Ferndale Healthcare Limited

Ferndale Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 2 August 2016 and was unannounced. Ferndale Nursing Home provides accommodation, nursing and personal care for up to 28 people living with dementia. At the time of inspection there were 28 people living at the service. People were mostly older with complex needs associated with living with dementia requiring assistance with personal care and nursing support. Accommodation is provided in an older style building over three floors with a dining area, small lounge and larger lounge situated on the ground floor. There are 18 single and five shared bedrooms some of which had ensuite facilities. All rooms on the first and second floors could be accessed by a passenger lift. The service is located in a residential area with a secure, accessible garden to the rear of the building.

There was an established registered manager in post. 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 service was previously inspected on 10 and 17 March 2015 and we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider submitted an action plan to address these shortfalls and we reviewed the effectiveness of this plan as part of our inspection.

At our previous inspection on 10 and 17 March 2015 we found that the provider did not always identify individual risks and that records of the care received were not always accurately maintained. At this inspection we found that individual risk care records had improved and individual risk had been identified appropriately. We also found that care records were an accurate reflection of care planned and care received.

At our previous inspection on 10 and 17 March 2015 we also found that the provider had not ensured that water was available and accessible to people at all times. Other drinks were not made available periodically throughout the day and night and people were not encouraged and supported to drink. At this inspection we found that improvements had been made and people were supported and encouraged to have sufficient to eat and drink. Cold drinks were freely available and accessible and a variety of hot drinks were offered to people throughout the day. Fluid and food charts had been completed for people at risk of malnutrition or dehydration and with their permission weights taken to ensure that people were maintaining adequate nutrition and hydration.

The management and administration of medicines was not always safe. People received their regular medicines safely and as prescribed. However, three people were prescribed, 'as required' medicines for pain but there was no guidance to staff on when these medicines should be administered or how to recognise when people were in pain. This meant that there was a risk of medicines being given inappropriately and has been identified as an area that needs improvement.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and sought people's consent to care and treatment appropriately. However, where people were assessed as lacking capacity it was not clear how or why decisions had been made on their behalf. This meant that decisions made in people's best interests were not recorded in line with legal requirements and this was identified as an area that needs improvement.

People were protected from harm. Staff had received safeguarding training, knew how to recognise the signs of abuse and understood their responsibilities to report any concerns or poor practice. There was a robust recruitment process in place to ensure that suitable staff were employed who were safe to work with people.
Individual risk assessments were in place to ensure that people's health needs were appropriately managed and these were updated regularly and in accordance with any changes detailed in the daily notes. Planned care accurately reflected care delivered. Environmental risks were managed through regular checks and servicing and there were emergency plans in place for the service and individuals.

There were sufficient suitable staff employed to keep people safe and meet their needs. A member of staff said, "There is more than enough staff." Staffing was calculated according to people's needs using a dependency score. The registered manager told us they also listened to feedback from people, staff and relatives when determining staffing levels at the service. One person told us, "I press the call bell that is what it is there for, no waiting around."
There was an infection control champion and processes in place to ensure that the environment was kept hygienic and tidy. Staff had received training in infection prevention and control and used personal protective equipment such as gloves and aprons appropriately.

Staff had the knowledge and skills to meet people's needs. One person told us, "I am very well looked after." There was a training plan in place to ensure that all staff received essential training such as moving and handling and health and safety. The annual training schedule also included training specific to the needs of people such as dementia care and oxygen therapy training. Staff were supported and developed through regular, documented supervision and appraisal.

Staff monitored people's health and wellbeing and supported people to access health care services such as chiropody, optical and dental services. They recognised if people were unwell or required further assessment or support and made appropriate and timely referrals to the GP or other health care services such as physiotherapy or the Tissue Viability Service.

People were treated with kindness and compassion. One person said, "They are nice to me." Staff delivered support sensitively and discreetly and encouraged and supported people to make day to day choices and to maintain their independence. Relatives and visitors told us that the service was, "Friendly and welcoming."
People received personalised care that was responsive to their needs. The registered manager held a weekly 'open surgery' and an annual relatives survey demonstrated that families were generally happy with the service and the way it was run.

