

Victoria Nursing Group Limited

Wells Lodge 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?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 24 and 25 January 2017 and was unannounced. Wells Lodge Nursing Home is registered to provide accommodation, personal and nursing care, for up to 22 people. There were 21 people using the service during our inspection. People were living with a range of care and health needs, including diabetes and Parkinson's. Many people needed support with all of their personal care and some with eating, drinking and mobility needs. Other people were more physically independent and needed less support from staff.

Wells Lodge Nursing Home is a large detached house with accommodation spread over three floors accessible by stairs and a passenger lift. People had access to a communal lounge/dining area, a seating area by the nurse's station, kitchenette and shared bathrooms. Each person's bedroom had its own ensuite facilities. There was a large garden which people could access when they wished.

A registered manager was in post. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

Although a long established service, this is the first time that Wells Lodge Nursing Home has been inspected while under the ownership of the Victoria Nursing Group Limited. This inspection highlighted some areas where regulations were not met and other aspects which required improvement.

Aspects of mandatory staff recruitment checks were incomplete and elements of some care plans lacked guidance for staff about how to communicate effectively with some people to meet their needs.

People who may become anxious or display behaviours which could challenge themselves or others were not always well supported. The processes in place to help support them were not always fully developed, they were stand alone and did not link into a plan to review or address possible causes or solutions.

New staff received induction training and, although staff were happy with training provided, checks of their understanding and observation of the practical application of training received were not in place.

Personal emergency evacuation plans were in place, however, some required further development to provide clear guidance to staff about the support some people required in the event of an emergency. The service could not demonstrate that the frequency of testing electrical appliances met with their policy or provide an electrical wiring conformity certificate for the service.

People had access to a complaints policy displayed in the main entrance of the service. However, people who could not leave their rooms could not access this document and people who had difficulties with communication had not been offered an alternative easy read version of the policy.

People commented that activities at the service were limited; the registered manager acknowledged this and was taking positive steps to recruit an activities coordinator.

The registered and deputy managers, together with their staff had a good understanding of the Mental Capacity Act 2005, and Deprivation of Liberty safeguards. They understood in what circumstances a person may need to be referred, and when there was a need for best interest meetings to take place. We found the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and that people's rights were respected and upheld.

There were enough staff to meet people's needs. People were safe because staff understood how to protect people from the risk of abuse and the action they needed to take to alert managers or other stakeholders if necessary, if they suspected a person was at risk.

There were low levels of incidents and accidents and these were managed appropriately by staff who sought appropriate action or intervention as needed to keep people safe.

People's care plans were reviewed regularly and included the views of the people and their relatives or advocates when needed. The service showed an awareness of people's changing needs and sought professional guidance, which was put into practice.

People were able to choose their food each meal time and snacks and drinks were available. The food was home-cooked. People told us they enjoyed their meals, describing them as "excellent" and "first class". However, food choice could be further improved by the use of pictures or objects of reference for people with communication difficulties.

The service was led by a registered manager who worked closely with the deputy manager and staff team. Staff were fully informed about the ethos of the service and its vision and values. They recognised their individual roles as important and there was good team work throughout the inspection. Staff showed respect and valued one another as well as people living at the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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.

People were not protected from the risks of unsuitable staff because recruitment checks were not fully completed.

People were not consistently supported with their behavioural needs because guidance required improvement to inform staff in detail.

Records of some premises safety checks were not available.

People's medicines were safely administered and stored correctly.

Staff knew how to recognise abuse and accidents, incidents and risks were managed appropriately.

Staff numbers were kept under review and adjustments made when needed; there were enough Registered Nurses and staff on duty.

Is the service effective?

Requires Improvement ●

The service was not always effective

All staff had received training, but improvements were needed to ensure checks were in place to assess if new staff had the right skills when providing people with care.

The service was meeting the requirement of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Peoples health needs were responded to quickly and referrals made to outside healthcare professionals.

