Chalgrove Care Home Limited

Chalgrove Care and Nursing Home

Inspection report

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Date of inspection visit:
05 December 2017
07 December 2017

Date of publication:
23 January 2018

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

Summary of findings

Overall summary

This comprehensive inspection took place on 5 and 7 December 2017. The first day was unannounced.

At our last comprehensive inspection in October 2016, we found breaches of the legal requirements in relation to person-centred care, safe care and treatment, and good governance. Care and treatment was not always satisfactorily planned to meet people's needs. Topical medicines such as creams and gels were not managed safely. Care given was not always accurately recorded. We also made recommendations regarding keeping staffing levels under review, keeping records of powers of attorney, and making life story information more readily available for people and staff. We rated the service 'requires improvement' in Safe and Responsive, and overall.

We also undertook a focused inspection in May 2017 in response to concerns relating to the safe management of swallowing difficulties, pressure area care and staffing levels. We found no breaches of regulation. Systems were in place to manage the risk of choking and to protect people from developing pressure ulcers. There were enough staff on duty to provide the care people needed.

When we completed our previous inspection in October 2016 we found concerns relating to the record keeping aspect of good governance. This topic area was then included under the key question of Responsive. We reviewed and refined our assessment framework and published the new assessment framework in October 2017. Under the new framework this topic area is included under the key question of Safe.

Following the inspection in October 2016, we asked the provider to complete an action plan to show what they would do and by when to meet the legal requirements. At this inspection we found these legal requirements had been met.

Chalgrove Care and Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home accommodates up to 60 people in two wings of one adapted building. Edwardian wing accommodates up to 35 people who require nursing care. There were 31 people staying there at the time of the inspection. The remaining beds are in Tudor wing, where nursing care is not provided. There were 23 people accommodated there at the start of the inspection. Accommodation is in individual bedrooms, some of which are large enough to share in the event a couple are admitted. The service operates a 'step down beds' scheme with some local hospitals, where people who no longer require acute care in hospital are admitted for further recuperation or until ongoing care is in place.

The registered manager had recently left the service and had applied to cancel her registration. A replacement manager had just started in post. They intended to apply to register. 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.

People were treated with kindness and respect by caring staff and almost all of the interactions we observed upheld people's privacy and dignity. We have made a recommendation regarding reminding staff of their responsibilities in relation to privacy and dignity.

People were protected from abuse and avoidable harm. The staff recruitment process included checks to help ensure staff were of good character and suitable to work in a care setting.

Staff morale was good and staff spoke enthusiastically about their work. People's care needs were met by staff who were supported through training and supervision to be able to perform their roles effectively. Staffing levels were calculated using the provider's dependency tool and were usually sufficient to provide the care people needed in a safe way.

People's rights to consent to their care or have it provided in their best interests were protected because staff worked in line with the requirements of the Mental Capacity Act 2005. People's consent was sought to their care. If people lacked the mental capacity to give consent to some aspect of their care, a best interests decision was made about this, with a view to minimising any restriction on them.

Care plans were personalised to the individual, and provided clear instructions to staff about what care should be provided and how. They were based on assessments of need undertaken before people came to stay at the service. They were reviewed regularly and were kept up to date. Staff kept clear records of the care provided.

People were supported to make decisions about their preferences for end of life care. Staff had training in end of life care. Where necessary, medicines that might be needed for relief of pain and distress were prescribed and kept in stock.

People had a choice of food and drink and their nutrition and hydration needs were met.

People had the support they needed with their health needs, including referral to doctors and other health professionals.

Medicines, including skin creams, were stored and managed safely. There were clear instructions for staff about how and to which area to apply skin creams.

Risks to people who used the service, and general risks to people, staff and others, were assessed and managed.

The premises and equipment were kept clean and free of unpleasant odours. There were adequate hand hygiene facilities and staff observed infection control precautions, such as the use of personal protective equipment.

Property and equipment maintenance was carried out regularly, with the required checks in place. There was a procedure for reporting faults, which were attended to promptly by maintenance staff or, if necessary, external contractors. We identified problems with two people's bed rails. Remedial action was taken

immediately, including the provision of a thicker air mattress and repairs to a bed rail that would not stay up. Managers undertook an audit of each bedroom that day, in case there were any other unknown faults.