The registered manager had been in post for a number of years and had a 'hands on' approach. Staff told us they enjoyed their sense of humour and described them as supportive and approachable. One member of staff said, "He is there for us, to guide us."

There were systems in place to monitor the quality of the service and improvements made since the last inspection had been successfully embedded into every day practice. The provider was working in partnership with other organisations to improve the quality of the service and had implemented champions

to the staff team to support different areas of practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Instructions for the administration of 'as required' medicines were not always available which meant that people could receive 'as required' medicines inappropriately.

Staff had received training and understood their responsibilities regarding keeping people safe from harm.

There were sufficient staff employed to meet people's needs. There was a robust recruitment process in place to ensure that staff employed were suitable to work with people.

Individual risks were identified and managed appropriately and planned care was consistent with care delivered.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought consent to care and treatment and supported people to make day to day decisions. However, where people were assessed as lacking capacity it was not clear how or why decisions had been made on their behalf.

Staff had the skills and knowledge to meet people's needs and were supported through regular supervision and appraisal.

People were encouraged and supported to have sufficient to eat and drink and to maintain a balanced diet.

People's health and wellbeing was monitored any referrals to health care professionals were appropriate and timely.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion. Relatives and visitors told us the service was friendly and welcoming.

There was guidance to staff on how to engage with people with complex needs to bring out the best in them.

People were supported to maintain their independence and make day to day decisions such as what to eat and what to do.

People were supported respectfully and with dignity.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Care plans included life histories and lifestyle preferences.

There were dedicated activities staff and an activities programme in place. Activities included 1:1 and sensory activities for those people with complex needs.

There was a complaints procedure in place and relatives and the provider sought feedback from relatives through an annual survey.

Is the service well-led?

Good

The service was well-led.

Staff and relatives had confidence in the registered manager who they described as supportive and approachable.

The service was organised to meet the needs and preferences of people.

The quality of the service was monitored and any improvements made had been sustained and embedded into everyday practice.

The provider was working in partnership with other organisations to improve the quality of services provided to people.

Ferndale 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.

The service was last inspected on 10 and 17 March 2015 where two breaches of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. The provider was asked to submit an action plan to address this breach and we looked at the effectiveness of this plan as part of this inspection.

The inspection took place on 2 August 2016 and was unannounced. The inspection team consisted of two inspectors.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including health and social care professionals involved in the service for their feedback.

During the inspection we observed the support that people received in the lounge dining and communal areas and where invited, in their individual rooms. We spoke to the registered manager, nine people who lived at the service, six members of staff, two relatives and a visitor.

We reviewed seven staff files, seven medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menu and activity plans. We looked at care records related to five people; these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. One person said, "I feel safe in bed." Another person said they were, "All looked after." People told us that there were plenty of staff and that someone was always available to help them, however the service was not always safe.

Medicines were not always managed safely. 'As required' medicines are meant to be taken occasionally when there is a specific need, for example, tablets for pain. Three people were prescribed 'as required' medicines but there was no guidance to staff as to when or how these medicines should be administered. For example one person was prescribed simple pain medication but there was no guidance in place to explain why the medicine had been prescribed or how to tell if the person was in pain. Staff knew people well and were able to explain what each medication was for and when it should be given and we observed them assessing whether 'as required' medicines should be given. However, without clear guidance there is a risk that 'as required' medicines could be given inconsistently or not in accordance with prescribing instructions and this was identified as an area that needs improvement.

Medicines were stored securely and appropriately and people received their regular medicines as they were prescribed. There was medication specific guidance in place for some regular medicines. For example, one person's medication record included guidance to ensure that the medication prescribed to regulate their heart rate was given appropriately and safely. Another person was diabetic. Their medication record included guidance on monitoring and managing their blood sugar levels in relation to their prescribed diabetic medicine.

Medication practice was person centred. There were risk assessments in place for people who self-administered their prescribed medicines. For example one person managed their own oxygen and there was a risk assessment and a self-management plan in place to support the person to administer their own oxygen as they needed it.

