Ward House Limited

Ward House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3 and 9 January 2019 and was unannounced.

Ward House Nursing Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide accommodation and personal care for up to 23 people and there were 21 people living at the home at the time of the inspection. Ward House is a detached older property which has been extended and adapted. There is a passenger lift so people can access the upper floors where most of the bedrooms are situated. Bedrooms were a mixture of single rooms and some shared by two people. Communal areas included a lounge dining room divided into several separate areas and a quiet room which could be used for small meetings or activities. An enclosed rear garden was fully accessible for people.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the overall rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Quality assurance process had not identified areas for improvement found during this inspection in relation to documentation and the recording of care. The registered manager responded promptly when we identified areas for improvement.

Where people were unable to make some or all decisions about their care the decision-making processes had not followed all the Mental Capacity Act 2005 (MCA) steps. Staff were aware of the need to gain people's consent to their care and support. People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible.

There were gaps in the recording of some care such as repositioning and food and drinks people had been provided with. The service had introduced a new computerised care planning and recording system which staff acknowledged had been hard to adjust to.

The provider had arrangements in place to protect people from risks to their safety and welfare. Arrangements were also in place to store medicines safely and to administer them according to people's needs and preferences.

People were supported to access healthcare services, such as GPs. At the end of their lives people received the care they required to remain comfortable and pain free.

Care and support were based on plans which considered people's needs and conditions, as well as their abilities and preferences. Care plans were adapted as people's needs changed, and were reviewed regularly.

People were supported to eat and drink enough to maintain their health and welfare. They could make choices about their food and drink, and meals were prepared appropriately where people had particular dietary needs.

Staffing levels enabled people to be supported safely and in a calm, professional manner. Recruitment processes were followed to make sure only workers who were suitable to work in a care setting were employed. New staff received appropriate training and arrangements were in place to ensure other staff completed required update training. Staff felt supported by the management team.

People and visitors found staff to be kind and caring. Staff respected people's individuality, privacy, dignity and independence. The home had an open, friendly atmosphere in which people, visitors and staff were encouraged to make their views and opinions known.

People could take part in activities which reflected their interests and provided mental and physical stimulation. Group and individual activities were available if people wished to take part.

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 continued to be safe.

Is the service effective?

Good

The service continued to provide effective care.

Is the service caring?

Good

The service continued to be caring.

Is the service responsive?

Good

The service continued to be responsive.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance process had not identified areas for improvement found during this inspection in relation to documentation and the recording of care. The registered manager responded promptly when we identified areas for improvement.

People were happy living at the home and had confidence in the management.

Staff were organised, motivated and worked well as a team. They felt supported and valued by the management team.

People described an open culture. Visitors were welcomed at any time.

Ward House 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 3 and 9 January 2019 and was unannounced. It was completed by one inspector 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.

Before the inspection we reviewed information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people who used the service and nine family members or friends of people who used the service. We spoke with the registered manager, two nurses, four care staff, two activities staff, a maintenance worker, two kitchen staff and two housekeepers. We received feedback from one health professional visiting the home.

We looked at care plans and associated records for six people and records relating to the management of the service, including: quality monitoring audits, duty rosters, staff recruitment files, accident and incident records and maintenance records.

We observed care and support being delivered in communal areas of the home.

Good

Is the service safe?

Our findings

People, their relatives and a visiting health professional said they felt the service was safe. A person told us "The people [staff] here make me feel safe." A visitor said, "If I don't come, I don't worry because I know that he is well looked after."

The registered manager and staff were aware of the risks posed by fluid thickening powder if consumed in its dry powder form. This was usually kept locked in the kitchen however we saw, in one person's bedroom, an in-use tin of fluid thickener powder. The person had returned from hospital the week prior to the inspection where fluid thickener powder had been commenced to aid swallowing and manage the risk of aspiration of fluids. This was detailed on the hospital discharge record and staff had requested thickening powder from the person's doctor and were using it correctly. Although documentation had not been completed the person had been receiving their drinks safely and neither they nor others would have been able to access the fluid thickener powder.

