Care Quality Commission

Southern Healthcare (Wessex) Ltd

# The Old Rectory 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? | Good |

## Overall summary

The Old Rectory Nursing Home is a care home with nursing for people with a physical disability and people with dementia. It is registered for a maximum of 47 people. There is a registered manager who is responsible for the home. 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 and associated Regulations about how the service is run.

At the last inspection carried out in July 2014 we had identified some concerns with the care provided to people who lived at the home. These were in relation to proper steps not being taken to ensure people were

# Summary of findings

protected against the risks of inappropriate care and treatment, insufficient numbers of staff, deployed in an effective way to meet peoples' needs, quality assurance failings and accurate records not being maintained. We found that since that inspection the service had worked very hard to rectify all of these areas to ensure that people were receiving a service which was safe, effective, caring, responsive and well led. We did not find any concerns during this inspection .

On the day of this inspection there was a calm and relaxed atmosphere in the home and staff interacted with people in a friendly and respectful way. People were encouraged and supported to maintain their independence. A high proportion of people living at the home were unable to mobilise unassisted, were cared for in their beds or were living with dementia. Where possible, people were able to make choices about their day to day lives which were respected by staff.

People said the home was a safe place for them to live. One person said they felt "completely safe" at the home, and that staff did their work in a safe way at all times. There were enough staff to meet people's needs in a timely way. Staff said the way staff were allocated to different areas in the home and new timings for shifts had enabled staff to work more effectively. For example, one person living with dementia relaxing on their own in one lounge who was unable to use a call bell effectively, was checked at least every fifteen minutes and offered drinks whenever awake by staff. Another person who chose to spend their time in their room said staff discreetly checked that he was alright throughout the day, in a way he found reassuring. One person added that staff were very careful and thorough when undertaking personal care tasks, for example when helping them to move from bed to wheelchair. Equipment was well maintained and checked regularly.

Staff had received training in how to recognise and report abuse. All were clear about how to report any concerns. Staff spoken with were confident any allegations made would be fully investigated to ensure people were protected. We had received notifications about any safeguarding issues and the home had been open and transparent in ensuring these issues were dealt with effectively to keep people safe. For example, following one safeguarding issue improvements had been shared with the staff team and food and fluid monitoring forms had been improved to ensure details of optimum inputs and outputs and weights were included.

People said they would not hesitate in speaking with staff if they had any concerns. People knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. Records of complaints were detailed and included detailed responses and actions taken.

People were well cared for and were involved in planning and reviewing their care where able. Relatives and advocates were also included as necessary where people lacked mental capacity and if people wished them to be included. There were regular reviews of people's health and staff responded promptly to changes in need. People were assisted to attend appointments with appropriate health and social care professionals to ensure they received treatment and support for their specific needs in a timely way. For example, staff were able to show us records of their actions when someone fell, which resulted in a timely visit by a GP because of a concern identified through staff monitoring the person. The person had also been referred to the local falls team for further advice to minimise risks of falling again after staff analysed the person's history of falling.

Staff had good knowledge of people including their needs and preferences. Staff were well trained and there were good opportunities for on-going training and for obtaining additional qualifications. Some staff members had lead roles as Link Nurse Champions in a range of topics such as end of life care, infection control and health and safety so they were able to guide staff practice in these areas. Comments about staff included " One senior carer is quite exceptional", "The two apprentices are excellent", "The carers are wonderful they will do anything", "Her key worker is very much on the ball" and "Staff are lovely and always very approachable. They know how to care for me. If you ask them to do anything for you they will do it".

People's privacy was respected. Staff ensured people kept in touch with family and friends. Each visitor we spoke with told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in private. One visitor said "We felt it was homely here, we could see Mum here

# Summary of findings

so we all agreed. The room's nice and it overlooks the garden, there's flowers outside. She stays in her room but there's always people coming up and down the corridor and the staff look in and speak to her".

People were provided with a variety of activities and supported by an activities co-ordinator who was knowledgeable about people's needs and preferences. People could choose to take part if they wished. Two people said they knew what was going on from the newsletter and they enjoyed some things but staff didn't push them to do anything. A trip to the beach was being planned for the warmer weather and there was a wide range of events including one to one chats with people to ensure that people were not isolated.

There was a management structure in the home which provided clear lines of responsibility and accountability. The registered manager and provider were very keen to provide the best level of care possible and had clearly made substantial improvements in how the service was run. Since the last inspection in July 2015 where some concerns were identified staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people. Staff said the home was much improved with more teamwork and understanding of their roles. One staff member said "It is so much more relaxed and organised here, a new way of working. We are listened to and the manager and owner take action". A non-care worker said they had really enjoyed being included in attending dementia care training with the nurses and care workers and had learnt a lot as a valued team member. Communication was good with regular meetings, detailed handover records and staff felt listened to.