Some people received their medicines covertly. This is where essential medicines are disguised in food or drink where people do not have the capacity to decide for themselves whether or not to take their medicines. There was a protocol in place for one person to have their medicines administered covertly. A nurse told us that the person often decided to take their medicines and therefore it was not always necessary to administer them covertly. The person's daily notes confirmed this and we observed the person knowingly taking their medicines at lunch time. This person centred, respectful approach meant that people were not routinely given their essential medications without their knowledge. Medicines were administered by nurses and we observed a nurse giving medicines at lunch time. The nurse asked two people if they were experiencing any pain or discomfort and observed two others for non-verbal signs of pain. One person was unable to communicate due to complex support needs. The nurse asked the member of staff if the person had shown any signs of discomfort during personal care or mobilising in order to determine if pain relieving medicines were required.

A pharmacy audit had been completed in September 2015 and an in house medication audit had been

introduced in July 2016 to monitor and improve medication practice. A senior nurse had undertaken competency checks with each nurse to ensure that they were safe to administer and manage medicines.

Staff were aware of their responsibilities in relation to keeping people safe. A member of staff told us, "Every one of us has a sense of responsibility towards the residents." Staff had received training in safeguarding people and were able to describe the different types of abuse and what action they would take if they suspected abuse had taken place. There was a safeguarding policy and a whistleblowing policy in place. Whistleblowing is where a member of staff can report concerns to a senior manager in the organisation or directly to external organisations. One member of staff told us how they had raised a concern with the registered manager and that they had dealt with it promptly and appropriately. The service also had identified a member of staff as a safeguarding champion. The safeguarding champion was someone staff could speak to if they had any concerns or needed more information.

At our previous inspection on 10 and 17 March 2015 we found that the provider did not maintain an accurate and complete record in respect of people including a record of care and treatment provided to people. This was identified as a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that new care plans had been introduced and individual risks had been identified appropriately. Individual care records had improved and were an accurate reflection of care planned and care received. People's individual risks had been identified and there was clear guidance to staff on how to manage these risks. For example, one person was assessed as at high risk of pressure wounds. The care plan detailed measures to reduce this risk such as the use of an air mattress and a pressure relieving cushion. The person was sitting on a pressure relieving cushion and there was an air mattress on their bed. This demonstrated that planned care was consistent with care delivered and the risk of a pressure wound reduced. Another person was at risk of self neglect. Their care plan included strategies to encourage them to accept support with personal care. Staff told us and we saw that these strategies were effective. Daily notes and monitoring forms were completed to reflect support given and individual risk assessments and care plans were reviewed and updated regularly.

Risks associated with the environment and equipment were identified and managed appropriately. There was an emergency plan in place and equipment, such as lifting equipment, had been checked and serviced regularly to ensure it was safe to use. A fire risk assessment had taken place in July 2016 and the associated action plan demonstrated completed actions and actions in progress. Staff received fire training with regular updates and fire drills. Individual Personal Emergency Evacuation Plans (PEEPs) were in place for people living at the service. PEEPs give guidance to staff on how to assist people to evacuate the building or an area of the building in the event of a fire. There was a process in place to record and monitor accidents and incidents.

There were sufficient suitable staff employed to keep people safe and meet their needs. One relative told us, "They never have agency they cover each other, its good here." Staffing levels were based on the needs of people which were calculated using a dependency score. In addition to this the registered manager told us that they would listen to feedback from people staff and relatives in order to determine staffing levels effectively. One person told us, "I press the call bell that is what it is here for, no waiting around."

Staff had been recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The service had obtained proof of identity, employment references and employment histories. Nurse registration and fitness to practice was also checked prior to employment to ensure that nurses employed were actively registered with the Nursing and

Midwifery Council and able to practice without restrictions.

Staff had received essential training in infection control and there had been an additional Infection Prevention and Control workshop for staff in March 2016. There was an infection control champion and a member of staff told us about improvements that had been made to the environment such as the replacement of old equipment. There was an annual infection control 'spot check' and cleaning schedules to include the deep cleaning of rooms and communal areas. We observed staff using personal protective equipment such as gloves and aprons appropriately and a member of staff told us that staff had been reminded of their responsibilities in relation to infection control and keeping the service clean and tidy at a recent staff meeting. Communal areas and individual bedrooms were clean and tidy with no malodours. One person told us, "I have never seen so many cleaners, it's clean and tidy all the time."

Requires Improvement

Is the service effective?