Management and governance arrangements were robust and had brought about improvements. Information from previous inspections, other stakeholders and the provider's own quality assurance processes was used to drive these improvements. Feedback was sought from people, their relatives and staff. Concerns and complaints were taken seriously and seen as an opportunity for learning.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse and avoidable harm. Medicines were managed safely.

Risks to people's safety and wellbeing were assessed and managed.

There were usually sufficient, competent, safely recruited staff on duty.

Is the service effective?

Good

The service was effective.

People had their needs met by staff who were supported to do so, through training and supervision.

People had a choice of food, and their nutrition and hydration needs were met.

People's health was monitored and timely referrals were made to doctors and other healthcare professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect.

Staff knew people well or were getting to know them. They treated people as individuals.

People were supported to express their views and these were respected.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved in planning and reviewing their care.

People received care that met their individual needs,

Concerns and complaints were taken seriously and seen as an opportunity for improvement.

Is the service well-led?

Good

The service was well led.

The service had clear governance, management and accountability arrangements. Action had been taken to bring about improvements.

Managers welcomed feedback from people, staff and other stakeholders. This was used to bring about improvements.

Chalgrove Care and Nursing Home

Detailed findings

Background to this inspection

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

This was a comprehensive inspection, which was due but which was brought forward as CQC had received information of concern in relation to staffing levels. The local authority safeguarding team was aware of these concerns.

The inspection took place on 5 and 7 December 2017 and the first day was unannounced. Two adult social care inspectors and an Expert by Experience were present on the first day. The Expert by Experience had personal experience of caring for someone who uses care services for older people. The lead inspector returned on the second day, with an inspection manager and a specialist advisor. The specialist advisor was a registered nurse with expertise in the care of older people and dementia care.

Before the inspection we reviewed the information CQC held about the service. This included notifications from the service about significant incidents and information from the local authority safeguarding team. We had also received a Provider Information Return. This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make. We also requested feedback from stakeholders, including the local authority safeguarding and service improvement teams, and obtained this from six of them.

During the inspection we spoke with 13 people who use the service, five visitors and two visiting health and social care professionals. Because people were not all able to tell us about their experience of the service, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care in communal areas to help us understand the experience of people who cannot describe this to us. We also

spoke with the home manager, the operations manager, the deputy manager, two nurses, six other care staff and three ancillary staff. We reviewed nine people's care records, medicines administration records on one floor of Tudor wing and two floors of Edwardian wing, four staff files and other records relating to how the service was managed.

Good

Is the service safe?

Our findings

At our inspection in October 2016 we found shortfalls in relation to the safe management of topical medicines and record keeping. These constituted breaches of Regulation 12 Safe care and treatment and Regulation 17 Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records were under the key question of Responsive in the previous assessment framework, but were moved to this key question when the framework was revised and refined.

Following the inspection in October 2016 the provider completed an action plan to show what they would do and by when to meet the legal requirements. At this inspection we found these legal requirements had been met.

People mostly said they were satisfied with arrangements for their medicines. For example, someone told us, "They chase me and find me! They make sure I take it." Two people expressed some disquiet with having their medicines administered by staff: "They took it away when I came in; I argued with them. They only thing I'm allowed is my Ventolin" and, "They bring it. I don't know if it's on time or not, it's not the routine I'm used to at home. It seems confusing. They took it all over." However, the manager and operations manager confirmed people were assessed for being able to self-administer their medicines. There were self-medication risk assessments on people's care files.

Peoples' medicines were managed and administered safely. Staff who administered medicines had been trained in handling medicines safely and their competence in doing so had been assessed. Staff administering medicines wore a 'do not disturb' red tabard. There were clear procedures for ordering, storing and disposing of medicines. There were clear instructions for staff in relation to medicines that were given when required, otherwise known as 'PRN' medicines. Where people had difficulty saying they were in pain, staff used a pain assessment tool to help them assess whether they required pain relief.

Medicines were stored securely at a suitable temperature to ensure they retained their efficacy. Effective air conditioning had been installed in a medicines storage room that had previously been very warm, to ensure it remained at a satisfactory temperature. There were dedicated medicines refrigerators for medicines that needed to be stored at a low temperature. Staff had not known how to reset the thermometer on one fridge so that maximum temperatures were recorded correctly. This was resolved during the inspection.