There were effective quality assurance processes in place to monitor care and plan on-going improvements. There were systems in place to share information and seek people's views about the running of the home. For example, there was a comprehensive action plan showing how the service was monitoring and responding to any issues with areas identified, actions, reviews and learning . The service gained feedback from regular "themed surveys" with people and their relatives, stakeholder surveys, complaints and compliments to continually develop the service. These outcomes were shared with everyone in the home on the notice board so people could see results.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Good

The service was safe. The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. There were enough staff deployed in an effective way to meet people's needs.

Staff were aware of how to recognise and report signs of abuse. They were confident that action would be taken to make sure people were safe if they reported any concerns. Where there had been safeguarding concerns the service had been open and transparent looking at ways to improve and taking appropriate action.

People were supported with their medicines in a safe way by staff who had appropriate training.

**Is the service effective?**

Good

The service was effective. People and/or their relatives were involved in their care and were cared for in accordance with their preferences and choices.

Staff had good knowledge of each person and how to meet their needs. Staff received on-going training to make sure they had the skills and knowledge to provide effective care to people.

People saw health and social care professionals when they needed to. This made sure they received appropriate care and treatment.

We found the service to be meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff had a good understanding of people's legal rights and the correct processes had been followed regarding the Deprivation of Liberty Safeguards.

**Is the service caring?**

Good

The service was caring. Staff were kind and compassionate and treated people with dignity and respect.

People and/or their relatives were consulted, listened to and their views were acted upon. People had access to advocacy services if they needed them.

Where people had specific wishes about the care they would like to receive at the end of their lives these were recorded in the care records. This ensured that all staff knew how the person wanted to be cared for at the end of their life.

**Is the service responsive?**

Good

The service was responsive. People and their relatives were involved in planning and reviewing their care if they wished. They received personalised care and support which was responsive to their changing needs.

People made choices about all aspects of their day to day lives as they were able. People took part in social activities and staff ensured that people were not at risk of being isolated.

People and their relatives shared their views on the care they received and on the home more generally. People's experiences, concerns or complaints were used to improve the service where possible and practical.

# Summary of findings

**Is the service well-led?**

Good

The service was well led. There was an honest and open culture within the staff team after a period of change and development. Staff now felt they worked well together, understood their roles and had the tools to provide effective care.

There were clear lines of accountability and responsibility within the management team. New roles had been explored and created such as two clinical leads, lead care workers, apprentices and a new operation manager.

Staff worked in partnership with other professionals to make sure people received appropriate support to meet their needs.

There were effective quality assurance systems in place to make sure that any areas for improvement were identified and addressed and the service took account of good practice guidelines.

# The Old Rectory Nursing Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider 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 23 and 26 February 2015. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. It was carried out by three inspectors and a pharmacist inspector. This was because as well as identifying concerns at the previous inspection, the home is laid out over three floors with four areas to which staff are allocated and there are a variety of communal areas. An expert by experience also attended. An expert by experience is a person who has experience of using or caring for someone who uses this type of care service.

At the time of this inspection there were 34 people living at the home, one of whom was in hospital. Most people living at the home were living with dementia and were not always able to tell us about their experiences directly. We spent time observing care in the communal areas and spoke with some people. During the day we also spoke with nine friends and relatives who were visiting and one health care professional. We spoke with ten members of staff, the registered manager and the provider. We looked at a sample of records relating to the running of the home and to the care of six individuals as well as 20 medication records. We also reviewed the information we held about the home such as notifications.

Good

# Is the service safe?

## Our findings

The provider had systems in place to make sure people were protected from abuse and avoidable harm. People told us they felt safe living at the home and with the staff who supported them. People had confidence the equipment and facilities were well maintained and unlikely to harm them. One person said they felt "completely safe" at the home, and that staff did their work in a safe way at all times.

Staff had received training in safeguarding adults. They had a good understanding of what may constitute abuse and how to report it. All were confident that any allegations would be fully investigated and action would be taken to make sure people were safe. Where there had been safeguarding concerns the provider and registered manager had been open and transparent, looking at ways to improve and taking appropriate action sharing their learning with the staff team and working in partnership with the local safeguarding team. For example, the registered manager had acted as a person's advocate and contacted us to discuss a complex safeguarding issue which they had identified in order to protect the person and staff.

Relatives and visitors said they felt the home was a safe place for people to live. They told us they would not hesitate to report any concerns if they had any, they felt they would be listened to and confident action would be taken to address any issues raised.