People were complimentary about the quality of food, specialist diets and drinking requirements were catered for.

Is the service caring?

Good ●

The service was caring.

People were treated with respect and their dignity was protected. Staff delivered support with consideration and kindness.

People were encouraged to be independent when they were able.

People's families and friends were able to visit at any time and were made welcome.

Is the service responsive?

The service was not always responsive.

Poor communication and language difficulties with some staff caused some people frustration.

People's individual support preferences had not always been fully established and some information was not detailed enough to guide staff how to support people consistently.

A complaints process was in place, however, it was not accessible to everybody.

People were provided with the opportunity to engage in a limited variety of activities.

Requires Improvement ●

Is the service well-led?

The service was not consistently well led.

Some quality assurance processes were not fully effective.

Staff felt supported and there was an open culture in the home which encouraged staff and people to share their views.

Staff had a good understanding of the values and goals of the service.□

Requires Improvement ●

Wells Lodge Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 24 and 25 January 2017 and was unannounced. The inspection was carried out by two inspectors. Before our inspection we reviewed information we held about the service, including previous inspection reports and notifications. A notification is information about important events, which the service is required to tell us about by law. We reviewed the Provider Information Return (PIR) and used this information when planning and undertaking the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

During the inspection we spoke with nine people, five visitors, and eight care staff including two nurses, the deputy manager and the registered manager. Not everyone was able to verbally share with us their experiences of life in the service so we spent time observing their support. We used the Short Observational Framework for Inspection (SOFI) during the day on the ground floor. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We inspected the service, including the bathrooms, communal areas, laundry and some people's bedrooms.

We 'pathway tracked' seven of the people living at the service. This is when we looked at people's care documentation in depth and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These including risk assessments, activity plans, daily records of care and support, six staff recruitment files, training records, medicine administration records, and quality assurance information. We asked the provider to send us some information after the inspection which we did not receive.

Is the service safe?

Our findings

.People told us they liked living in the service and felt safe. One person said, "I am very comfortable, I feel completely safe and well looked after. They are always careful to check I am okay and ask if I am in pain". A visitor commented, "I visit frequently, there seem to be a fair number of staff about, the home smells fresh and is always clean". However, during our inspection we identified a breach of regulation and two areas which required improvement.

Recruitment systems were not sufficiently robust to provide assurance of the suitability of some staff to work with people living in the service. Four staff files contained employment gaps. One staff member's reference had been returned with no information which had not been followed up by the provider. Another reference was unclear as to who had completed it and their suitability to provide information. One member of staff had not completed a health declaration which meant the provider could not be assured they were physically or mentally suitable for the role. Other uncertainties about the eligibility of some staff to work within the UK was resolved on the day of our inspection, however, this should have been explored prior to the employment of the staff. The registered manager acknowledged there were gaps in the recruitment files and began an audit of the staff files with the service administrator during the inspection.

The lack of complete and safe recruitment processes did not meet with requirements and was a breach of Regulation 19 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most safety checks around the service had been completed and were up to date including, gas safety, passenger lift checks, water temperature checks, checks on hoisting equipment and fire drills. However, the provider was unable to locate a copy of their electrical installation safety certificate or a copy of their policy addressing why they did not test electrical equipment annually. In addition, although people had individual personal emergency evacuation plans (PEEPs) to be followed in the event of a fire or emergency evacuation, they provided only basic information which did not offer staff enough instruction about how to support people. For example, one person's PEEP said, 'Behaviour can be non-compliant'. It was unclear what this meant or how staff should support the person in the event of an emergency. A lack of clear guidance presented a risk people would not be supported to safely in the event of a fire or other emergency. This was an area identified as requiring improvement.