Where people had prescribed topical medicines such as creams, these were applied in line with their prescription. There were charts for each topical medicine with clear written instructions and body maps, telling staff how and to which part of the skin to apply the medicine. Staff initialled the chart on each occasion they applied the cream, and there were no unexplained gaps on these charts. People confirmed they had their creams as prescribed. Creams had pharmacy labels, and staff dated the containers when they opened them.

At the last comprehensive inspection we made a recommendation regarding the provider's ongoing monitoring of staffing levels. Prior to this inspection we received information of concern in relation to

sufficient staffing levels. However, people were supported by sufficient staff with the right skills and knowledge to meet their individual needs. People told us there were sufficient staff to meet their needs. One person commented that at very busy times staff were sometimes borrowed from the other wing but there were enough on duty overall. Three people said that at busy periods they sometimes had to wait for staff to answer their call bell. Staff also confirmed there were enough of them on duty to be able to perform their roles effectively. A member of staff told us that sometimes staffing levels had increased because of the level of demand, and also that sickness absence was covered by agency staff if necessary. Call bells were answered promptly throughout the inspection and people received the care they required, including at mealtimes. The service manager and operations manager confirmed the provider's dependency tool was used to calculate the number of staff that needed to be rostered. They also confirmed that call bell response times were checked regularly.

Safe recruitment practices were followed before new staff were employed. Checks were made to ensure staff were of good character and suitable for their role. Staff files included application forms, records of interview and appropriate references. Criminal records checks had been made with the Disclosure and Barring Service to make sure candidates were suitable to work in a care setting. The operations manager advised us that although the service had a core of long-serving staff, recruitment remained challenging; there were currently two day and one night full time equivalent vacancies.

People and their visitors told us they felt comfortable with the staff and their loved ones were safe at Chalgrove Care and Nursing Home. Comments included: "Everybody's OK", "I'm quite content. The care workers are good" and "He's safer here than at home; there's more people at hand. Here he's not going about trying to do things he can't do any more and putting himself at risk."

People were protected against abuse. Staff had a good understanding of how to keep people safe and their responsibilities in relation to safeguarding adults. Information was displayed about how to report concerns about abuse.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Risks assessed included not being able to use the call bell, falls, moving and handling, tissue viability and choking. These risk assessments were reviewed monthly. When risks had been identified, care plans contained clear guidance for staff on how to manage these. People at risk of developing pressure sores were assisted to reposition at the intervals specified in their care plan. They also had the necessary pressure-relieving equipment in place, such as auto-adjusting air mattresses and pressure cushions. Where people had swallowing difficulties that could present a risk of choking or aspiration, a speech and language therapist had assessed their swallowing and devised a safe swallow plan. Safe swallow plans were readily available to staff serving meals and were clearly displayed in people's bedrooms. Drinks and meals were provided to the consistency set out in the safe swallow plan.

Some people used bed rails when in bed. Bed rails can be an effective way of reducing the risk of falls, when used with the right bed, in the right way, for the right person. However, they can introduce other risks and so require risk assessment and checks to ensure they are used safely. Where bed rails were used, bed rail risk assessments had been undertaken and regular checks were made by staff. One person told us they did not feel secure because their bed rail did not stay up. With their consent we drew this to the attention of the manager and operations manager, and it was promptly repaired. We saw another person with their leg through their bed rail. We immediately drew this to the attention of the operations manager and nursing staff. They acted straight away to maintain the person's safety, reviewing the risk assessment and changing to a thicker pressure-relieving mattress to mitigate the risk of entrapment. The operations manager advised us at the end of the first day that there had been a full audit of rooms to ensure bed rails fitted properly.

People were protected against environmental hazards such as slips, trips and falls. The building was well maintained. The fire system had been inspected and tested on a regular basis, including periodic inspections by a specialist contractor. People had personal emergency evacuation plans that set out the assistance they would need from staff and fire and rescue service personnel. A recent inspection by the fire and rescue service had found satisfactory precautions in place. A specialist contractor had assessed lifts and lifting equipment as safe within the previous six months. There had been a landlord's gas safety check within the past year. Where we identified hazards, prompt action was taken to address these. For example, a wall heater in someone's room was covered with a radiator guard by the second day of the inspection.