Other risks were being managed safely. Risk assessments had been completed for identified risks, together with action staff needed to take to reduce the risks. These included the risk of people falling, nutrition and moving around the home. Risk assessments had been regularly reviewed and were individualised to each person. These procedures helped ensure people were safe from avoidable harm. Staff had been trained to support people to move safely and we saw equipment, such as slide sheets used for moving people safely in bed, were available for all people who required these. Staff explained the risks relating to individual people and what action they needed to take to mitigate these risks.

Where an incident or accident had occurred, there was a clear record, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. For example, where people had fallen, records showed they had been monitored for any head injuries, assessments were completed of all known risk factors and additional measures put in place to protect people where possible. All incidents and accidents were reviewed by the registered manager to identify any patterns or trends.

Environmental risks were assessed and managed appropriately. Risks associated with the environment and the running of the home had been assessed and actions to mitigate risks were in place. Environmental risk assessments were robust and were reviewed as and when required and as part of the provider's quality monitoring procedures. They included the use of electrical equipment and fire risks. Cleaning chemicals and other substances hazardous to health (COSHH) were stored securely.

People were supported to receive their medicines safely. One visitor told us, "[Person's name] has his medication on time at 8am, 12pm and 4:30pm." Whilst another visitor said, "[Person's name] always has his medication at the appropriate time." Arrangements were in place for obtaining, safely storing, recording, administering and disposing of prescribed medicines. Medicine administration records included individual information as to how people liked to take their medicines and liquid medicines were available for people with swallowing difficulties. Records relating to the administration of medicines were accurate and complete. The provider used 'as and when necessary' (PRN) protocols for pain relieving medicines, and a

recognised pain assessment tool was in use for when people were not able to verbally communicate they were in pain. There were suitable systems to ensure other prescribed medicines, such as nutritional supplements and topical creams, were provided to people. All medicines were administered by nursing staff who had completed training. Their competency was assessed regularly to ensure they had the skills and knowledge to administer medicines safely.

There were clear emergency procedures in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff had undertaken first aid training and were able to describe the action they would take in a medical emergency. A call bell system was located within all areas of the home and staff told us this included an emergency button, meaning staff could get prompt support in an emergency. Emergency suction and resuscitation equipment was available should this be required.

Staff had received training in safeguarding adults and had a clear understanding of their responsibilities and the responsibilities of others. We spoke with staff including registered nurses, care staff, activity co-ordinators, catering and housekeeping staff, who were confident in recognising signs of potential abuse and how to report and respond to concerns. One staff member said, "I would go to [the registered manager] and if needed, I could go to the owner and to you [CQC]", another said "I would speak to a nurse or [the registered manager]. I know they would do the right thing." The service had a clear policy in place to support people to know how to respond and report safeguarding concerns. We saw safeguarding flow charts for staff were visible in accessible areas. Staff also confirmed they had completed safeguarding training and had access to information about safeguarding should they need this. The registered manager explained the action they would take if they had a safeguarding concern. The action described would ensure the person's safety and help reduce the risk of any further concerns.

People told us staff were available when they needed them and that staff responded promptly to call bells. A visitor said, "If there is a shortage of staff, they always seem to get people in." Another visitor said, "If the call bell is used, someone always answers." One visitor told us, "During the day I believe that there are enough staff, I have no experience of night." The registered manager monitored call bell response times. They stated that, where there was an indication that staff took longer to answer call bells, they would review staffing levels to address this. We saw staff responded promptly when movement alert equipment activated. The registered manager told us staffing levels were based on the needs of the people using the service. There was a duty roster system in place, which detailed the planned cover for the home. This provided the opportunity for short term absences, such as those due to staff sickness, to be managed using agency staff and existing staff working additional hours. Care staff felt that staffing levels were suitable to meet people's needs.

Safe and effective recruitment processes were in place. There was a clear recruitment pathway which ensured all new staff underwent relevant pre-employment checks, including obtaining references and disclosure and barring service (DBS) checks before they commenced employment. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We spoke with a recently employed staff member who confirmed pre-employment checks had been completed and they had received an interview.