Some people's behaviours were, on occasion, physically and verbally challenging. Although behaviour charts were used to record incidents, robust strategies and interventions had not always been developed for staff to follow to support people in the most appropriate way. This meant staff may not understand potential triggers and people may receive inconsistent support to manage their behaviours. For example, one person had been referred to a psychologist following episodes of verbal aggression. Guidance documents stated, 'Staff to try diversion techniques to try to alter mood'. This did not offer staff enough information about how this could be achieved, for example, how to positively engage with the person. Another person had been diagnosed with anxiety. There was limited information for staff to refer to which could help them support the person with their anxieties which they found distressing. The guidance said, 'Spend time with person and calm them down'. There was no information about how this could be

accomplished or what to do if the person remained agitated. Although instances of aggression and anxiety were recorded, these were not reviewed as an on going process to establish or validate the effectiveness of support provided. Guidance, strategies and evaluation required further development to ensure people received consistent support. This was an area identified as requiring improvement.

Feedback about the number of staff on duty was mixed. Throughout the inspection we observed staff responding to people's needs and requests for support in a timely way. A person said, "First thing in the morning when they wash people and lunch can be hard, but other times you don't wait longer than 3 or 4 minutes when you use the call bell". A relative said, "There just doesn't seem to be enough hands/bodies of a night time. The nurse has to do a drugs round leaving one staff, staffing levels at night are on the thin side". A staff member said, "We need more staff in the afternoon and at night". Another staff member said, "I work at night; I think we manage at night. There are a few independent people and a few who need help but most people sleep through the night. The only problem we had was with (person) who fell a lot before but since they received one to one support it's much better".

The registered manager used a dependency tool to analyse the needs of people and plan how many staff were needed to be deployed during shifts. The staff on duty matched the number assessed as needed. Accident, incident and falls data showed a low number of instances and did not reflect a trend, which may have indicated shortages of staff or supervision of people at particular times. In discussion with the registered manager, they acknowledged some times staff were busy at particular points during day, however, they were able to demonstrate staff numbers were kept under continuous review and provided an example of when additional staff had been deployed to meet with a person's needs. There were sufficient staff to meet people's needs.

People were protected from abuse. Staff had access to the safeguarding policy which included information about how alerts should be made and who concerns could be raised with outside of the organisation. A staff member said, "I would tell the manager if I thought a person was abused. I would talk to my colleague or CQC". The registered manager understood their duty to notify the Commission about any incidents of abuse.

People had their own individual risk assessments according to their needs. Risk assessments had been completed to support people to remain safe. Accidents and incidents were recorded and reported to the registered manager who audited to identify patterns. Incident forms were used to record information about the incident and what action could be taken to prevent a re-occurrence. The last recorded accident had been in October 2016 when a person had fallen. The risk of this re-occurring had been significantly reduced since the person had been allocated their own one to one hours of support.

People who had mobility problems were supported to move safely. Individual guidance was in place to direct staff of the appropriate way to offer support. Communal hoists and standing aids were well maintained and people had their own individual slings to assist them when using equipment. Some people required special air mattresses designed to help protect their skin. People's weights were recorded regularly and mattresses were set accordingly. Regular checks had been made of mattress settings to ensure they took into account people's weight. The mattresses were pumped to suitable levels, so that people would be comfortable and the risk of pressure wounds reduced.

Medicines were managed safely. One person said, "Staff are very good, no problems at all. I always receive medicines when expected. I feel my diabetes is well managed". People had their own lockable storage facilities in their bedrooms to store their medicines, Medicine Administration Record (MAR), percutaneous endoscopic gastrostomy (PEG) charts and topical cream application records. A PEG feeding tube is a tube

which goes directly into the stomach. Only nurses administered people's medicines although carers could administer people's cream if they had completed the required medicines training. Additional stocks of medicines and medicines to be returned were stored in the medicine stock room which only nurses and the registered manager had access to. Medicine, such as insulin, which needed to be kept refrigerated was stored appropriately and temperatures taken and recorded of the refrigeration equipment. Medicines were checked regularly to ensure errors were identified and minimised. If people required occasional medicine (PRN) staff had good guidance to refer to as to how much should be given and what to do if the medicine did not work as expected. Weekly and monthly audits were conducted by the registered manager to ensure good oversight was maintained.