We observed an unattended cleaning trolley with cleaning detergents and dirty water in a hallway and spoke to the cleaner about the risks involved with this. The operations manager told us they had addressed this with the cleaner and that the risk of harm was minimal as no ambulant residents lived on that floor.

People involved in accidents and incidents were supported to stay safe and action had been taken to prevent further injury or harm. The deputy manager was responsible for overseeing Tudor wing. They had issued a staff memo that read: "Staff to go to rooms at 4pm and put lights on and turn down beds – to reduce falls from people entering dark rooms." When people had accidents, incidents or near misses these were recorded and monitored by the management team, to ensure all necessary action had been taken to maintain people's safety and wellbeing. The managers and provider monitored for developing trends.

The service was generally clean and free of malodours. A food safety inspection the month before had given the service the highest rating for food safety. There was a current contract for the disposal of clinical waste. Whilst the laundry was mostly orderly, there were some areas of chipped and damaged plaster, the handwashing sink had empty bags piled on top, and there were bags of soiled laundry stored under an ironing board, on top of which were piled clean items. This disrupted the dirty-to-clean workflow. We drew these matters to the attention of the manager and operations manager, who said they would ensure the laundry was maintained in a proper condition in future. We will check this at future inspections.

Staff followed infection control guidance in order to protect people from the risk of acquiring infections. Hand gels were positioned throughout the service. Staff's hand hygiene and use of PPE was observed as part of the manager's infection control audit. Personal protective equipment (PPE) was readily available for staff, who wore the PPE provided. There were adequate supplies of PPE in the storeroom. A member of staff commented that it could be frustrating if they were about to give personal care and found the PPE in someone's room had not been replenished. Staff were allocated to check stocks and place orders with the administrator. The administrator said that for the past two months there had been no concerns with supplies running out.

Infection clinical audits were done monthly. Infections, such as urinary tract infections and chest infections, and treatment outcomes, were monitored and recorded monthly. There were very few infections. Staff told us they identified early signs of infections and liaised with the GP.

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "The staff are very competent, they look after you well", "The staff are very good", and, "They seem to know what they are doing when they speak to us. [Relative] lost speech after the stroke. She makes herself understood. Staff seem to understand."

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed, and were supported to refresh their training. Training completed included safeguarding, infection control, moving and handling, nutrition for older adults, dementia awareness, end of life care, health and safety, and fire safety. Staff who were new to care were expected to gain the Care Certificate, a national qualification for staff in health and social care. Nurses confirmed they had the training and development needed in order to maintain their registration.

Staff were also supported through supervision meetings with their line manager. Staff described the management team as supportive and said they were able to discuss things openly at supervision or between times if necessary. For example, a member of staff who worked on Tudor wing described the deputy manager as "very supportive".

People's needs were assessed before they came to stay at the service. Information was sought from the person, their relatives and other professionals involved in their care. For people admitted from hospital under the step down beds scheme, this was done by a 'trusted assessor' who worked at the hospital. A health and social care professional involved with the step down beds scheme gave positive feedback about the service's prompt communication and decision-making regarding these admissions. Information from pre-admission assessments, whoever they were undertaken by, was used to devise people's care plans.

People were supported to have a meal of their choice by organised and attentive staff. They were asked where they wanted to sit to eat. People told us they were satisfied with the food and that there was plenty for them to eat. Comments included: "The food is good. There's a good choice", "I like the food. It's very varied", "They show her the menu and she points. If she didn't want either, they do offer sandwiches" and, "The food's adequate. They're cooking in bulk. It's not as good as at home, it's not like you do it at home." We saw people tucking into meals that looked appetising. Staff conversed with people and were patient, assisting people at a pace that suited them.

People's dietary needs and preferences were documented in nutrition care plans that provided clear guidance for staff. Records of dietary needs were kept in the kitchen. People's risk of malnutrition was monitored monthly using a recognised malnutrition screening tool. Appropriate action was taken if the risk was elevated, including the provision of a higher calorie diet, more frequent weight monitoring and pursuing a dietitian referral.

People told us they had plenty to drink, for example, "They bring fresh water every day and she can go to the dining room. There's juice available" and "I've got to drink plenty of water and they fill my bottles." People

had drinks to hand much of the time and staff encouraged them to drink. Where people's fluid intake was being monitored, their fluid charts showed their target intake had mostly been met.