People were protected from the risk of infection and there was a dedicated housekeeping team responsible for daily and deep cleaning tasks in people's bedrooms and communal areas. One visitor commented, "It always seems clean – they do a good job." On the first day of the inspection we identified that one bedroom had an unpleasant aroma. However, before we raised this with the registered manager, we noted that the carpet was being washed. Housekeeping staff said this was done on a regular basis although this was not

always possible as the person sometimes declined to leave their bedroom to enable carpet cleaning to be undertaken. Staff received infection control training and had a good understanding of their individual roles and responsibilities. They also confirmed they had plenty of personal protective equipment available, such as single use gloves and aprons, which were observed to be used consistently by all staff across the service. Housekeeping staff kept daily recordings and had a system in place to ensure all cleaning was completed as required. They described how they processed soiled linen, using special bags that could be put straight into the washing machines in the laundry. The laundry was organised in a way that minimised the risk of cross contamination.

The service sought advice and guidance from the local infection control team when required for specific infection concerns and three-monthly infection control audits were undertaken. The service had been awarded five stars (the maximum) for food hygiene by the local environmental health team. The registered manager was aware of the actions they should take should there be a potentially infectious outbreak at the home.

Good

Is the service effective?

Our findings

Where people were unable to make some or all decisions about their care the decision-making processes had not followed all the Mental Capacity Act 2005 (MCA) steps. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. 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. Some of the people living at Ward House Nursing Home lacked capacity to make some or all decisions relating to their care needs. Where this was the case, the person's capacity to make some specific decisions such as the use of bed safety rails had been assessed using an appropriate tool. People close to the person had been consulted and best interest decisions had been made. Relatives had been involved in other decisions about how care would be provided however, the decision-making process had not formally followed all the MCA steps. We raised these concerns with the registered manager, who undertook to complete the additional assessments as required. We heard staff seeking verbal consent from people before providing care and staff described how they always acted in the best interests of the people they were supporting.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met. Staff knew which people were subject to DoLS and processes were in place to monitor the expiry dates of the DoLS and to submit renewal applications in good time.

Wherever possible, staff supported people to make choices about their lives. One staff member said, "We show them choices like two shirts so they can touch the one they want. We always ask people what they want." We saw staff offering people choices such as where they would like to sit in the lounge or what they preferred to eat and drink. Staff had learnt a few key words and phrases to communicate with a person whose first language was not English. This meant they could inform the person of what they planned to do and therefore gain consent prior to providing care. The registered manager was aware of how to access advocacy services should these be required.

Prior to admission, the registered manager undertook a comprehensive assessment of the person's needs. They gave an example of when they had decided not to admit a person whose assessments had shown the home would not be able to meet their needs. Nursing, care and catering staff told us they had been provided with information about new people prior to them being admitted. Where people had specific needs in relation to their lifestyle choices, we saw through interactions with care staff and care records, that their needs were being considered and met. Staff demonstrated a good understanding of people's needs and wishes.

A person said, "They [staff] look after me very well." A family member told us, "The care here is excellent." Another visitor told us their relative had moved to the home as their previous home could not meet their

needs. The visitor was happy that all needs, physical and relating to dementia were now being met.

Where people's skin integrity was compromised, there was a plan in place to prevent or treat any pressure areas. Where people had wounds, there were clear plans in place and staff used photographs to assess and monitor the wound although measuring tools had not been used as per best practice guidance. The registered manager was aware these should be used and described how they would do this in future. There was a process in place to help ensure pressure relieving mattresses remained at the right setting, according to the person's weight. Staff described how they supported people to reposition on a regular basis, although records did not always confirm this had occurred. We discussed this with care staff, who confirmed that they were aware of which people required support to change position and provided this care appropriately. The service had implemented a new electronic system of recording people's daily notes, including repositioning records. It was evident that some areas of the system were taking time to become fully embedded into practice and the registered manager undertook to ensure records of people's repositioning needs were recorded in a timely manner. Comprehensive care plans had been developed to support people living with specific health conditions such as diabetes.

Staff worked collaboratively with other healthcare providers to ensure the delivery of effective care and support. We spoke with a visiting health care professional who was positive about the way the home met people's health care needs. A chiropodist attended the home every six weeks and the registered manager was aware of how to access home visiting professionals, such as opticians and dentists. When people were transferred to hospital or to another care setting, staff ensured all key information about the person's needs was passed on. These arrangements helped ensure continuity of care for the person.