There were enough staff deployed in an effective way to meet people's needs. New roles had been explored and created such as two clinical leads, lead care workers, apprentices and a new operation manager. The recruitment of apprentices who carried out non-personal care tasks such as providing regular drinks had enabled care staff to focus on people's care needs more effectively. Staff were allocated named people to care for over the four identified areas of the home. For example, staff were more visible throughout the home and regularly checked people who chose to or their needs required them to stay in their rooms. People received care and support in a timely manner. One person said staff discreetly ''checked they were alright'' throughout the day, in a way they found reassuring. Another person said they felt safe at the home, and that staff were very careful and thorough when undertaking personal care tasks, for example when helping them to move from bed to wheelchair and other transfers. They added that staff were concerned to make sure they felt safe being interviewed by a male inspector as their care plan noted their preference for female care workers

Staffing numbers were determined by using a dependency tool, although these remained flexible. Staff confirmed that sickness levels were monitored to minimise absence and the registered manager sought cover from agencies to maintain a full team was in place where practically possible. Staffing could be changed if required, for example if people became particularly unwell or if a person was nearing the end of their life

Records also showed checks were being carried out and call bells were responded to appropriately. Some people we met had their call bell within reach. Where one person did not, their care records included that they would not be able to use one because of their needs. Other measures were in place to ensure their safety and welfare in these circumstances, such as regular visits by staff, day and night.

Staff had time to assist people with eating and drinking in an unrushed manner at people's own pace. New arrangements within the staff rota and availability of staff ensured people were able to get up when they chose and receive appropriate assistance in a timely way to meet their needs safely.

Support was provided as indicated in people's care plans to promote their safety while eating and drinking. For example, staff did not rush the person they were assisting, and checked they had finished their mouthful before offering the next. Staff sat with individuals to support them at mealtimes, enabling better communication such as through eye contact for example. Two care plans stated people were to be positioned in certain ways before eating or drinking, to promote their safety during such activity. Staff attended to this before assisting these people to eat and drink. Risks of scalding (by hot drinks) had been assessed, with staff able to explain in line with individuals' care plans how identified risks were to be managed.

We saw people's care plan included risk assessments for moving and handling as well as falls. These had been reviewed monthly and the management plan updated when the outcome of the risk assessment had changed.

We met one person who had some faded bruising. They told us they remembered falling down but could not tell us more, such as about how staff responded. Staff were able

Good

# Is the service safe?

to show us records of their action, which resulted in a timely visit by a GP after the fall because of a concern identified through staff monitoring. The person had also been referred to the local 'Falls team' after staff analysed their history of falling.

A 'Falls risk reduction plan' included the person was to be checked hourly by staff and have certain equipment [pressure mat and door gate] in place, to manage identified risks. We observed and also saw from records that staff carried out the checks and the equipment was in place as indicated. Their walking frame was kept within their reach. There was also an alarm mat placed further away, to alert staff should the person try to walk a distance that might be beyond their capability and unsafe for them. The 'Falls incident analysis form' showed a marked reduction in the number of falls they had in recent months compared to previous months.

There were detailed risk assessments relating to the use of bedrails where staff thought there was a risk the person might fall out of bed. These showed explanations for the decision reached, as sometimes it had been decided not to use bedrails for safety reasons. Assessments relating to risks of malnutrition and skin pressure damage were up to date.

There was a full time maintenance/housekeeper. There were "room risk assessments" in people's care files. These included people's ability to understand certain environmental risks, and action taken to minimise risks, including securing furniture that could be made to fall over (with potential for injury ). A cable type of window restrictor was in use around the home to minimise risks of people falling out of windows. Electrical equipment had been labelled to show electrical safety checks had been carried out within the last year (as is good practice) and when they were next due. There were clear advisory notices to staff to ensure people's safety, including individual instructions prominently displayed in people's rooms about their care, mobility and emergency evacuation procedures.

The home was clean with no unpleasant smells and people appeared well cared for in a personalised way. One visitor commented there was sometimes an issue with laundry, sometimes people were not wearing their own clothes even though they were name-tagged. The registered manager was addressing this issue and there were staff responsible for laundry.

Medicines were managed so that people received them safely. We watched one of the nurses giving some people their medicines at lunchtime and saw they were given in a safe and caring way. People were asked if they needed any medicines prescribed to be given "when required", for example pain killers. There were no people looking after their own medicines at the time of this inspection, but risk assessments showed people could do this if it had been assessed as safe for them. There was a policy and risk assessment process that would be followed, and that people would have safe lockable storage in their rooms.

