

Foxleigh Grove Nursing Home

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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

Foxleigh Grove Nursing Home was originally a large private house dating back to the late 18th century. The owners improved the fabric and furnishings of the building and carefully designed extensions were added in order to preserve the character and dignity of the original house. Full registration to care for older adults and people with disabilities was obtained and they admitted the first residents in 1983. The location is now registered to accommodate 39 people. The service is located in Holyport, a scenic village near Maidenhead in Berkshire. The service is surrounded by expansive landscaped gardens.

At the time of the inspection, there was a registered manager. 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 location was last inspected under the 2010 Regulations on 3 December 2013, where the five outcomes we inspected were compliant. This is the first inspection of the location under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Foxleigh Grove Nursing Home. People were safe from abuse and neglect. Staff we spoke with were knowledgeable of how to act if abuse occurred and how to report this to managers or other authorities.

Proper maintenance of the premises and grounds was evident. The registered manager and maintenance staff were knowledgeable about risks from the building and completed assessments and coordinated repairs to effectively prevent harm to people. We made a recommendation regarding Legionella prevention and control.

The service had robust recruitment procedures and detailed personnel files. People we spoke with told us staffing levels met their needs. People's common statement was that call bells were not always answered in a timely manner. When we spoke with nursing staff and care workers, they felt that staffing levels were sufficient. We examined records about staffing deployment and observed staff perform their roles. We found that during peak periods, like meal times, staff were busy but that safe deployment was evident.

Medicines were not always ordered, stored, administered or recorded safely. This meant that people were at risk of medicines errors. This was confirmed by pharmacist audits. We advised the provider to seek guidance and support to ensure people's medicines were safely managed.

Infection prevention and control practices required improved. The service was clean and tidy but national best practice for cleaning processes was not implemented. Some risks regarding chemicals were not mitigated by the provider.

Staff training, supervision and performance development required some improvement. Although induction programmes and training had occurred, competency checks and repetition of training was needed to ensure effective care. The provider sent us information after the inspection which demonstrated they listened to our findings and took action to ensure effective staff knowledge and skills.

The service was not compliant with the requirements of the Mental Capacity Act 2005. In some cases people were deprived of their liberty without the required legal authorisation. The registered manager explained they were aware and that actions had commenced to remedy this issue. We made a recommendation about the service's compliance with the requirements of the Mental Capacity Act 2005.

People received nutritious food which they enjoyed. Hydration was offered to people to ensure they did not become dehydrated. However, there were some risks about malnutrition that were not detected by staff or the service. The computer documentation system contributed to incorrect risk scores for people. This meant people were placed at risk and some had lost weight without correct intervention from a multidisciplinary team.

People felt staff were caring and friendly. People were able to voice their opinion and the service listened to what their thoughts were. People had the right to choose or refuse and this was respected by staff. We saw people's privacy and dignity was respected during the care provision.

Responsive care was provided to people. Their wishes, preferences, likes and dislikes were considered and accommodated. Staff knew about the complaints procedure and people had the ability to complain. Managers investigated complaints and provided responses so that people knew their issue was recorded and where possible resolved.

The workplace culture at Foxleigh Grove Nursing Home was good. Management was stable at the service and there was a low staff turnover. Staff described a positive place to work and care for people. Staff told us they enjoyed their roles and found management approachable and reasonable. The registered manager and head of care were knowledgeable about quality care and accountable in their roles.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

People told us they felt safe.

People were safeguarded from abuse and neglect.

The service had appropriate risk assessments and maintenance procedures.

Sufficient staff were deployed to meet people's needs.

People were not always protected against the risks associated with medicines.

People were not always protected by safe infection prevention and control practices.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People were cared for by staff that received effective training. A lack of some staff training placed people at risk.

Staff did not always act in compliance with the Mental Capacity Act (2005).

People were satisfied by the menu and meals they were provided.

People were sometimes at risk of malnutrition.

People received appropriate support from external healthcare professionals.

Is the service caring?

Good ●

The service was caring.

People told us that staff were kind.

People were aware of care planning but did not always participate.

People's privacy and dignity was respected.

Confidential personal information was protected.

Is the service responsive?

Good ●

The service was responsive.

People's preferences were taken into account.

People's care was personalised.

People's care was reviewed at regular intervals.

People had the ability to make complaints and these would be investigated appropriately.

Is the service well-led?

Good ●

The service was well-led.

People had positive opinions about management.

There was a good workplace culture for staff.

Managers were knowledgeable, friendly and approachable.

Actions were taken by managers to address issues when they occurred, to ensure quality of care.

Foxleigh Grove 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 inspection was undertaken by an adult social care inspector and three specialist advisors. Our specialist advisors were a registered nurse, a dietician and a Mental Capacity Act 2005 (MCA) assessor. Our inspection team included an Expert by Experience (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspection took place on 8 June 2016 and 10 June 2016 and was unannounced.

For this inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we already held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public leading up to the inspection. We asked the local authority and clinical commissioning group (CCG) for information to aid planning of our inspection.

At the time of the inspection, there were 55 staff who worked at Foxleigh Grove Nursing Home. During the inspection we spoke with the registered manager, the head of care, two maintenance people, two activities coordinators, two cleaners, a laundry worker, the chef and a kitchen assistant. We also spoke with three registered nurses, three care workers and a visiting health professional.

