health and safety checks of the building had only just started to be completed and so it was not possible to evidence this practice had been fully embedded in the service. This meant it had not been identified the PEEP's (Personal Emergency Evacuation Plan) in place for people in the event of a fire had been regularly reviewed. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. Residents meetings had not been regularly held to enable them to give their views on the care and support provided. Although there were opportunities for people to give feedback using the Choices NHS website, questionnaires had only just started to be used to gain feedback in the service. Therefore people had not had a range of opportunities to formally give their feedback, and for the staff to demonstrate how the service has moved forward and made improvements following feedback received. These are areas of practice which require improvement.

People told us they felt safe. One person told us, "There is always a member of staff around to reassure me. You only have to ring the bell and they come." Another person told us, "I feel safe because I always get my pills on time." A third person said, "It's very safe here the carers are very good-they help me a lot." People were cared for by staff who had been recruited through safe procedures. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and

responsibilities effectively. Training records were kept up-to-date, and plans were in place to promote good practice and develop the knowledge and skills of staff. People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the registered manager. There was a maintenance programme in place which ensured repairs were carried out in a timely way. Medicines were stored correctly and there were systems to manage medicine safely. Audits and stock checks were completed to ensure people received their medicines as prescribed.

Staff were aware of their responsibilities from the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) Where people lacked capacity to make decisions about their care and treatment this had been considered in their best interests. People and their relatives told us staff were kind and caring. One person told us, "This is a home from home." People were treated with respect and dignity by the staff. They were spoken with and supported in a sensitive, respectful and professional manner.

People told us there were enough staff on duty to meet their care needs. Senior staff monitored people's dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Staff told us there were adequate staff on duty to meet people's care needs. One member of staff told us, "Staffing is better now we have five on in the morning, it's a really good team here and new staff says we're friendly." Another member of staff told us, "We have enough staff and normally finish the personal care by 11.00am. At the moment most are self-caring and mobile and there are only seven rooms that need help. We are there to encourage and supervise. It's quiet at the moment."

People told us they had felt involved in making decisions about their care and treatment and felt listened to. Care and support provided was personalised and based on the identified needs of each individual. One person told us, "I like my independence. They always listen to me, I have been here a long time so they know all about me .I tell them I am homeless because I couldn't live alone at home. They say this is your home and we are your family. It is different care from the hospital when you depend on nurses, it's free and easy here with no pressure. I leave my room once a day for activities." People's care and support plans and risk assessments were detailed and reviewed regularly giving clear guidance for care staff to follow. People's healthcare needs were monitored and they had access to health care professionals when they needed to.

People were supported to take part in a range of recreational activities. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

Staff told us that communication throughout the service was good and included comprehensive handovers at the beginning of each shift and regular staff meetings. They felt they knew people's care and support needs and were kept informed of any changes. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. They confirmed that they felt valued and supported by the managers, who they described as very approachable. They told us the team worked well together.

People's nutritional needs had been assessed and they had a selection of choices of dishes to select from at each meal. People said the food was good and plentiful. Staff told us that an individual's dietary requirements formed part of their pre-admission assessment and people were regularly consulted about their food preferences.

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.

People were cared for by staff recruited through safe recruitment procedures. Staffing levels were monitored to ensure there were enough staff to meet people's care needs.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed.

Medicines were managed, stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff were aware of their responsibilities from the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) Where people lacked capacity to make decisions about their care and treatment this had been considered in their best interests.

Staff had a good understanding of peoples care and support needs. People were supported by staff that had the necessary skills and knowledge.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals when they needed them.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People had been assessed and their care and support needs identified. Care plans were in place to ensure people received care which was personalised to meet their needs and wishes.

People were supported to take part in a range of recreational activities. These were organised in line with peoples' preferences. Family members and friends continued to play an important role and people spent time with them.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Requires Improvement

The service was not consistently wel- led.

Quality assurance was used to monitor and to help improve standards of service delivery. However, there had not been regular opportunities for people to be able to comment on and be involved with the service provided to influence service delivery. Health and safety checks had not been completed to meet the provider's policy and procedures.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of the service was approachable and very supportive.

Systems were in place to ensure accidents and incidents were reported and acted upon.

Victoria Chatsworth

Detailed findings

Background to this inspection

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

This inspection took place on 10 January 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience helped us to get feedback from people being supported and their visitors.