Is the service effective?

Our findings

People told us they had confidence in the staff who supported them, they felt staff understood their needs and trained in how to meet them. One person said, "The nursing care I have received has been very good, my legs are all healed, the nurses were wonderful". However, although people commented positively, the service was not always effective and some areas of practice required improvement.

Induction training for new staff required further development to demonstrate staff were competent in practice. Induction included staff completing e-learning and shadowing experienced staff for approximately two weeks. This could be shorter or longer depending on the abilities of the staff member. During the induction period, staff were provided with information specific to their role and areas such as fire drills, and rotas.

All new staff were subject to a three month probationary period which was reviewed by the registered manager. However, competency checks and observations of new staff had not been made or recorded. Areas where staff may have required more training and support had not been identified and the provider had not assessed if staff demonstrated the right skills or good practice when providing people with care. The service did not use the Care Certificate or equivalent to supplement their induction process although this was something they wanted to introduce. The Care Certificate was introduced in April 2015 by Skills for Care. These are a set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. While good practice this is not a legal requirement. Although the provider could not demonstrate the training provided suitably prepared staff for their role to meet the needs of people using the service, none of the staff spoken with raised concerns about the quality of training. The registered manager said induction training and competency assessments were an area they were in the process of improving. This was an area identified as requiring improvement.

All staff completed mandatory training in the form of face to face or e-learning sessions. Mandatory training included; first aid, health and safety, moving and handling, infection control, fire safety, food hygiene, Mental Capacity Act and Deprivation of Liberty Safeguards, and safeguarding. The administrator kept a record of staff training which highlighted when staff training required refreshing in each area. During the inspection a training session was delivered to increase staff awareness when supporting individuals with sight impairment.

Staff received support to understand their roles and responsibilities and were offered supervisions every four months with the deputy or registered manager. A staff member said, "Normally the manager will talk to us in handover and they have an open door policy. Normally I have supervisions' with the manager and the deputy. I feel listened to and changes do happen, some may take time but I am listened to". The registered manager said because they had taken up their post late in 2016 their focus had been to complete supervisions and get to know the staff and identify any developmental needs or other issues they may have. Some longer established staff had received an annual appraisal in December 2016; other staff had only received supervision as they had taken up post more recently.

People told us they had enough to eat and drink, they enjoyed the food and felt it was of good quality. One person said, "There is a good choice of food, I am very happy with the food provided". Another person said, "I'm very happy with food, there's a good selection of meals". People and their relatives were invited to meetings to discuss the menu choices available, and people were given two options for main meals each day. Food dairies were kept to record the individual preferences of people and to monitor how well people had been eating. The chef had a list of special dietary requirements recorded for each person so food could be prepared in the appropriate way. The list also contained details of allergies and any specialised equipment people needed to eat their meals such as plate guards or beakers. Some relative's feedback to us that although staff were aware that some people needed particular equipment this was sometimes forgotten. The chef told us they met with one of the nurses each week to discuss the menu for people who were diabetic. When people were identified as having difficulties with eating or drinking referrals were made to the speech and language therapists (SALT). The guidelines implemented by SALT were followed which minimised the risk of harm to people whilst they drank and ate. Some people ate their meals alone in their rooms others chose to eat in the dining room. Some people eating in the dining room were joined by their relatives and staff assisted people who needed support in a patient and relaxed way.

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. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Three DoLS authorisations had been granted and two further authorisations had been applied for. The provider was working within the principles of the Act; we saw recorded documentation of how the provider had responded to meet the requirements of this law and the needs of the people living there. The service had correctly notified CQC when authorisations had been granted. The registered manager and deputy had a good understanding of the MCA and DoLS. Staff understood the importance of asking people to consent to the support, care and treatment they received. One person said, "Staff knock on the door and say what they are going to do, asking if it's okay that they do it".