Medicines were given by nurses who were trained and assessed to make sure they gave medicines safely. There were policies and procedures to guide staff, and medicines information was available for staff and people living at the home and/or their advocates. One nurse was telling other staff a new person's medication allergies and this information was also included in people's care records.

Medicines were stored safely and securely, and at appropriate temperatures to make sure they would be safe and effective. There were suitable arrangements for controlled drugs, and for the ordering, receipt and disposal of medicines.

Medication administration records were well completed when people received their medicines, or appropriate reasons were recorded for any regular doses not given. Any creams or other external preparations were recorded on separate charts in people's rooms, which contained details of how and where they should be applied. There were clear procedures in place for reporting any issues or concerns with medicines, and regular medicines audits were being completed. Medicines administration was discussed regularly at nurses' meetings and any necessary actions were being recorded and implemented, to help improve medicines handling and management in the home.

Good

# Is the service effective?

## Our findings

There was a stable staff team at the home who had good individual knowledge of people's needs. Staff were able to tell us about how they cared for each individual to ensure they received effective care and support. People spoke positively about the staff. One person said the staff recognised when their relative was displaying negative behaviour and treat them very considerately and explain what they're going to do. I've no reason to be concerned about her care." Other comments about staff included "The senior carer is quite exceptional", "The two apprentices are excellent.", "Her key worker is very much on the ball" and "Staff are lovely and always very approachable, though some staff are better trained and more sensitive than others."

Staff had good opportunities for on-going training and for obtaining additional qualifications. A number of staff had attained a nationally recognised qualification in care. Staff were expected and encouraged to complete external qualifications in care. There was a programme to make sure staff training was kept up to date and a training matrix showed which staff had completed which training. The administrator showed us how they checked the matrix and booked staff on training sessions when they were due. Training consisted of a mix of workbooks, DVDs and face to face sessions held externally and in the home's own training room. This ensured staff had up to date knowledge of current good practice. One non-care staff member said they felt very included in the team and privileged to be involved. They had been "transfixed" when attending a recent conference about dementia care. Another care worker described Link Nurse Champions who specialised in various topics such as palliative care, health and safety and diabetes, which they found helpful.

Staff were put into groups with named supervisors for each for them to go to for advice or concerns. Staff said they could also use the "concerns chart" to raise issues easily. Staff received regular one to one supervision sessions and appraisals which records and staff confirmed. There was a three month induction programme with a workbook for new staff to follow with a named mentor. One care worker said "I am liking it here very much, they are a great team. I have a great mentor and I've learnt a lot from her. They go that extra mile."

Staff understood the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how they applied this in practice. Staff knew what actions they would take if they felt people were being unlawfully deprived of their freedom to keep them safe. For example, appropriate applications had been made to the local DoLS team for assessment about specific restrictive decision making such as preventing a person from leaving the home to maintain their safety. Relevant people's files included information about outstanding applications (including self-authorisations made in urgent circumstances) and conditions applied to authorisations that had been agreed. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

Staff were aware of the importance of ensuring people had opportunities to consent to care and treatment. For example, asking people if it was 'okay' to sit them up in bed, or if they wanted to get up. They waited for the person's response and then acted in accordance with their wishes. One person, for example, stayed in bed initially before accepting a later offer of help to get up for the day. One person's care records included they had someone acting for them as a "Power of Attorney", The registered manager obtained a copy of such documentation to confirm the legal arrangements in place. Consent to care forms in people's care files had been signed by the individual or their representatives. This covered agreements with the person's planned care and sharing of personal information with relevant professionals, for example. A relative said, " They do look after my relative well."

The provider had developed forms for use when assessing people's ability to make decisions about activities of daily living, such as dressing, washing and continence. These were appropriately completed, together with information about decisions that had been taken on people's behalf and how they affected their daily lives and care. More significant assessments and decisions were recorded separately. Records showed there were good arrangements for assessing capacity and making decisions when this was needed. For one person, staff had assessed the person had capacity to make the decisions if they were given

appropriate support such as explanations, time to respond or returning at a more suitable time for discussions. A best interest decision making process had also been used to ensure the correct use of equipment which could be seen as restrictive for people without capacity to make that decision.

There were regular reviews of people's health and staff responded to changes in need. A visitor told us that any concerns they voiced about their relative's health were followed up by staff. They gave an example of a health issue we had read in the person's care file. Staff used a specific form for recording communications with community health professionals, making it easier to follow up if or what action had been taken. This demonstrated the staff were involving external health professionals to make sure people's needs were met. We noted records of health observations such as blood sugar levels and temperature were recorded in different places making them difficult to find. The registered manager immediately devised a new form with a nurse for recording these in a clear way. Therefore staff could monitor progress carefully and share findings with external health professionals promptly .