Our findings

People felt that the staff were well trained and that they were looked after well. A visitor told us that they thought their friend was, "Very well looked after." A relative said, "Staff are competent." One person told us how much their health had improved and how well they felt and a relative told us how much better their family member was since coming to live at the service. However the service was not always effective.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLs).We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the principles of the MCA. One member of staff explained the importance of supporting people to make decisions and make choices. There were robust mental capacity assessments in place for people who did not always have mental capacity to make decisions about their care. However, where people were assessed as not having the capacity it was not clear how or why decisions had been made on their behalf. For example, one person was assessed as not having mental capacity to consent to personal care. A decision to give personal care had been made in the person's best interest however there was a lack of documentation to evidence how this was in the persons best interest, such as, who was consulted and the reasons why the decision was made. This meant that people's rights may not always have been respected and this was identified as an area that needs improvement.

Four people had a DoLs authorisation in place. One person's DoLs authorisation had expired in May 2016 and the registered manager had submitted a further application in a timely manner so that another DoLs authorisation was obtained without delay. The registered manager had identified other people who were also subject to restrictions that deprived them of their liberties and had made appropriate applications to the local authority.

At our previous inspection on 10 and 17 March 2015 we also found that the provider had not ensured that water was available and accessible to people at all times. Other drinks were not made available periodically throughout the day and night and people were not encouraged and supported to drink. This was identified as a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made to the provision and delivery of food and drink and that food and fluid charts to monitor intake for people at risk of malnutrition and dehydration were complete and up to date. The improvements had been sustained over time and were embedded into

the culture of the home.

Staff supported people to have sufficient nutrition and hydration and encouraged people to enjoy a balanced diet. People told us they liked the food. One person said, "Dinner is good, really lovely, and really nice." There was a four week menu on display and people were asked what they would like to have a few hours before their meal. On the day of inspection one person asked if they could have their meal served without vegetables and the member of staff taking people's orders replied, "OK no problem." Another asked that they only have a small amount of gravy." The member of staff taking people's orders used pictures to help people make their meal choices. They took time to understand what people wanted to eat and wrote their orders down. One person told us, "Nice girl, she writes it all down."

The chef was aware of people at risk of malnutrition and explained how foods were fortified to support people to maintain their weight. There was clear information available in the kitchen regarding people's allergies, food preferences and any special dietary requirements. For example, modified diets where foods are prepared to a prescribed consistency such as puree. The kitchen was clean and well organised. There were cleaning scheduled in place and food was stored and prepared appropriately and at the correct temperatures. The chef came to talk to people during lunch which meant that they were able to see if people were enjoying their food and obtain feedback on the food they had prepared.

We observed people's lunch time experience in the dining room and the lounge. Staff served people individually and spoke to them about their meal. One member of staff came to support a person to eat their meal. They said, "I'll help you sir," and the person responded with a big smile. The different foods that made up the person's meal had been pureed and arranged separately on the plate. The member of staff told the person what each food item was and supported the person to eat at their own pace. One person was not eating their lunch. A member of staff offered them a sandwich as an alternative. They said to the person, "Try one you haven't eaten since breakfast." One person preferred to eat their meal in their room. A member of staff served their meal to them on a tray and checked that the person had everything that they needed. Another member of staff was supporting a person to eat their meal in bed. They helped the person to sit up and chatted to them as they prepared to support them to eat. They asked the person if they were ready to begin and gave words of encouragement throughout the meal.

One person had been assessed as being at high risk of malnutrition. They also had swallowing difficulties. The person had been referred to a Speech and Language Therapist (SALT) to assess their ability to swallow and any recommendations had been incorporated into their care plan. The chef told us how they fortified this person's meals and at lunch time we observed a member of staff adding a thickening agent to the person's drink in accordance with their care plan and SALT recommendations.

There were jugs of squash and water available in the lounge, dining room and in people's bedrooms and staff offered people a variety of hot and cold drinks throughout the day. Where people were assessed as being at risk of malnutrition or dehydration their intake was monitored. A member of staff told us that if a person had not drunk much during the day they would tell the night staff so that they would also encourage the person to drink.

Staff told us they explained the person's care to them and gained consent before carrying out care. Throughout the inspection, we saw staff speaking clearly and gently and waiting for responses. Staff members recognised that people had the right to refuse consent.