People were complementary of the food provided. A person said, "There is always a choice of two main meals." A family member told us, "The food is brilliant and there is always a choice of two items each meal." One visitor felt more could be done to encourage their relative to eat as they were often refusing meals. However, we saw a person who was reluctant to eat and staff made a number of suggestions as to what may tempt them. We saw people had access to hot and cold drinks throughout the day and were prompted to drink often. Each person had a nutritional assessment to identify their dietary needs. Some people needed a special diet or needed their meals and drinks prepared in a certain way to meet their individual needs and we saw these were provided consistently. Staff monitored people's nutritional intake and weight and acted when people started to lose weight. For example, they fortified people's meals with additional calories or referred people to dieticians. When people needed support to eat, this was provided in a dignified way on a one-to-one basis.

Where people had their nutritional needs met via a PEG, this was managed correctly and we saw people were positioned at a safe posture when using their PEG. A PEG is a tube which allows liquid nutrition to be received directly into the person's digestive tract. We viewed the records of nutrition and fluids provided for a person and found these were confusing and did not record the amount of fluid being provided each day. Nursing staff could describe how the person's hydration needs were met, which correlated to prescriptions from the dietician. We raised our concerns around the recording of nutritional needs to the registered manager, who identified that the electronic recording system in use was not being used consistently by nursing staff and undertook to amend the recording procedures for PEG fluids.

People were supported by staff who understood how to meet their needs and had completed relevant training. New staff completed an effective induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily

working life. Experienced staff received regular training in all key subjects. Nurses were supported to undertake training that met the continued professional development (CPD) needs of their registration.

Staff told us they felt supported in their work. For example, one staff member told us, "I can go to [the registered manager] about things even if it's not always to do with work. They are always available and will sort things out." Staff were also supported by formal one-to-one sessions of supervision and each staff member received an annual appraisal to assess their performance over the previous year. Staff worked together for the benefit of people. We spoke with ancillary staff who told us they had completed the same basic training as care staff, including emergency training. This meant that they would be able to assist other staff if required, such as during a fire.

The environment was appropriate for the care of people with nursing care needs. A passenger lift gave access to upper floors. The main communal area was divided into several areas including a smaller seating area decorated in the style of a cosy cottage. This would provide a more relaxed sitting area and had been designed with people living with dementia in mind. There was level access into the building and to a rear garden on the ground floor. The rear garden had a patio area and was accessible to everyone. A programme of redecoration was ongoing.

Staff made appropriate use of technology to support people. For example, movement alert equipment was used to alert staff of the need to support people when they moved to unsafe positions. Special pressure relieving mattresses had been provided to support people at risk of pressure injuries and an alarm system had been used for a person living with unstable epilepsy. An electronic call bell system allowed people to call for assistance when needed. One person, who was unable to use a standard call system, had been provided with a much larger single touch call system.

Good

Is the service caring?

Our findings

Everyone we met spoke positively about the attitude and approach of staff. One person said, "Staff here are kind and couldn't be more helpful." A visitor said, "The staff here are caring, they care as much for [person's name] as me." Another visitor told us their relative "has chosen to stay here", indicating that the person was happy with the care they received. Many visitors described the staff team and people living at the home as friends, which demonstrated the caring atmosphere of Ward House. The registered manager and staff frequently used the term "family" when talking about each other and the people living at the home.

Interactions between people and staff were positive and supportive. Staff engaged with people, checked they were comfortable, bent down to their level and used touch appropriately to reassure. Staff could tell us about people's life histories and this information was also available within care plans. For example, they were aware of people's previous occupations and family members that were important to them. Care plans also contained information as to how the people's emotional and social needs should be met and what was important for them. As many people living at Ward House were unable to leave the home due to their medical needs, the registered manager said they "aimed to bring the outside in". For example, one person had wanted to visit a nearby donkey sanctuary. This had not been possible, so it had been arranged for a donkey to visit the home.