Each person had their nutritional needs assessed and met. The home monitored people's weight in line with their nutritional assessment with evidence of timely action to address weight loss. For example, contacting the person's GP, referring and seeking advice from a dietician and provision of high calorie diets and supplements. One person's care plan showed supplements were to be given, records showed they had been and the person's weight had begun to increase. We noted that one fluid chart for a person at high risk of weight loss was sometimes not completed when they had visitors. However, the registered manager and staff told us the visitor always assisted with food and fluids and they would check these were included in the food and fluid totals. We saw that staff had discussed a person's weight loss with a GP when their 'MUST' score changed (indicating an increased risk of malnutrition). Staff were following advice subsequently obtained from a Speech and Language Therapist (SLT) that would increase the person's calorie intake. Staff told us the SLT had been contacted because staff were concerned about the person's ability to swallow safely. The person had since gained weight .

We discussed with senior staff that food intake records, although completed regularly, were not always detailed enough for assessment of individuals' nutrient intake. For example, staff had sometimes written 'main meal' rather than what the meal taken included so it was not possible to check what had actually been eaten. Also, daily care records did not include intake targets or analysis of intake charts to show whether or not care planned or support given was sufficient to meet the individual's needs. We saw fluid intake had been totalled each day and discussed at staff handovers, whist daily notes included phrases such as 'eaten well.' When we visited on the second day this had been resolved and there was sufficient information in individuals' care plans and care notes for monitoring and ensuring individuals' wellbeing over time.

There was information on people's dietary preferences or dislikes in care files which were readily available to supporting care staff. This had also been signed by the person and/or their relative and given to kitchen staff. People were happy with the food and drinks provided in the home and appeared to be enjoying their meals. One person said they had a daily choice of meals and the staff were aware of their preferences, and that it was as good as you could expect from a communal setting".

People sat at tables which were nicely laid and each had condiments for people to use and were offered drinks including alcoholic beverages. There was an incident where a fork mashable diet was required and had been sent out ready for staff to mash. However, the staff member did not know to mash it and we asked senior staff to check on this situation and they intervened immediately to ensure the meal was given as recommended. When we discussed this with the registered manager she told us that kitchen staff would be asked to mash this person's food before it left the kitchen in future to ensure meals were ready for people to eat. She since confirmed this action has been taken and meals were plated up individually ready for people to eat. People were discreetly assisted with eating and drinking and staff were able to sit and have their meals with people, making it a social occasion.

Most people were living with dementia and we discussed the use of pictures to aid choice which the registered manager said they would introduce. One care worker did not engage effectively with people during lunch, talking to staff and not communicating well with someone living with dementia. The registered manager was aware of this issue and already monitoring the care worker.

Good

# Is the service caring?

## Our findings

People were supported by kind and caring staff. They said the staff and management all treated them with kindness and respect. Staff talked with us about individuals living in the home. They had good knowledge and spoke about people in a compassionate, caring way.

Each visitor we spoke with said they thought all the staff were caring. One person told us they felt staff looked after them well, and their relative was satisfied with the care provided by staff. They said "My relative was like a scared rabbit when she came in her and now she's so much better.' Another relative said "I have never seen any staff be unkind to anybody in any way. My relative is very kindly treated, people seem quite fond of them. The staff are very sweet and kind. They're well-selected with the right attitude". The relative said they had asked one staff member how they could do what they do and the care worker had replied, "I just love it here." Other comments included "We felt it was homely here, we could see Mum here so we all agreed. The room's nice and it overlooks the garden, there's flowers outside. She stays in her room but there's always people coming up and down the corridor and the staff look in and speak to her." and "We looked at lots of places and my son said he thought this was the best one and I agreed."

Throughout the day staff interacted with people who lived at the home in a caring and professional way. There was a good rapport between people, they chatted happily between themselves and with staff. Staff spoke to people politely and were interested and concerned for the person, waiting for people to reply to questions they asked and not rushing them. Where practical support was needed, staff explained what they were about to do and talked with people whilst providing this care. Staff supported people who were in pain or anxious in a sensitive and discreet way. One person who had memory problems was eating their lunch with their fingers. Staff gently and occasionally suggested the person used the cutlery on their plate, supportively commenting that it was good the person was enjoying their meal. Another staff member began a joyful singing session with some people who had been becoming anxious and they clearly enjoyed the interaction.