There was a training plan in place and an annual training schedule. Staff had received training the provider considered to be essential such as health and safety and moving and handling training. In addition to

essential training there were a series of workshops programmed throughout the year which delivered training specific to people's needs such as dementia care and oxygen therapy training. Staff were supported and developed through regular, documented supervision and appraisals and they understood their roles and responsibilities well.

Staff monitored people's health and wellbeing and supported people to access health care services such as chiropody, optical and dental services. One person told us, "They call the GP if I need it." Referrals to other health care professionals were made promptly and appropriately and any recommendations were incorporated into individual care plans. For example, one person been referred to a Tissue Viability Nurse for advice on a skin condition and their assessment and recommendations were detailed in the person's care plan.

Good

Is the service caring?

Our findings

People were treated with kindness and respect. One person told us that staff were nice and that they got on with them. Another told us that they had got to know staff well and that, "They are lovely people. We have a nice chat."

Staff approached people with empathy and understanding. One person found comfort in holding a doll. The staff member who brought her lunch told them, "I'll move your baby," before placing the doll on a chair so that the person could have their meal. Another person was not eating. A member of staff knelt beside them and leant in to discreetly whisper, "Have some dinner." They guided the person's hand gently to their spoon and they began to eat. One member of staff told us how they had encouraged a person to accept support with personal care by complimenting them on their appearance. They said that making the person feel good about themselves gave them more confidence and that the person had gradually accepted their support. Care plans gave guidance to staff on how to interact with people with complex needs. For example one person's care plan suggested that staff greet the person with a smile, maintain a positive attitude and use singing as a distraction to alleviate the person's anxiety.

People were treated with dignity and respect. Two members of staff were supporting a person in the lounge area to move using a hoist. They used a screen to protect the person's privacy, explained to the person what they were going to do and checked throughout the procedure that the person was feeling ok and knew what was going on. Another member of a staff asked a person for their glasses explaining to them that they were going to, "Give them a clean."

Staff promoted peoples independence. For example, a member of staff told us how they supported one person to take themselves to the toilet by ensuring that the route to their ensuite was kept free from clutter. This person also managed their own long term condition through the self-administration of oxygen and there was a risk assessment and care plan in their individual record to support this.

People living at the service had complex health needs and were not always able to make decisions about their care and support. Staff encouraged and supported people to make every day choices such as what to wear, eat or do wherever possible. The activities coordinator told us they asked people what they wanted to in the morning and changed her plans if people wanted to do something different. Staff supported people to move around the service as they wished and were flexible in their approach. For example one person ate their main course at the dining table but took their pudding in the lounge.

Relatives and visitors were able to visit without restriction. One person told us that their granddaughter visited them regularly. Another told us that they had lots of visitors so they were never bored. A visitor said that staff were, "Very welcoming, they all know me now." Two relatives told us that they made regular visits to the service. They said that the service was welcoming and easy going and that the staff appeared to enjoy helping their family member.

English was not the first language for some people living at the service so staff had learnt some key words in

other languages. One person's relative had asked staff to address their relative using a form of address reserved for a close family member. Staff told us that their relatives felt that this would help the person to feel closer to the staff and more comfortable with receiving care from them and staff told us that the person had responded positively to this.

Good

Is the service responsive?

Our findings

Staff knew people well and care was personalised and responsive to people's needs. Staff responded promptly and appropriately to people's requests for assistance and checked on people constantly to ensure that they had everything they needed and were comfortable.

Care plans were personalised and contained a map of life for each person which detailed social information about people such as where they were brought up, their family members and their likes and dislikes. For example one person's care plan stated that the person "Gives a big smile when they know a song." Another person became anxious if their meal tray was left in their room after they had finished eating. Their care plan stated that their tray should be removed as soon as they had finished their meal and when we spoke to the person immediately following lunch we saw that their tray had been taken away.

Staff responded to people appropriately. One member of staff had written in the daily notes that the person, 'Looked sad.' They wrote that they had asked why and given reassurance to the person. Another entry said that the same person had, 'Looked scared,' during a transfer and that again the staff member had offered reassurance to them. Throughout the day staff responded promptly and appropriately to requests for support and constantly checked with people that they were comfortable and had everything that they needed. One member of staff noticed that a person was finding it difficult to eat their lunch due to the symptoms of a cold. They told the nurse in charge so that they could check the person and call the GP if necessary.