People's healthcare needs were monitored and any changes in their health or well-being prompted a referral to their GP or other healthcare professionals as appropriate. People and relatives commented, "They soon get you a doctor" and "When the doctor is required, they call them." People had access to opticians and chiropodists, although a relative commented that there was no longer a visiting dentist so they had to take their family member to see one. A visiting healthcare professional commented that staff acted quickly if anyone's health caused concern and that staff communication with their team was good.

People's care files contained 'grab sheets', which summarised key information about their health and their care needs. These were intended for sharing with paramedics and hospital staff in the event of a health emergency or hospital admission.

People's bedrooms were personalised with pictures, photographs and other personal possessions, as they chose. From both wings of the building there was access to enclosed, attractive garden areas with lawns, paved areas, seating and tables. Bathroom and toilet doors were labelled as such. People entertained visitors in their rooms or in communal areas. There was a quieter lounge, without windows, on the first floor. This was sometimes used as space for meetings.

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's rights were protected because the staff acted in accordance with the Mental Capacity Act 2005. People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. People told us staff asked for their consent before assisting them. For example, a person said, "They always ask permission. I'm easy going, I always say 'yes'. If they want to do something different, they ask permission." Someone else told us, "I do what I want to do. I'm not forced to do anything." If there were concerns that someone might lack the mental capacity to make a decision about a particular aspect of their care, this was assessed. Where people were found to lack capacity, staff had recorded a best interests decision about this and care was provided accordingly. For example, there was a clear recording of a mental capacity assessment that found a person had no capacity to make decisions about end of life care. A best interests decision had been made with the involvement of family, health professionals and an advocate, for the person to remain at the service rather than receiving aggressive treatment for infections. Other examples of best interests decisions covered the use of bed rails, photographs, call bells, medication, personal care, and finances.

People can only be deprived of their liberty so that they can 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). Managers had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the appropriate supervisory body. There was a system for monitoring any conditions on DoLS authorisations and when authorisations were due to expire. Applications for replacement DoLS authorisations had been made prior to the expiry of the existing authorisation.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. They told us staff were caring. Comments included: "Treated beautifully… They treat me with such respect", "[of night staff] Ever so nice; if I have a pain, they get me a hot water bottle and blanket", "They are really nice. They are very caring and they work very hard", "They're very kind", and, "They are all very attentive and helpful. They ask if you need anything." The interactions we observed were friendly, kind and respectful. When people showed signs of distress staff recognised this and promptly provided the support they needed.

People's independence was encouraged. For example, a member of staff offered to cut up someone's food but the person said they would prefer to do it themselves. The member of staff respected this and asked the person if they wanted to wear their glasses. Care plans reflected what people were able to do for themselves.

Staff generally respected people's privacy and dignity. A visitor told us, "I have to leave [person's room] when they're doing anything." As far as we saw, personal care took place behind closed doors. However, someone told us, "Well, they don't shut the door when they cream my legs, but that's alright isn't it? They don't have to do that, do they?" We informed the manager and operations manager of this; they agreed that creams should be applied in private. On all bar one occasion, staff were discreet in offering assistance. The exception was where a member of staff spoke loudly of their intention to take someone to the toilet, repeating this several times. Staff had received training in dignity and respect or had this pending.

We recommend the service reminds and reinforces to staff the importance of always upholding people's privacy and dignity.

People received care and support from staff who knew, or were getting to know, them well. Many staff had worked at the service for a number of years and people spoke about some of them by name. Staff knew about people's likes, dislikes and care preferences, which were clearly set out in their care plans. For example, one person tended to enjoy the company of others in the lounge and could become worried when they were alone in their room. Their mood lifted when staff took them to the lounge.

The provider's quality lead also had a role as a consultant Admiral Nurse. Admiral Nurses provide specialist dementia support for the families of people who live with dementia. In this role, the quality lead carried a small caseload of families.

At the comprehensive inspection in October 2016 we made a recommendation about people's 'This is Me' life story documents being readily available to people, relatives and staff. At this inspection, these life story documents were easily accessible in people's rooms.