Some people used communal areas of the home and others chose to spend time in their own rooms. People, if able, had a call bell to alert staff if they required any assistance. Call bell times were monitored electronically and average responses were in a timely way. Staff always knocked on bedroom doors and waited for a response before entering.

People were able to make choices about their day to day lives and were encouraged to be as independent as possible. Care plans described personalised information so staff would know what to do even if the person was unable to express their wishes easily due to living with dementia. For example, one person had expressed a preference for female staff and this was respected.

Visitors were made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room. People's doors had names and pictures on to aid independent identification. There were a variety of spaces which people could access, they did not have to stay in their own wing. There were small lounges, a conservatory area, a television room, a quieter lounge where guinea pigs were housed, dining areas with tables and an enclosed courtyard garden. Many areas around the home had wall displays, pictures, motifs and murals which provide interesting and stimulating experiences for people living at the home and their visitors. These included, for example, a display of wedding pictures in the 'Orangery' area of the home.

The hall and entrance areas of the home were welcoming and included notice boards with a variety of helpful information, for example staff photographs, names and pen pictures and information about local transport links and social activities. People said this helped them get to know staff, and provided useful reminders about their names and roles. The home had a no staff uniform policy which had been discussed with people and staff. It is sometimes used to avoid an institutional feel and promote a friendly approach especially in dementia care. Staff wore large name badges stating "Hi I'm…"

People's privacy was respected. All rooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to. People could leave their doors open or closed when in their rooms. Bedrooms had been personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. We saw that bedroom,

Good

# Is the service caring?

bathroom and toilet doors were always kept closed when people were being supported with personal care. Staff did not discuss people in front of others and respected confidentiality.

People and/or their relatives were involved in decisions about the running of the home as well as their own care. Resident and relative meetings occurred regularly and minutes were recorded. These were detailed and included general care and also where people liked to sit, the food, opinions on any changes at the home and activities. For example, one person enjoyed bird watching outside and staff would arrange this for the warmer weather, a curry tasting evening was planned and another relative had offered to help with an arts and crafts project.

Care records contained detailed information about the way people would like to be cared for at the end of their lives. There was information which showed the provider had discussed with people if they wished to be resuscitated.

Appropriate health care professionals and family representatives had also been involved in these discussions. Treatment escalation plans (TEP) were in people's care records. A TEP is a tool used to enhance the delivery of end of life care for a person. The TEP is used to facilitate and document a conversation between the person and their GP about decisions relating to further treatment, and/or resuscitation. One relative said "They ring my sister who has POA if she's not well. We were all involved in the decision for non-invasive treatment only." In one case, the person had been assessed as not having the mental ability to make a decision about such support. We saw their family had been involved in decision-making. Other relatives said they were appropriately consulted about their relative's treatment if the relative could not make their own decisions. The registered manager also reviewed and checked TEPs which are completed by GPs to ensure they had been correctly carried out.

Good

# Is the service responsive?

## Our findings

People received care and support that was responsive to their needs because staff had a good knowledge of the people who lived at the home. Staff were able to tell us detailed information about how people liked to be supported and what was important to them. One relative said "They keep me informed and they do respond to concerns." People said they were happy with the way the staff provided care, and that they did so in a way that was responsive to people's needs and preferences.

People who wished to move to the home had their needs assessed to ensure the home was able to meet their needs and expectations. People were involved in discussing their needs and wishes; people's relatives also contributed and provided information to complete "My Life History" forms which linked to care plans.

Care files were personal to the individual which meant staff had details about each person's specific needs and how they liked to be supported. People and/or their relatives were involved in planning and reviewing their care. People's care plans were discussed with them each month and changes were made if necessary. People had signed some of their care records if they were able there was a record of each monthly review. Bedrooms included summaries of people's needs, backgrounds and preferences to further help staff to provide a personal and informed service.

People's health needs were assessed and met by staff and other health professionals where appropriate. During the inspection we looked at six people's care records. These showed people had access to appropriate professionals such as GPs, dentists, district nurses and speech and language therapists. People said staff made sure they saw the relevant professional if they were unwell. One visitor said, "Staff know her better than I do now and they make frequent comments about state of mind and tell me if they've enjoyed something like the hairdresser. We discussed care before we came and we've been notified of any changes. We had a phone call yesterday about their skin condition for example."

Daily records showed staff provided other related care described in the person's care plan for preventing pressure damage. A care worker explained support they had provided in line with the care plan for one person. For example, they changed the person's position regularly and planned ahead to take into account mealtimes, when the person was to be in a certain position to eat safely. The person was not, therefore, unnecessarily moved and disturbed. This showed staff knew people's care needs and had planned how they could best provide the support to meet people's individual needs as effectively as possible.