Before the inspection, we reviewed information we held about the service. This included any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. This helped us to plan our inspection. We requested the provider to complete 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 improvements they plan to make. We spoke to the local authority commissioning team who have responsibility for monitoring the quality and safety of the service provided to local authority funded people. We also spoke with the Clinical Commissioning Group (CCG) for feedback on the care provided. Following our visit, we received feedback from three health care and a social care professionals about their experiences of the service provided.

We spoke with nine people, and three visitors. We spoke with the registered manager, a registered general nurse (RGN), two senior care staff, an activity co-ordinator, an occupational therapist, a visiting health care professional, the maintenance person and a chef. We observed the care and support provided in the communal areas, medicines administration, activities provided and the mealtime experience for people over lunchtime.

We looked around the service in general including the communal areas, people's bedrooms, and the garden. As part of our inspection we looked in detail at the care provided to six people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medicines administration

records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and five staff personnel records. We also looked at the provider's own improvement plan and quality assurance audits.

This is the first inspection of the service since the re-registration of the provider's legal entity.

Good

Is the service safe?

Our findings

People and their visitors told us they felt people were safe, happy and were well treated in Victoria Chatsworth. This was because there were enough staff on duty to meet their care needs. One person told us, "Even if they are likely to be delayed, they pop in and say 'we'll be with you in a few minutes'." Another person told us, "Most times there are enough staff on duty; there are five in the morning and two at night. I suppose holidays and sickness cause problems. But the agency staff are not strangers to us." One member of staff told us, "We make sure they are safe, they trust us. We do safeguarding training on E learning and understand different types of abuse such as verbal, emotional, physical or financial. We would report to the registered nurse in charge if we had concerns or call the safeguarding team the number is in the office, or go higher (management.)"

People had individual assessments of potential risks to their health and welfare and these were reviewed regularly. Where risks were identified, staff were given clear guidance about how these should be managed. Staff also told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. One person told us how they had made choices around their risks, "I make decisions about risks I can take. I have lots of plasters. One day I fell and the door handle went through my skin. It takes longer to heal but it is getting better. My decision is not to leave my room anymore." Where people had an air mattress (inflatable mattress which could protect people from the risk of pressure damage) where they had been assessed as high risk of skin breakdown (pressure sore). We were informed by staff the air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. Records we looked at confirmed this. Where people had also been assessed as requiring to be turned periodically during the day there were checks in place to ensure the recording had been completed to demonstrate this had been done and inform the staff team of people's care needs.

A dedicated maintenance worker was responsible for the general maintenance, alongside external contactors who were used for service checks and repairs. Staff we spoke with confirmed that any faults were repaired promptly. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. Records we looked at confirmed this. The registered manager told us about the regular checks and audits which had been completed for example in relation to infection control. One person told us, "The room is safe, they clean it every day, and there are no trip hazards the call bell is always within reach so I have no worries. The cleaners work very hard they have no time to chat." There was an emergency on call rota of senior staff available for help and support. Contingency plans were in place to respond to any emergencies such as flood or fire. A new fire alarm system was in the process of being fitted in the service. One person told us, "They look after our safety. All these workmen are fitting new fire alarms in all the rooms and corridors."

Medicines were managed safely. One person told us, "They never give the impression that a task is too much trouble. If you are in pain they give you painkillers." Another person told us, "Staff always help us. If anything is hurting they give me paracetamol." A third person told us, "They give me a morphine tablet if the pain is very bad." We looked at the management of medicines. There were appropriate arrangements in place to

protect people against the risks associated with the unsafe use and management of medicines. Medicines were kept securely and within their recommended temperature ranges. The nursing staff were trained in the administration of medicines and had their competency regularly checked. Staff told us the system for medicines administration worked well in the service. Systems were in place to ensure repeat medicines were ordered in a timely way. A member of staff described how they completed the medicines administration records (MAR). MAR charts are the formal record of administration of medicine within a care setting and we found these had been fully completed. Regular audits and stock checks were completed to ensure people received their medicines as prescribed. Where people took medicines on an 'as and when' basis (PRN) there was guidance in place for staff to follow to ensure this was administered correctly. Where people had topical creams applied recording had been completed to evidence it had been applied and inform other care staff of its application. We observed one member of staff administer some medicines. They informed the person why they had come to see them and what the tablets they were being given were for. People were supported to self-administer their medicines through a risk management process, particularly if people were staying for a short period and then returning home. One member of staff told us, "If they are here for a while we see if they can do it for themselves and check that they are ok, not many can. We would get them blister packs."