Staff expressed a commitment to treating people according to their individual needs, wishes and preferences. One staff member said, "We always try to offer a choice, if they [people] don't want to get up, we always go back later and see them." People and their relatives told us they were involved in discussing the support they wished to receive. Staff promoted choice and respected people's autonomy by enabling them to make as many of their own decisions as possible. We heard people being offered choices throughout the inspection. People confirmed staff offered them choices and respected their wishes. A relative said, "Before [name of person] moved here I came to visit. [The registered manager] spent a long time asking lots of questions to find out all about [name of person] and what they liked." The registered manager told us that should people have no regular visitors, staff would undertake shopping for treats and specific items on behalf of the person. This ensured people had all items they wanted and needed.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People's care plans included information as to what support they needed. At lunch time we saw a range of adapted crockery and cups were provided when necessary, meaning people could continue to eat independently. The registered manager explained how adaptations had been made to enable a person who required a specific piece of equipment at all times to move this around with them. This meant the person could continue to move around independently and access toilets or their bedroom without staff support. This not only promoted the persons independence, but also their dignity, privacy and sense of self-worth.

Staff understood the importance of protecting people's privacy and dignity and ensuring people were happy to receive care before providing this. We saw staff knocking on bedroom doors before entering, greeting people by name and closing bedroom doors before discussing or providing care. Several bedrooms were

shared by two people. Visitors confirmed they had been informed that their relative would be sharing a room where this was the case. We saw privacy curtains were available and care staff told us they used these when providing personal care for either person. This would ensure people's privacy and dignity was maintained. Staff described how they kept people covered as much as possible when providing personal care. One staff member said, "I use a large towel and keep them [people] covered up as much as possible to protect their dignity." Some people had asked to receive personal care from staff of a specific gender or a specific staff member. One staff member explained how they always told one person which staff were on duty to enable them to choose who would provide their personal care. The staff member said, "We just swap around which staff provides care so they [the person] get who [staff member] they have chosen."

People's relationships with their family and friends was encouraged and staff ensured family members were kept up to date with events that had occurred for their relative. One relative told us how staff always welcomed them when they visited and offered them a refreshment such as a hot drink. We saw staff knew visitors by name and welcomed them on their arrival. Visiting, including with pets such as dogs, was unrestricted. Staff were aware of important dates for people's family members, such as wedding anniversaries and purchased cards and gifts for the person to give. Birthdays and special occasions were also celebrated. A visitor said, "Christmas Day here was fantastic, there were three Christmas trees in the lounge; presents for all the residents and one for each family member. I am looking forward to Burns Night and there is a planned birthday party and the resident has requested a fish 'n' chips supper."

Ward House was also caring of people's family members. The registered manager told us that they knew some visitors were vulnerable and living on their own since their relative had been admitted to the home. They explained they "kept and eye" on these relatives and told us about an occasion when they had become concerned as a regular visitor had not attended as per their usual routine. They had tried to telephone the relative but when no reply was received, staff had gone to the relative's home to check they were all right. Where they knew some relatives were socially isolated, they had been invited to various events at the home and outings organised by the service.

During pre-admission assessments, the registered manager explored people's faith needs and staff supported people to follow their faith. They told us they explored other aspects of people's cultural and diversity needs during ongoing discussions with people about their backgrounds, interests and beliefs. Where people had particular wishes or needs, these were considered and met. For example, one person was passionate about the royal family and their bedroom had been decorated to reflect this interest. Other people had been supported to decorate their bedrooms with pictures and posters reflecting their interests.

Confidential information, such as care records, were kept in the registered manager's office and only accessed by staff authorised to view them. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood their individual care and support needs. One person told us, "They [staff] couldn't have done more for me. [The registered manager] collected me from hospital, I don't know how she managed it. The [care team] are always welcoming. I am so thankful to be here." A visitor explained, "When I am here, they [staff] pop in every hour or so. [Person's name] takes time to get to know people, so new staff are introduced slowly." Another visitor said, "We wouldn't want her to be anywhere else."

Assessments of people's needs were completed by the registered manager before people moved to the home. This information was then used to develop an appropriate individual care plan in consultation with the person and their relatives, where appropriate. A visitor told us, "I have input into the care plan." Care plans contained comprehensive information to enable staff to provide personalised care and were reviewed regularly. Staff demonstrated a good awareness of the individual support needs of people living at the home. Care staff confirmed they could read care plans, which were accessible at all times via hand held computers, and that they were provided with all necessary information to enable them to meet people's needs. Where people's needs changed, staff were responsive to these. For example, one person was receiving regular day care at Ward House, when it became apparent that it may be unsafe for them to return home. The home had a vacant room and the person was able to be admitted, until plans could be made for the person to safely return home. A visitor told us, "When [name of person] was more well, I used to take her out in a wheelchair, if ever I got stuck (the area has some very steep hills) I could always ring the staff for help."