Peoples health needs were responded to quickly and referrals to outside healthcare professionals such as psychologist, tissues viability nurses and neurologists were made promptly. Wound care plans were reviewed and updated which reflected people's current support needs to maintain healthy skin. People were weighed monthly and action was taken in response to weight gains and losses to ensure people were supported to stay in good health. For example, one person's weight had recently increased so their supplementary PEG feeding was reduced in accordance. Staff had access to detailed information to support people with their individual health needs such as managing diabetes and demonstrated they understood how to deliver this support in line with the guidance.

Is the service caring?

Our findings

People gave us positive feedback about the care they received. One person said, "There is a high quality of staff and care. I'm happy to speak to staff if I felt anything was wrong, I find them approachable". Another person said, "Nurses take care of you and staff, if you want to talk to staff they will. They talk to people who can't communicate as well like people". Another person told us, "I am well looked after, I find all of the staff kind and genuine, they want to do a good job".

Staff had a caring approach with people and supported their individual needs. When one person became anxious, staff spoke to the person in a gentle manner using a soft voice. They held the person's hand to provide reassurance throughout the interaction which helped the person's distress decrease. Another person received support from a staff member who was helping them to put on their slippers in a patient and engaging manner. This helped the person to remain calm and relaxed throughout the task.

Staff explained to people what they were doing when they supported them. Staff gave some people a narrative, such as 'your lunch has arrived', 'tell me what you would like to drink' and 'would you like me to assist you'. This respectfully helped people to make decisions. When staff spoke to people they made sure they were at the same level, made eye contact and used people's names. This helped to orientate people to what was being said, helping to maximise understanding and promote involvement and communication.

Staff spoke about the people they cared for with affection and knew about people's specific individual needs. Staff knew about people's background and lives before they moved to the home, including what was important to them.. Staff took the time to recognise how people were feeling when they spoke with them. For example, recognising and asking if people may be in pain and providing pain relief medication.

People's hair was brushed, they were helped with nail care, jewellery or make-up, or assisted with shaving as they wanted. This helped to demonstrate that staff valued and respected the people they supported. Relatives found staff knowledgeable about the support their family member needed. People were supported to maintain important relationships outside of the service. Relatives told us there were no restrictions on the times they could visit the, they were always made welcome and invited to events. Staff recognised people's visiting relatives and greeted them in a friendly manner. Visitors told us they could speak to people in private if they wished and were generally positive about how staff communicated with them, telling us staff always contacted them if they had any concerns about their family members. An advocacy service was made available to anyone requesting support, but particularly to people who could not easily express their wishes, or did not have family and friends to support them to make decisions about their care.

People were supported to remain as independent as possible. One person who was visually impaired had an instructions document in their bedroom which described where they needed their personal belongings to be positioned in their room. The belongings had been left in the right position to help the person stay as independent as possible. Another person had been encouraged to record their own blood sugar results and produce a monthly graph showing the variations of the readings which they gave to the diabetic nurse to

review.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a dignified manner. Care records were stored securely and information kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies and procedures to underpin this.

The environment had been kept well maintained which provided comfortable living conditions to people. The lounge/dining area had been recently decorated and was light, welcoming and in good order. People's bedrooms were clean and decorated and accessorised according to their wishes. People had many objects such as stuffed toys, photographs, ornaments, computers, DVDs, CDs and pictures. People told us this helped to make their rooms feel homely and comfortable, adding to feelings of individuality, worth and dignity.

Is the service responsive?

Our findings

The service was not always responsive. People, staff and visitors told us that communication could be difficult and inconsistent with some staff due to language barriers. A relative said, "When (relative's name) first came here there was a lot more English speaking staff, we don't have a problem with non-English speaking staff but it's created a barrier. Sometimes it's more difficult with regards to the care aspect". A person said they were frustrated about communication in general and felt some staff were difficult to understand and some staff could not understand what they asked them. A staff member said, "Some of the people have said staff speak in their own language in front of them in their rooms and laugh, sometimes people think they are laughing at them".