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They were aware they had to notify the CQC when safeguarding issues had arisen at the service in line with registration requirements, and therefore we could monitor that all appropriate action had been taken to safeguard people from harm. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. Staff told us that they would immediately report any bruising and finger marks, change of behaviour or if people became withdrawn.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Accidents and incidents were recorded and staff knew how and where to record the information. Remedial action was taken and any learning outcomes were logged. Steps were then taken to prevent similar events from happening in the future.

People told us they felt safe and well attended to by staff. Care staff were supported by the ancillary staff who covered catering, domestic, maintenance and administrative tasks in the service. Bedrooms had an emergency call bell which people could press if they required urgent attention and a call bell to press if they required assistance. We found that call bells were answered promptly by staff on the day of the inspection. People and visitors told us there were enough staff on duty to meet people's needs. One person told us, "There is always a member of staff around to reassure me. You only have to ring the bell and they come." On the day of the inspection there were adequate staff on duty to meet people's care needs. The registered manager was on duty with a registered general nurse (RGN), a senior care worker and five care staff.

The staff demonstrated they knew the people well. The registered manager told us they regularly met with the RGNs to identify the level of staffing needed. A dependency tool was used to inform and ensure

adequate levels of staff were on duty. Staff told us that at times it could be busy, but there was adequate staff on duty to meet people's care needs. One member of staff told us, "It can be stressful especially since we started taking more short term beds as it creates extra work. The paperwork has increased but we would get bank staff in if we were worried." Another member of staff told us, "We have good seniors here and they provide leadership. The RGNs do dressings and meds and sort out staff problems." A third member of staff said, "There is improved staffing and the carers are experienced." They told us minimum staffing levels were maintained. They also spoke of good team spirit. A sample of the records we looked at showed that the minimum staffing level was adhered to.

People were cared for by staff who had been recruited through safe recruitment procedures. Where staff had applied to work at Victoria Chatsworth they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written references requested. Where registered nurses were being recruited we saw that checks had been made on their pin number. This is an information system which can be accessed to ensure nursing staff were still registered to work as a nurse provided nursing care. This meant that all the information required had been available for a decision to be made as to the suitability of a person to work with adults. One new member of staff was able to confirm the process followed.

Good

Is the service effective?

Our findings

People and visitors told us they felt the care was good and people's health care needs had been met. One person told us, "You can always see a GP or an Optician. The optician came at Christmas and I have new glasses." They spoke very well of the food provided. One person told us, "You can always have a choice. If you don't like anything you can have a jacket potato, which I like."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the staff were working within the principles of the MCA. Staff understood the principles of the MCA. They were aware that any decisions made for people who lacked capacity had to be in their best interests. They gave us examples of how they would follow appropriate procedures in practice. There were clear policies around the MCA. Care staff told us they had completed this training and all had a good understanding of the need for people to consent to any care or treatment to be provided. One member of staff told us, "We have done best interest meetings." Another member of staff told us, "I did MCA training a year ago and it's about decision making and capacity." One person told us, "They never do anything without asking permission and they explain what they are doing." There were records on people's care plans that, where possible, people had been asked to consent to their care and treatment. Care staff confirmed they always asked for people's consent before they undertook any care or treatment. One member of staff told us, "We get consent and tell them what is going to happen and try to make them independent and they will ask for help if needed." Another member of staff told us if people refuse any care, "We respect refusals and write it down."

The registered manager told us they were aware of how to make an application and about the DoLS (Deprivation of Liberty Safeguards) applications that had already been made and had been agreed. They were monitoring and ensuring these were being followed and updated as required. Care staff told us they had completed this training and had a good understanding of what this meant for people to have a DoLS application agreed, and they were clear who had been put forward for a DoLS application. People's records also highlighted to care staff who had a DoLS in place, or if there were any actions they had to follow to support people where an application had been agreed. Bed rail risk assessments were in place for people where bed rails were used and where possible people had consented to their use.