Irrespective of their role, all staff responded promptly to people's requests for support. For example, when a person asked to go outside, the activities coordinator checked what they wanted and requested care staff to provide assistance. We saw housekeeping staff talking with people as they completed their cleaning tasks and ensured people had everything they needed before leaving the person's bedroom.

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. This was confirmed by letters from family members of people who had recently died at the home. Comments included: 'I would like to send heartfelt love and admiration for the perfect love and attention toward [name of person] on his stay with you. The kindness shown until his last breath was comforting to me and all his family' and 'Thank you for the loving care you have shown to [person's name] while she has been at Ward House. You made her feel part of a family during her final months.' People's end of life wishes were discussed with them and their families and recorded in their care plans. This helped ensure staff would know what was important to the person at this stage in their life and who they wished to be consulted. The registered manager, nursing and care staff were able to describe how they supported family members and people as they approached the end of their lives. These discussions showed that people would be treated with kindness and compassion and staff would ensure they were as comfortable as possible. External health professionals were involved to help ensure people received appropriate care to manage any symptoms. Key staff such as nurses, had undertaken additional training to provide them with the knowledge and skills to ensure people received appropriate care and symptoms were managed.

People were happy with the activities provided. One person who was unable to leave their bedroom for health reasons told us, "The [activities coordinator] sits and chats to me." Another person said, "I enjoy singing and dancing. If I stay in my room someone [staff or activities coordinator] will come and talk to me." People were supported to take part in activities and we saw an activities board, which had many photographs of the activities and events that had been held at the home over the last year. Examples of this were photographs of visiting animals, parties and celebrations. The home employed a part time and a full-time activities coordinator, who organised activities in small groups or individually depending on people's needs and wishes. They adapted the activities offered to meet the needs of the people and would often provide individual activities in people's bedrooms, if they either chose to or were unable to participate in the communal areas. They told us, "We don't have lots of planned activities we just see what people want to do each day." We asked several people who were in their bedrooms if they were asked to join in with lounge activities and they said, "Yes". During the inspection, we saw activities including reading to people, art work and a music activity occurring. Local children from a nearby school visited the home every month for a joint activity session. We were told these sessions were popular for both the children and people living at the home.

People and visitors were provided with information about how to complain or make comments about the service, through information given to them during the admission process and information displayed at the entrance of the home. Most relatives and people told us they had not had reason to complain, but knew how to if necessary. They said they would not hesitate to speak to the staff or the registered manager, who they said they saw regularly and was very approachable. One relative told us they had contacted the registered manager but did not feel that these issues had been addressed to their satisfaction. The registered manager was aware of the issues and was working to resolve these. Should formal complaints be received, there was a process in place which would ensure these were recorded, fully investigated and a written response provided to the person who made the complaint.

Requires Improvement

Is the service well-led?

Our findings

During the inspection we identified that, where people lacked the ability to make decisions about aspects of their care, staff were acting in their best interests to administer medicines, provide personal and continence care and use equipment for repositioning. However, the person's ability to agree to this care had not been formally assessed under the mental Capacity Act 2005 (MCA). The registered manager had not identified the need to formally access these specific decisions in relation to the MCA. They undertook to complete these assessments and where required complete best interest decisions. We also identified that there were gaps in the recording of some care such as repositioning and food and drinks people had been provided with. We discussed this with the registered manager. The service had recently introduced a new computerised care planning and recording system which staff acknowledged had initially been hard to adjust to, however they were now finding it easier. The registered manager acted in respect of the gaps in recording of care provided. They had confirmed with staff that this was a recording error and the care had been provided. The registered manager had also contacted the computer system provider and identified new aspects of the programme which would enable nurses to undertake additional daily monitoring of staff recording for repositioning, food and drink, and care provided. This meant that, where staff failed to record all care correctly, this could be identified and promptly addressed. The registered manager had also identified some other aspects of the system which would help with monitoring the service, such as infections and incidents. Where we identified other areas of improvement the registered manager was responsive and described how they would address these issues.