One visitor told us that assumptions were often made about the preferences of their relative. This was because the person needed time to process information and could not always reply immediately to requests made by staff, however, staff did not always give them sufficient time to reply. We spoke with the person. They told us how this had made them feel disempowered and frustrated. They gave a further example where they had complained to staff that the shower water was too hot. The member of staff supporting them told them it was not too hot; this made the person feel they were not believed which annoyed them. Another visitor said their relative was given limited choices with everyday decisions, especially their meals. Staff had not tried to communicate with the person in alternative ways and made decisions on their behalf. Pictorial references or other methods of communication had not been introduced to support the person which had led to their frustration with staff.

The provider had not designed care and treatment with a view to achieving people's preferences and ensuring their needs were met. This was a breach of Regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples care plans were in the process of being updated. The updated care plans contained good detail to describe people's individual needs but more description was required to guide staff how to respond and offer support consistently to the person's identified needs. For example, one person's care plan said, 'As (person's name) lives with dementia they experience fluctuations of mood which has a knock on effect on their behaviour, staff reassure (person) when they get agitated, offer them cups of tea, give them time to express them self'. The information did not describe how the person may behave or how staff could recognise the person was agitated. Another person's care plan said they could become agitated over the slightest things but did not describe what these may be. There were no de-escalation strategies other than staff should offer reassurance to help the person calm down. However, there was no information describing how staff should do this. The person's care plan also said their usual routines should be strictly adhered to but there was no information about what these routines were. The lack of guidance means people may not receive consistent support suited to their needs. This was an area identified as requiring improvement.

People gave us mixed feedback about making a complaint and information about complaints was not readily available for all people using the service. Two relatives said they had not been told about how to complain when they voiced concerns about the treatment their family member was receiving. One person

said they had a positive experience since moving into the service. They knew who the registered manager was, but had not needed to complain to staff but could talk to them if needed. A complaints policy was available for people to refer to and was displayed in the main entrance of the service. However, people who could not leave their rooms could not access this document and people who had difficulties with communication had not been offered an alternative easy read version of the policy. During the inspection the registered manager recorded a verbal complaint a person had made about their bedroom. The registered manager explained to the person what action they proposed to take to improve the situation which reassured them. In 2016 two complaints had been made which had been recorded and responded to appropriately to the satisfaction of the complainants. We spoke with the registered manager about ensuring complaints information was available for each person and in a format suited to their needs, they undertook to do this. This was an area identified as requiring improvement.

There were mixed views about activities within the service. A person said, "There's not a lot to do in the house. There was an activity girl before. I do my jigsaws, we've had card games. All they do is watch TV. I would like to go out more". A staff member said, "There used to be an activities co-ordinator which was good, people could do painting and crafts. No one comes in usually but at Christmas there was a panto". The activity co-ordinators post had been vacant since December 2016 which the registered manager was actively trying to fill. Additional staff cover was planned so particular events could be offered such as birthday and Christmas parties and taking people to church. During the inspection staff sat with people doing puzzles, playing dominoes, reading the newspaper and talking to them about their interests. However, a greater choice of engaging activities allows people to choose to take part in an activity which matches their interests and enables them to maintain and improve their quality of life. This was an area identified as requiring improvement.

Before people moved into the home, a pre-admission assessment was completed. This was to ensure the service could meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after people moved to the service. Each person had a care plan and people and their relatives had been involved in planning their care, where appropriate. Their physical health, mental health and social care needs were assessed and care plans were developed to meet those needs. Care plans included information such as people's next of kin, medication, dietary needs and health care needs. People's updated care plans contained good personal history records. Changes in health or social needs were responded to. Short term care plans were written for people with acute conditions, for example, chest and urinary infections.