People were supported by care staff that had the knowledge and skills to carry out their role and meet people's individual care and support needs. The registered manager told us all care staff completed an induction before they supported people. This had been reviewed to incorporate the requirements of the new care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more

experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. We observed a new member of staff being shadowed and orientated to the service. We spoke to their supervisor and were told the new member of staff was, "Being broken in gently for the first day and that training was being arranged." By the end of the shift the new staff member had been given their Care Certificate documentation.

Staff received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. Training had also been provided with the dementia in reach team. Nursing staff had been supported and provided with information on courses they could attend to keep their clinical skills updated and current. The training completed was given through a mixture of E-learning packages or practical sessions. Care staff told us their training was up-to-date and had helped them understand and support people. One member of staff told us, "We had dementia training yesterday and diabetes care, whatever you want you can do it." Another member of staff told us, "Training is very good we learn how to handle equipment and do practical as well as E learning." Staff showed us a notice board where all the staff training with due dates were posted; and one member of staff told us, "There is always new training up there as soon as we have completed one lot."

Staff told us that the team worked well together and that communication was good. They told us they were involved with any review of the care and support plans. They used shift handovers, to share and update themselves of any changes in people's care. Care staff received supervision from the registered manager or deputy manager. They told us they provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance to identify any further training or support they required. Staff told us that supervision was a two way process and that they could have informal chats and go through the training. There were also periodic staff meeting to keep staff up-to-date with the running of the service.

People's nutritional needs were assessed and recorded, and people's likes and dislikes had been discussed as part of the admissions process. People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. One member of staff told us when there were any concerns, "For example, if they were losing weight we would speak to speech and language team (SALT) or if they had a problem with swallowing."

People and visitors spoke well of the food provided and the food was very good. One person told us, "I usually eat what they bring to my room" Another person told us, "I have to keep telling them not to send such big portions. "The chef told us there was a rotating menu, which was based on people's likes and dislikes. One person told us, "Now and again they ask about the meals we like or dislike." Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the chef. The chef showed us they had information available on the dietary requirements and likes and dislikes of each person. the chef went round each evening with menu choices. For example, whether a pureed or soft diet was required. This showed us that staff were aware of individual's preferences, needs and nutritional requirements. One person who had a pureed meal told us, "It was very well presented under the circumstances. "Lunchtime was relaxed and people were considerately supported to move to the dining area, or could choose to eat in their bedroom. People were encouraged to be independent throughout the meal and staff were available if people wanted

support, or extra food or drinks. Some people had support with eating their meals. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation.

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, or the speech and language team (SALT) and when referrals had been made. Care staff told us that they knew the people well and if they found a person was poorly they should report this to a manager. People were supported to maintain good health and received ongoing healthcare support. One person told us, "They will send for a GP if you are ill. I have my own GP who came once but said he would come anytime I needed him. Another person told us, "I have dentures so I do not need a dentist. They take my teeth away at night and soak them." A third person said, "The Chiropodist comes in regularly because I have diabetes."

There was a policy and procedure for nursing staff to follow for wound care. There was guidance for nursing staff to follow, and recording and on-going photographic evidence to help monitor and review how the wound was progressing with treatment. Effective monitoring systems to evaluate and ensure the person's health and well-being was maintained, in relation to any wounds, were in place. There were no people being provided with end of life care. A senior RGN was the end of life coordinator for the home and responsible for end of life advanced care plans which involved the family and to ensure that anticipatory needs were taken care of such as analgesia (Pain relief).

Good

Is the service caring?

Our findings

People and visitors told us people were treated with kindness and compassion in their day-to-day care. They were satisfied with the care and support people received. They were happy and they liked the staff. One person told us, "They are very good with difficult residents. One lady has dementia and they sit and talk to her. They calm her down and stroke her face and tell her she is beautiful. They are so kind and caring." Another person told us, "They help us all the time, you cannot fault them." A third person said, "They support me and help me manage my life." A compliment which had been received in the service detailed, 'Thank you all so much for the care, kindness and consideration during (Person's name) stay at Victoria Chatsworth.' Another compliment detailed, 'Thank you very much for the excellent compassion and care you gave. Thank you for working in partnership with (Person's name) and I.' a third compliment detailed, 'You are all stars.'