There was a registered manager in place. 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. The registered manager was a qualified nurse who regularly worked as a member of nursing staff, providing hands on care for people. They identified that this helped them to understand the pressures felt by other staff and ensured they knew people and their relatives. However, they had also identified that this impacted on their time to undertake all management tasks. They told us an additional part time nurse had been recruited and once in post would enable the registered manager and deputy manager to undertake more management activities. The registered manager identified that this would ensure issues, such as those we found with record keeping during this inspection, should not occur in future.

The home had governance, management and accountability arrangements although these had not identified the areas for improvement identified above. There were a variety of audits for the maintenance and safety of the home that had been undertaken by the registered manager. Where these had identified areas for improvement, we saw that action had been taken. Where audits had been completed, these were thorough and comprehensive. The home had a system for monitoring accidents and incidents and could identify any patterns that may require action to be taken. Ward House Nursing Home employed a full-time maintenance person who was able to carry out regular tasks that were required, such as maintaining the building, décor and repairing or replacing anything as necessary. The maintenance person also carried out regular checks and monitoring of health and safety requirements within the home. Relative's views about

the service were sought through an annual survey and resident and relatives meetings had been held. There was a suggestions box in the front entrance.

People and their relatives were happy with the service provided at Ward House Nursing Home and felt it was well managed. A person said, "I love the spirit of the place. The carers are good, and they do care. Christmas lunch was lovely." Another person said, "I am amongst friends who are supportive and will be sympathetic if you need it. If you asked me to mark the home, I would give it 10/10." People and visitors felt able to approach and speak with the registered manager or other staff and were confident any issues would be sorted out. A visiting health professional told us, "I'm very happy with the care provided here." They confirmed that they would recommend the home should a person require nursing home care.

People were cared for by staff who were well motivated and led by an established management team. Staff understood their roles and worked well as a team. They praised the management who they described as "always available" and said they were encouraged to raise any issues or concerns. Staff told us there were regular staff meetings. The registered manager had introduced short daily meetings for all staff (including nursing, care, housekeeping and catering) so that all staff were kept informed about anything which may be affecting the home, even if not always relevant to their specific role. The registered manager described the home's values as being, "To be focused on the individual and to provide a friendly, family environment for the resident and their families." One care staff member described the home's values and purpose as being to "Make the best possible quality of life [for people], to provide comfortable, person centred care." All staff said they enjoyed working at the home and would be happy for a member of their own family to receive care at Ward House.

The management team and staff demonstrated that they had a well-developed understanding of equality, diversity and human rights in order to provide safe, compassionate and individual care. Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. The registered manager understood this and their other legal responsibilities. They were aware of the need to notify the CQC of significant events, in line with the requirements of the provider's registration. The rating from the previous inspection report was displayed in the reception area.

There was an open and transparent culture within the home. Visitors were welcomed and there were good working relationships with external professionals. Relatives told us the registered manager, nurses and other staff were "approachable" and "caring". We saw one visitor asked to speak with the registered manager about the medicines their relative was prescribed. A suitable time for both was agreed for the discussion. The registered manager's office was located on the ground floor and was easily accessible to people, staff and visitors. Staff felt able to make suggestions for the benefit of people. We saw the activities staff member was involved in a community singing group. They had suggested that weekly sessions could be held at the home, meaning people could join in. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. For example, care staff told us they could approach the local authority or CQC if they felt it was necessary.

Ward House aimed to involve itself in the local community and many staff and people were from the local area. Each month, children from a local school were invited to visit the home and participate in an activity, such as craft or music, with people living at Ward House. For example, the children had been involved in decorating a wall along one side of the garden. At the previous inspection, the registered manager told us they would like to increase their involvement in the local community by offering day care. At this inspection, we saw that throughout the week several local people attended the home for support with social and care

needs. The service also provided short stay respite care and we met several people who had been admitted whilst waiting for the local authority to organise home care packages.

There was an extensive range of policies and procedures which had been adapted to the home and service provided. This ensured that staff had access to appropriate and up to date information about how the service should be run. Folders containing policies and procedures were available to all staff in the nurse's office.