People were supported in line with individualised care plans. One person's care plan included that the person had experienced pain and were therefore prescribed medication for pain relief when required. Daily care notes showed staff had been mindful of this as they included that the person had not had any pain recently. The person told us they were comfortable when we met them. One person, unable to speak with us in detail because of their communication needs, dozed for periods during our visit. They had their television and their glasses on, despite dozing. Their care plan included this support because the person liked watching TV and could therefore do so whenever they woke up. Another person's care plan included their views on their appearance, and a certain perfume they liked to use daily and staff supported them accordingly.

Pressure relieving mattresses were in place for people who needed them. Staff were able to tell us how these were to be maintained to meet the particular needs of each individual. Records showed staff checked such equipment daily and mattresses were set correctly according to people's weight. However, we noted weights were recorded on initial forms which then were archived when completed, so staff could no longer check people's weight in their room in relation to mattress pressure. The registered manager immediately rectified this. One person's care plan included they were to be assisted to change their position every two hours, with records showing this was achieved. The person's visitor told us staff came in at the required time when they were visiting, ensuring this aspect of care was continued. People at high risk of pressure damage were being seen regularly by the local tissue viability team.

People were supported to maintain contact with friends and family. Visitors we spoke with said they were able to visit at any time and were always made welcome. The home had a new activity co-ordinator. They were very knowledgeable about people's personalities, needs and preferences and made sure they went round to see each person every day. The home provided a variety of daily

Good

# Is the service responsive?

activities and people were given information about them in a weekly programme detailing morning and afternoon events. Activities included word games, external musicians and entertainers, exercises, arts and crafts, cinema and games. A donkey had visited the home at Christmas and events were provided to celebrate Valentine's Day, Shrove Tuesday and other holidays. People could choose whether they wanted to join in, observe or do something else. Two people we spoke with were aware of the programme, but neither wanted to take part which the staff respected. They had every confidence they would be helped to do so if they wanted. Noticeboards displayed a range of activities in pictures as well as words. During the inspection, several people attended a religious service. One relative said their relative had stopped going to bingo so staff had encouraged them to chat with another person they got on with along the corridor which they were doing.

The activity co-ordinator kept detailed records about each person to ensure their wellbeing was maintained and they were not at risk of becoming isolated. They were able to spend time with people on a one to one basis and staff told us the provider encouraged them to comment on wellbeing and mood in daily records, which we saw.

There was information in people's rooms about the home's complaints procedure. Some of it was out of date however, for example advising that people could make complaints to a previous regulator; other information appropriately directed people to others who could assist them, such as the funders of the person's care or the Ombudsman. There were contact details for advocacy agencies also. The registered manager addressed this by the second day of our visit.

People and/or their relatives said they would not hesitate in speaking with staff if they had any concerns and knew how to make a formal complaint if they needed to but felt that issues would usually be resolved informally. One relative said "I had an issue with the room but the manager sorted this out immediately and I've had no complaints since then". Two people we spoke to had never had any concerns or complaints about the service, nor had they made any complaints since arriving. Another relative said "If I see something that's not right I'll tell the carer and then tell the manager. I have also completed comments slips and it has made a difference."

We saw one person's care records included details of concerns raised on occasions by their relative, who we spoke with. They told us they could always speak with the registered manager and she sorted out any problems, giving an example of the matter we had read about in the person's care file. One person said, "My relative has a food supplement and sometimes it was not given to her. Now the food and fluid charts are better. I complained to the owner and manager and they addressed it." We saw detailed records were kept by the registered manager of complaints or concerns. There were equally detailed responses to complainants by senior staff. Not all records confirmed that the complainant was happy with the outcome and the registered manager said they would include this in the future.

Good

# Is the service well-led?

## Our findings

People were satisfied with the way the home was run and their involvement in giving feedback. There was a management structure in the home which provided clear lines of responsibility and accountability. All staff commented on the amount of change and improvement since the last inspection. All staff had been aware of the issues and involved in decision making and improvements and there were regular staff meetings as a team and individual roles. A registered manager was in post who had overall responsibility for the home. They kept up to date with current good practice by attending training courses and linking with appropriate professionals in the area. People living at the home said the manager called by to see them from time to time, they found her friendly and genuinely interested in their lives and what they had to say. While the registered manager was discussing a matter with one person, we observed staff went to tell her there was a phone call for her. The registered manager told staff as she was in discussion so she would ring the caller back later. This showed an individual-focused approach.