During our inspection we spent time in the communal areas with people and staff. People were seen to be comfortable with staff and frequently engaged in friendly conversation. People were enabled to make choices about their care and treatment. Staff ensured they asked people if they were happy to have any care or support provided. For example, we observed the activity members of staff informing and encouraging people to take part in the activities arranged on that day. Staff provided care in a kind, compassionate and sensitive way. They answered questions, gave explanations and offered reassurance to people who were anxious. Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listened to people, and there was a close and supportive relationship between them.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met people's individual needs. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it affected them today. Care staff demonstrated they were knowledgeable about people's likes, dislikes and the type of activities they enjoyed. Staff spoke positively about the standard of care provided and the approach of the staff working in the service.

Throughout the inspection, people were observed moving around the service and spending time in the lounge or dining area. People's rooms were personalised with their belongings and memorabilia. People showed us their photographs and other items that were important to them. People were supported to maintain their personal and physical appearance. They were dressed in the clothes they preferred and in the way they wanted.

We looked at the arrangements in place to protect and uphold people's confidentiality, privacy and dignity. People told us care staff ensured their privacy and dignity was considered when personal care was provided. One person told us, "I am always treated with dignity and respect. I don't mind if it is a male or female carer

they just get on with the job." Another person told us, "They never rush me they seem to know what is required." As part of staff's induction this was covered and the registered manager undertook checks to ensure staff were adhering to the principles of privacy and dignity. They were able to describe how they worked in a way that protected this. One member of staff told us, "We close the door when washing them and cover them with a towel. We put signs on the door to say that we are doing personal care and not to enter. We knock the door and ask permission before we go in. Another member of staff told us," We provide personalised care and we tell them step by step what we did and tell others to read the care plan to find out. We go to the rooms first and ask if they want to get up we respect their decisions and do the care later if they want to get up later."

People had been supported to keep in contact with their family and friends. One person told us, "Friends come in, they are made very welcome. "Visitors told us there was flexible visiting. The registered manager was able to confirm they knew how to support people and had information on how to access an advocacy service should people require this service. Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. Staff demonstrated they were aware of the importance of protecting people's private information.

Good

Is the service responsive?

Our findings

People said they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. One person told us, "They watch me shower but let me do what I can manage myself." Another person told us, "I like my independence. They always listen to me, I have been here a long time so they know all about me. I tell them I am homeless because I couldn't live alone at home. They say this is your home and we are your family. It is different care from the hospital when you depend on nurses. It's free and easy here with no pressure. I leave my room once a day for activities." People were enabled to join in a range of activities. One person told us, "I like pets coming and arts &crafts and quizzes.

Before a person moved into the service, a pre-admission assessment took place. This identified the care and support people required to ensure their safety, so staff could ensure that people's care needs could be met. Staff told us that care and support was personalised and confirmed that, where possible, people were directly involved in their care planning. One person told us, "I suppose you mean can we live a normal life- the answer is 'yes' as far as is possible." Another person told us, "I can get up and go to bed when I want." Staff told us that they provide personalised care. One member of staff told us, "We know what they like and ask them sometimes we decide for them." People's care plans contained a document titled 'My Life'. This identified the person's family history, interests, hobbies and employment history and provided staff with an insight into people's lives. The care and support plans were detailed and contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and manual handling had been completed. There were instructions for care staff on how to provide support that was tailored and specific to the needs of each person. Where possible people were supported to be independent and care plans detailed the care people liked to undertake themselves and where they needed support. A nominated RGN had been allocated for each person to ensure care plans were reviewed and updated. These had been reviewed and audits were being completed to monitor the quality of the completed care and support plans. There was a 'Resident of the day' system where people's care plans were reviewed, people were weighed and had special treatments such as pampering and having their nails done. One person told us, "They look after you well. You get full attention according to your room number. I am number 10 so today being January 10th I have had a blood test and they weighed me etc. My husband is Room 21, so his special day is the 21st of each month." Care staff told us the care plans gave them the information they needed to support people. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the speech and language team (SALT). During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well. People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans. One visitor told us, "When I come in I discuss my mother's care and progress at any time so I do not have any concerns."