People were encouraged to express their views and these were listened to and respected. People told us: "I can get up and go to bed when I choose" and "To wash me and all that. I don't want the male ones doing that. I get a female one, eventually, but they try to persuade me and expect me to have a male carer. But I

don't want one. That's how I am." A person was slouched in their chair in the lounge. Staff asked if they were comfortable and whether they would like assistance to change position. The person insisted they wanted to stay as they were, which staff respected. On another occasion, a member of staff talked with the same person about what should be recorded in their daily notes. Staff also asked people for their preferences about what music should be playing in the lounge. Someone was asleep in their room with a newspaper on their table. Their request for a daily paper was clearly detailed in their care plan. Another person had not wanted to attend a medical appointment and so this had been cancelled.

Good

Is the service responsive?

Our findings

At our inspection in October 2016 we found shortfalls in relation to care planning. Some people had needs that were not addressed in care plans. Some care plans were not up to date and some contained insufficient detail. This constituted breaches of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection in October 2016 the provider completed an action plan to show what they would do and by when to meet the legal requirements. At this inspection we found these legal requirements had been met.

Care plans were personalised and contained information about the person's preferences and choices. They were reviewed regularly and as required. A relative told us, "We go to reviews once a year. And they always phone if there's a problem; I'm next of kin."

Care plans contained sufficient detail about how staff should meet the person's needs. For example, two people on insulin for diabetes had clear care plans for how to manage their medication. This included the dose, signs of high and low blood sugar, changing sites when administering the medication, monitoring blood sugar levels and what readings were normal for them. There had been reviews with the GP. Staff told us these people's diabetes was well controlled and they had no concerns. Another person had a plan in place for managing seizures. This included detail about medication, an emergency seizure plan, checks and observations to be done, and diet and fluid to minimise constipation, which can cause seizures. Staff were confident on how they managed the person's condition and the need to liaise with the GP, epilepsy nurse and 999 when required. Another person also had a clearly documented care plan on epilepsy and staff said this was well controlled with medication. A further person had been admitted with some existing wounds; care plans gave clear instructions about the care of each of these wounds and wound care charts reflected that these instructions had been followed to good effect.

The service complied with the Accessible Information Standard. Factors that could make communication difficult, such as sensory impairment and difficulty speaking, were identified at assessment and were flagged up in people's hospital 'grab sheets' and care plans. Staff were aware of people's communication needs and acted accordingly. For example, someone with a hearing impairment was wearing their hearing aids and was able to talk with us. There was a "Something's Wrong" information guide in symbols displayed on a staff noticeboard, and we saw this available in someone's bedroom.

People and their relatives told us they were happy with their or their loved one's care. Comments included: ""I am well looked after, only got to ask and they seem to know what to do", "No complaints; wonderful", "They look after me", "Quite good on the whole… getting everything I want and beyond", and, "Always clean; has her hair done and her feet". People looked clean and well cared for, and those in bed were comfortable.

Handovers between staff at the start of each shift ensured that important information was shared, acted

upon where necessary and recorded to ensure people's progress was monitored. The manager was developing a new handover template to help communicate important information efficiently.

Some group and individual activities were provided. For example, during the inspection there was a visiting musician, and children visited from a local nursery school. Staff spent time with people individually, chatting or doing jigsaws. People's comments about activities were mixed: "You can go outside when the weather is nice and they have dancing in the living room", "I think so [have enough to do]. It depends on the person. I can amuse myself. Some people like those things and some like peace and quiet", and, "They don't [have enough activities]. They have a singsong, but I don't know any of the songs, I'm used to classical music. I would go to quizzes and scrabble." The management team explained that fewer activities were being provided than usual because the previous activities coordinator had left and the new one had yet to start work. In addition, the social care worker was off work, although additional care staff were being allocated to activities in their absence.

Many people stayed in their rooms, according to their preference and needs. Stimulation was available through television, radio and reading matter. For example, someone who was cared for in bed liked classical music; classical music was playing in their room.

People's preferences regarding their end of life care were clearly recorded. For example, in one person's plan there were details of where they wanted to be cared for in relation to their end of life care. Some people had Allow a Natural Death decisions in place, otherwise known as Do Not Attempt Cardiopulmonary Resuscitation orders, where they wanted this or if it was in their best interests, where they lacked the mental capacity to make a decision about resuscitation. These had been signed by doctors, in discussion with people, their families and staff. Anticipatory medicines had been prescribed and were held for people whose death was expected soon, in case they needed these for relief of pain and agitation. Staff had received training in end of life care, and the provider had also organised some training on end of life requirements in particular cultures.