People described the management of the home as open and approachable. The registered manager showed a great enthusiasm in wanting to provide the best level of care possible. Staff had clearly adopted the same ethos and enthusiasm and this showed in the way they cared for people. One staff member said "We have had a shake up since the last inspection but in a good way. We can talk to the manager and the provider. We feel valued and listened to and there is now opportunity for progression. It's much better."

The staff team and shift patterns had been analysed looking at people's needs and dependencies and new roles and changes in staff deployment and shifts had occurred. For example, the registered manager was supported by clinical nurse leads, senior lead care workers, an administrator. A new nurse administrator post had been developed to enable the registered nurses to focus on health care. For example, to ensure care plan reviews were up to date, gain resident and relative views and maintain inclusion and assist nurses in following up communication with GP surgeries. Some members of the staff team had lead roles such as end of life care, dementia, diabetes and dignity so they were able to guide staff practice in these areas. Training needs were monitored. For example, records showed a clear system which monitored which staff were due refresher updates and who was due training .

At present, the provider's director of nursing helped to monitor the quality of the service by carrying out auditing visits. A new role of operations manager had recently been filled and was due to start shortly. Their role has overall responsibility for the provider's four services supporting the managers, lead the implementation of the on-going action plans, monitor safeguarding, audits and meet CQC standards.

The registered manager, care leads, clinical nurse leads, administrator, nurse administrator and provider were all available throughout the inspection. All took an active role in the running of the home and had a good knowledge of the people who used the service and the staff. People appeared very comfortable and relaxed with the management team, who were chatting and laughing with people who lived at the home and made themselves available to personal and professional visitors. Staff said there was always a more senior person available for advice and support and they felt well supported.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided. The home had also notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.

There were systems in place to share information and seek people's views about the running of the home. These views were acted upon where possible and practical. Smaller satisfaction surveys were on-going and focussed on varying topics each time. For example, the home had trialled serving vegetables in dishes for people to serve themselves but a survey showed this had not been successful so meals were now served plated individually. A survey sent to staff had resulted in the registered manager looking at ways to improve links with the local community such as churches, pet visits, dementia friends and local entertainment, which were happening. The results of all surveys were available on the main noticeboard for people to see. Resident and relative meetings occurred regularly and minutes were recorded. These were detailed and included general care and also where people liked to sit, the food, opinions on

Good

# Is the service well-led?

any changes at the home and activities. For example, one person enjoyed bird watching outside and staff would arrange this for the warmer weather, a curry tasting evening was planned and another relative had offered to help with an arts and crafts project. This enabled the home to monitor people's satisfaction with the service provided and ensure any changes made were in line with people's wishes and needs.

There was a clear business plan with objectives for the next 12 months in financial, care, facilities and developing people. For example, during 2015 the home were seeking progress towards the 360 Forward accreditation. The 360 Standard Framework is accreditation which offers practical means of "defining and transforming care cultures as measurable person centred outcomes." The registered manager and provider were aware there was more work to be done regarding providing a more dementia friendly environment. For example, providing more effective ways of communicating such as using pictures, ensuring staff communicated well with people living with dementia, reducing noise and consistently engaging with people.

This year the home was beginning a plan to introduce the Eden Alternative philosophy to the service. This was a programme to work within the philosophy "Beyond person-centred care" and looks at ways to improve people's quality of life through personal, organisational and physical transformations. We had noted that the home was large and had many corridors, nooks and crannies which could make it difficult for someone living with dementia to orientate themselves independently. Differentiating doors using different colours for different kinds of room and other kinds of orientation signage, symbols and 'maps' would help people living with dementia and others who are new to the building to find their way around. We discussed this with the registered manager who was already aware of these issues and was looking at ways to improve the environment in particularly for people with dementia. At present few people living with dementia at the home were able to mobilise independently.

There were effective quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care. Where shortfalls in the service had been identified action had been taken to improve practice. There was a system in place that would highlight any themes or common factors arising in complaints. The system included an action plan for addressing such matters in order to prevent complaints arising in future. Complaints from professionals who supported people at the home had been responded to, as well as being used to review individuals' care or the home's practices in general. We looked at care plan audits and any shortfalls had been addressed with staff.

The service action plan was extremely detailed covering safe, caring, responsive, effective and well led care topics. It showed how and when issues were being addressed and plans for the future. We saw how the action plan was on-going and updated as a live document on the computer system. For example, care records had been simplified to ensure care workers and nurses recorded in the same place to aid consistent care and communication. A health professional commented that this was much better. The treatment room had been refurbished and completed with a sensor alarm within the timescale. Housekeeping tasks had not previously been recorded, these were now documented regularly and a staff member said it was nice to show what they had done. This showed the service was committed to on-going and continuous improvement.