People told us there were regular activities provided which they could join in with if they wished to. On the morning of the inspection people were playing a word game. In the afternoon they were making arts and

crafts. The activity co-ordinator was seen to be attentive, using strategies to engage people, who appeared to enjoy the activities. An activities co-ordinator arranged activities in the service five days a week. Or external groups or entertainers were booked to come in and entertain people. People were being reminded and encouraged to join in the activities on offer on the day. There was internet access available for people to use. There were opportunities to go out. One person told us, "At Christmas we were taken to other homes in the group, for concerts or to join in activities." A visitor told us, "My mother likes to go to the lounge and join in activities." Not everyone told us they joined in the activities. One person told us they chose not to and said, "At present I am reading a book. I am not interested in activities." Another person told us, "I am not madly interested in activities I would rather stay in my room and read and watch TV." Meeting people's religious and cultural needs was part of everyday practice at the service. Staff were able to describe how people's religious customs were respected, and a range of pastoral visitors and church leaders visited. One person told us, "The Church of England come in every Sunday and we have Communion. "Another person told us, "Sometimes we go to church." A third person said, "The vicar has been in to see me, so I know they involve the community."

Where people were resident for a short period of time before returning home, they told us they had guidance and regular support from the physiotherapists (physio), and occupational therapists. These specialists had worked with them to improve their mobility prior to returning home. One person told us, "I feel well cared for the physio came yesterday and will be back today." Another person told us, "They said that the physio will take me back to my flat to check I can manage if I go home."

There were systems in place to record any compliments, concerns or complaints. People were encouraged to raise any concerns and knew who to speck to if they had any concerns. One person told us, "I have no complaints but I would tell the manager if I had any problems." People were made aware of the complaints procedures which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. Care staff were aware that if people or their visitors had any concerns these should be discussed with the registered manager. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Requires Improvement

Is the service well-led?

Our findings

People and visitors told us they felt the service was well led. One person told us, "They are very well organised. The manager comes in for a chat, there are no problems." Another person told us, "The manager came in last week to explain what the workmen were doing." One member of staff told us, "There is no concern about management, the care here is excellent." However, there were some areas of practice in relation to recording and audits undertaken which required improvement.

Senior staff carried out a range of internal audits, including care planning, checks that people were receiving the care they needed, medication, and infection control. They were able to show us that following the audits any areas identified for improvement had been collated into an action plan, work completed to address any shortfalls and how and when these had been addressed. However, fire and health and safety checks of the building had not been regularly completed and embedded into the practice of the service in line with the provider's policy and procedure. This had meant it had not been identified the PEEP's had not been regularly reviewed. Residents meetings had not been regularly held to enable them to give their views on the care and support provided. Although there were opportunities for people to give feedback using the Choices NHS website, questionnaires had only just started to be used to gain feedback in the service. So there were limited opportunities for people to formally give their feedback and for the staff to demonstrate how the service has moved forward and made improvements following feedback gained. These are areas of practice which require improvement.

There was a clear management structure with identified leadership roles. The registered manager was also the registered manager for another of the provider's service. They were supported by a deputy manager a team of registered nurses (RGN's) and senior members of care staff. The senior staff promoted an open and inclusive culture by ensuring people, their representatives, and staff were able to comment on the standard of care and influence the care provided. Staff members told us they felt the registered manager was accessible, the service was well led and that they were well supported at work. They told us the managers were approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "The manager is very approachable and helpful she is easy to talk to." Another member of staff told us, "The management is very good if we make a rota request they are very approachable." Policies and procedures were in place for staff to follow. Staff supervision and staff meetings had provided the opportunity to both discuss problems arising within the service, as well as to reflect on any incidents.

Feedback from the health and social care professionals was of good interactions with staff who contacted them appropriately and followed guidance given. They spoke of good relationships with people's keyworkers who had a good understanding of people's needs. Appointments were easy to arrange and kept to, staff were responsive to requests for information. A good professional relationship had been developed. The aim of staff working in the service was, 'We place the rights of residents at the forefront of our philosophy of care. We seek to advance these rights in all aspects of the environment and the services we provide and to encourage our residents to exercise their rights to the full.' Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, and diversity and understood the importance of respecting

people's privacy and dignity.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. The manager had regularly sent statistical information to the provider to keep them up-to-date with the service delivery. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run. The registered manager was able to attend regular management meeting with other registered managers of the provider's services. This was an opportunity to discuss changes to be implemented and share practice issues and discuss improvements within the service.