The provider employed dedicated activities staff to plan and deliver activities to people living at the service. A member of the activities staff told us that they delivered a selection of activities such as quizzes, cookery, sing-a-longs and bingo. They told us that they asked people what they wanted to do in the morning and were generally able to accommodate their preferred activities during the course of the day. Activities staff knew people and their preferred activities well. They told us how one person liked quizzes and was particularly good at remembering proverbs and that another person was fond of Irish music. One person told us how one of the activities staff spent time with chatting with them two or three times a week and two people told us that they enjoyed playing scrabble. One of these people explained that there was a large print scrabble board for people with visual impairment. In addition to in house activities entertainers and activities were booked to visit the service such as a local choir and music therapy sessions. There were also organised events and there had been a recent summer barbeque. One person told us how they had enjoyed celebrating the Queen's Birthday, they told us, "Had a lovely day when we sat here and joined in. Tambourines and music, flags waving for the Queen's Birthday." There was an activities noticeboard advertising future activities and displaying photographs of previous events and a newsletter to inform people about available activities and to encourage people to join in. On the morning of inspection people were invited to play bingo at the table in the dining room. One person told us "We play for chocolate biscuits I like it." Another was asked where she wanted to sit to play bingo and chose to sit next to another person already at the table.

One member of staff told us how they had attended training and how this had helped them to deliver

activities to people with complex health needs who could not always engage or respond to group activities. They told us that they used pictures to stimulate conversation and sensory activities such as touching different kinds of fabrics or smelling different smells. Involvement in activities was recorded in the daily notes, for example, one person had received five one to one sessions with a member of staff during the course of a week. One to one sessions had included activities such as reading the newspaper and this was recorded in their daily notes.

There was a complaints procedure displayed on the main noticeboard the summer newsletter reminded people, relatives and visitors to speak to management team with any concerns regarding a family member or how the service is run. There was also a suggestion box by the front door for people and relatives to post their comments should they wish to.

The registered manager held a regular drop in surgery for relatives and there was an annual relative survey to which relatives had responded positively. The survey covered areas such as cleanliness and communication and asked relatives whether the service was welcoming and if staff were friendly.

Good

Is the service well-led?

Our findings

Two relatives described the registered manager as, "Really approachable." A member of staff told us the registered manager was "Supporting and approachable. Anything we need he is there for us, he guides us."

There was an established registered manager in post supported by a team of nurses and an administrator. There was also a senior nurse available who supported the service with training and quality initiatives, for example, the senior nurse undertook medication competency assessments with the nursing staff and had assisted the service to review and update their care planning documents.

Staff told us they felt supported and encouraged by the management team. There were minuted staff meetings and an annual staff survey to which staff had responded positively. Staff commented in the survey that, 'Management support,' and 'Team work,' were some of the things they liked best about their job. They told us the registered manager had a great sense of humour and had a 'hands on' approach to managing the service.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted notifications, in a timely manner, about any events or incidents they were required by law to tell us about. Staff and social and health care professionals told us that the registered manager acted in accordance with the requirements following the implementation of the Care Act 2014. For example, the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided.

The culture of the service was person centred both in the delivery and organisation of care. For example shifts had been organised so that day and night staff were available to support people at 8am. The registered manager explained that this was because most people wanted to get up around the same time and having extra staff meant that no one had to get up earlier or later than they wanted. This meant that the service was organised to support people's preferences.

There was a quality assurance system in place which included health and safety and infection control audits. There were action plans in place to address any shortfalls and actions had been completed in a timely manner. The registered manager had also appointed individual members of staff as champions to oversee and advise on different aspects of care and quality. For example, there were champions for infection control, safeguarding, blood sugar monitoring and a fire warden. One member of staff told us how the registered manager had made improvements to the environment based on their recommendations such as replacing old equipment.

In addition the provider was working in partnership with the Integrated Response Team (IRT) to improve and monitor people's hydration through the Hydration Project. Two members of staff had been nominated as Hydration Champions and had attended training with the Integrated Response Team at Crawley Hospital and the project was in progress at the time of the inspection.