Is the service well-led?

Our findings

People told us the service was well led. One person said they felt the atmosphere in the service was open and friendly and that staff carried out their duties well. Some people told us they knew there were resident meetings but did not feel the need to attend them. A relative said, "I find the new manager good, they've got more staff and want to improve activities". The registered manager said, "The biggest challenge for the home is recruitment of nurses". A staff member told us, "The manager is nice, there's a lot of change since they have been here which has been good. Other colleagues seem happy. There have been changes with paperwork and rotas". People and staff felt there was visible improvement around the service and the changes made were positive.

Our inspection found the registered manager had identified and started to make improvements to the service. They had identified areas such as person centred care and care planning, staff induction and competency, communication and providing a complaints process accessible to all visitors and people using the service. Audits had identified these areas and plans were in place to address them. However, the registered manager recognised some further improvement was needed in order for the quality assurance framework to be fully effective. These included an emphasis on communication and ensuring complete records were held for the service, for example, safety records relating to the electrical wiring and working to policy in terms of testing of electrical appliances. This was an area identified as requiring improvement.

Staff had a positive attitude towards people and the delivery of care, one staff member commented, "If the home isn't good enough for my parents, then it's not good enough for me". Staff conducted verbal and documented handovers between each shift to ensure any change in people's conditions or any incidents were communicated to other members of the team. This ensured staff had an in-depth knowledge of the people they were caring for and their current needs were highlighted so support could be personalised. Staff were aware of the vision and values of the service, they were available for staff on the provider's main website and was also discussed during supervisions.

The registered manager sought feedback from people and their representatives to improve the quality of care people experienced. People and relatives were invited to regular meetings to discuss what they felt was going well at the service and suggest any changes they wanted made. When feedback was given, this was acted on. For example, a relative had suggested sight impairment training would be beneficial for staff, so they could support their family member in a more person centred way. The training was taking place during our inspection. This demonstrated people's feedback was listened to and acted upon to improve outcomes for people.

People and relatives attended meetings where the registered manager invited them to give feedback about food, care plans and activities. The registered manager also spent time answering queries, explaining how they planned to improve the quality of care and gave updates of what changes had happened within the service. For example, during the meeting in August 2016 people and their relatives were informed the activities person was leaving and a new person was being recruited.

There were systems in place to oversee the quality of the service. Regular audits were made of aspects of people's care and treatment including medicines, health and safety, infection control, and the environment. Recent audits had not identified any serious issues. The provider organised compliance audits. Audits were conducted and reports made to identify areas that required action so improvements could be made. A previous compliance visit identified that infection control audits were not in place which had now been introduced. Compliance visits had recognised that care plans were not person centred enough which were now being updated.

When action had been taken to improve areas identified, this was documented on the action plan to demonstrate continuous improvement. For example, there had been no evidence people or their relatives were involved in developing their care plans. The action plan was updated to say; 'Care plans are being signed by residents able to or family members, letters have gone to other families asking them to see nurses to review care plans, over half of them done so far'. This indicated a more open approach to care planning, involving people and their relatives to ensure planning and delivery of care reflected people's wishes and preferences.

The registered manager had sent quality assurance surveys in December 2016 to people. They had received some responses and had begun to analyse the results so they could determine areas where peoples felt improvement was needed. Some comments made included, 'Food could be hotter at times and more activities as we used to have'. 'Care and attention is very good so also is the accommodation and food'. The registered manager gave assurances that an action plan would be developed to address all of issues identified from the surveys.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	The provider had not ensured people received person centred care and treatment appropriate to meet their needs and reflect their personal preferences. Regulation 9 (1)(b)(c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed
Treatment of disease, disorder or injury	Recruitment procedures were not established and operated effectively to ensure that persons employed met conditions set out in Schedule 3 of the Regulation. Regulation 19 (2)(a)