Complaints and concerns were taken seriously and used as an opportunity to improve the service. A person who used the service told us, "I did make a complaint and it was resolved, eventually." There were five complaints on file for 2017, from January, February and March. The complaints file did not initially contain details of an investigation, but this was provided when we requested it. They had been investigated and responded to in good time. People said they would feel able to raise a complaint with the manager, although one person commented that there had been changes in management and they were not sure who the current manager was.

Good

Is the service well-led?

Our findings

Over the past year or so the service had undergone changes in its organisation, including a recent change of manager. When we inspected in October 2016 the service had started separating nursing and non-nursing beds into the Edwardian and Tudor wings respectively. The changes had since been embedded, with some staff on Tudor wing having had additional training and development to develop and review care plans and handle medicines. These tasks had previously been undertaken by nurses. Tudor wing, whilst remaining part of the same service, was running almost autonomously under the leadership of the deputy manager.

A visiting professional, who had not been to the service for a year or so, told us the service had "definitely upped their game". They said the atmosphere at the service had improved. Staff also told us how the service had improved over the past year or so. One of them said it was well organised now and was a "nicer place to work" than it had been in previous years. A member of staff commented of the new manager, "good support and good guidance from her… She's there to guide us. Happy to have her here."

Staff were positive about their roles, telling us that morale was good and that they enjoyed their roles. Comments included: "I love it here" and "It feels like I'm in a big family". Many staff at the service had worked there for a number of years. The provider had recognised challenges with recruitment and was undertaking a review of the recruitment process and measures to retain staff. They were running a 'Believe in Good Care' campaign to remind people, relatives, staff and other stakeholders what good social care provision means for people, contrasting with negative media coverage of social care. It was hoped that this would help boost staff morale and raise the profile of care work.

People and those important to them had opportunities to feed back their views about the quality of the service they received and action had been taken accordingly. For example, a vegetarian option was included on the menu after people said they did not want to eat meat every day. People told us they could speak informally with the people in charge if they had any concerns. The deputy manager had regular contact with families of people on Tudor wing and the new manager told us they were looking forward to getting to know people's families well. They said they were planning meetings with people on both sides of the building and with families. The provider also undertook annual surveys of people who used the service, their families and staff. The responses to the survey earlier in 2017 were mostly positive and actions had been planned and undertaken to address negative areas. For example, letters were now routinely sent to people's families inviting them to reviews.

The manager valued feedback from staff. They told us they operated an 'open door' policy, and that they got to meet night staff as well as day staff, as they were present when night staff finished their shifts in the morning. The service had a whistleblowing procedure, which staff were aware of. Information about how to blow the whistle was displayed on staff noticeboards. However, staff had not reported to nurses or managers a faulty bed rail that would not stay up by itself. Managers reminded staff of the expectation that such faults should be reported immediately. A member of staff told us that if they were aware of a broken bed rail they would report it, We will monitor the reporting of faults at future inspections.

Quality assurance systems were in place to monitor the quality of service being delivered. Where internal audits and quality assurance surveys had indicated shortfalls, these had been addressed. For example, the provider had identified work was needed to ensure initial admissions were successful. Work had been done on customer service and welcome packs with information about the service were now placed in people's rooms. The service and provider had also acted on feedback from the comprehensive and focused inspections in 2016 and 2017, and from other stakeholders, to bring about improvements.

Audits were undertaken within the service and by the provider's management team. These included monthly infection control, tissue viability, nutrition, accidents and incidents, medicines, call bells, complaints and care file audits. There were also periodic audits including mattresses, dignity and staff files.

Support was available for the manager. They confirmed the operations manager was just a phone call away and visited regularly to support the service. There were quarterly peer support meetings for home managers, as well as more formal monitoring through regular reporting and by the quality team.

The service took steps to promote equality and diversity in the provision of care and within its workforce. Attitudes to equality and diversity were considered at interview, where staff were asked a scenario question about the gender of staff providing care. All staff had equality and diversity training during their induction. Equality and diversity was also reflected in staff rostering and annual leave approval, for example, staff from particular ethnic groups liked to take Christmas Eve off work as this was an important celebration for them.

The management team had notified CQC about significant events. We use this information to monitor the service and ensure they respond appropriately to keep people safe.

The service's previous CQC rating was clearly displayed in the entrance hall and on the provider's website.