We spoke with eight people who used the service and one relative. We looked at 13 sets of records related to people's individual care needs. These included care plans, risk assessments and daily monitoring records.

We also looked at four staff personnel files and records associated with the management of the service, including quality audits. We asked the provider to send further documents after the inspection.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection. Observations, where they took place, were from general observations.

Is the service safe?

Our findings

We asked five people whether they felt safe living at Foxleigh Grove Nursing Home. People confirmed they felt safe living there. One person said, "Yes very safe; they always check my patio doors are locked at night and I've never felt unsafe here". Another person told us, "I've been here for 16 years and haven't seen anything bad here. The staff here are very good and, yes very safe at night". A third person we spoke with told us, "Yes, it's not in the middle of town and when I use my call bell they come very quickly. Ten times I've used it [on one shift] and at night I have no problems".

People were protected from abuse and neglect. There was a good knowledge by registered nurses, care workers and management regarding the principles of potential abuse and how to ensure people were safeguarded should allegations occur. Staff displayed confidence in their knowledge of types of abuse, signs of abuse and the action they would take if they suspected or witnessed abuse. Staff we spoke with told us they would report colleagues if they found neglect had occurred. All staff we spoke with were aware of whistleblowing and authorities that they could approach if they needed to report something. The registered manager was clear about their role in managing safeguarding concerns.

We examined safety of the premises and routine safety checks with the registered manager and two maintenance persons. This registered manager had a good understanding of maintenance and safety procedures and was able to demonstrate continued mitigation of risks. There was extensive evidence and documentation that regular examination and testing of building and grounds safety were maintained. For example, we saw records such as risk assessments and maintenance plans for fire safety, portable appliance testing (PAT), lifting equipment (hoists and lifts), window restrictors and bed rails. We also reviewed prevention and control measures for Legionella. We examined a Legionella risk assessment conducted at the location by an external contractor dated 3 November 2015. The risk assessment rated the risk of Legionella as 'high'. A number of actions were required to be undertaken by the service. In 2016, a review of the risk assessment was completed. This showed that the water temperatures in the building's boiler were not always within the required range. The provider sought expert advice regarding this which showed it was not always possible to achieve this. Biological water sampling however determined that Legionella was not present in the water within the service. After consultation with the Health and Safety Executive guidance, we found that based on the content of the risk assessment and susceptibility risks for people who used the service, better prevention of Legionella was required.

We recommend that the provider seeks expert advice regarding the prevention and control of Legionella.

The number of people who used the service was stable. We reviewed the deployment of all staff categories with the registered manager as part of the inspection. We were advised of the daily staff shift patterns and deployment. The service had a stable workforce and there were no vacancies for registered nurses or care workers. Agency staff were not required at the service. We reviewed some rotas for 2016. These records matched the staffing deployment that the registered manager and head of care told us were planned in advance.

People and staff we spoke with told us they felt that there were sufficient staff at most times of the day. Some people we spoke with said they felt that call bells were often not answered quickly and that people sometimes had to wait extended periods for a response. Our observation found that call bells were answered promptly by staff, and the registered manager advised a system issue with the call bells was resolved to ensure an improved response from staff. During peak times like breakfast and lunch time, staff we observed were busy but not rushed to care for people. During busy periods, staff acted calmly and ensured that people's care was safe and appropriate. People's care was safe because there were sufficient staff deployed.

We looked at four staff personnel files. The location's registered manager was responsible for ensuring fit and proper person checks were completed and recorded for new staff. We found the service had strong recruitment and selection procedures that ensured suitable, experienced applicants were offered and accepted employment. A high percentage of staff had long periods of service for the provider. Some new staff were recruited when others left the service. Staff we spoke with told us they had to pass a number of stages to be successful in gaining their employment. This included a face to face interview with a manager and question-based scenarios. Personnel files contained all of the necessary information required by the regulations and no documents or checks were missing. We found this included criminal history checks via the Disclosure and Barring Service (DBS), checks of previous conduct in other roles, and proof of identification. We also checked the staff's legal rights to work in the UK.

A business continuity plan and emergency procedures were in place and updated so that if there were events which may impede safety for people, staff or visitors, appropriate procedures were followed. When we spoke with staff, they told us they knew what to do in the event of emergencies.

We looked at medicines safety at the service. We found medicines were not always stored securely. We had concerns that the medicines room and the staff station were within the same room where the door was always held back. This meant distraction from staff within the room while medicines were prepared could increase the risks of an error. In addition, when staff were not present in the room, there was the ability for other people to enter the room where medicines were stored. Medicines requiring refrigeration and those stored in the room were kept within recommended temperature ranges, although better information recording was required. We looked in storage cupboards and found a limited number of items were overstocked, which meant the medicines were at risk of expiring before they were able to be used. Controlled drugs were appropriately locked away, the record book reflected the quantity levels in the cupboard and checks occurred to ensure stock was safely controlled.

Homely remedies (medicines which the public can buy to treat minor illnesses like headaches and colds) were available within the home. However, staff were unable to locate the GP authorisations to use homely remedies or records of administration. We found that the 'homely remedies' supply was not well-maintained and accounted for. Information about allergies, "how I like to take my medicines", "when required" and "variable dose" medicines was held within each person's medicines administration record (MAR). One person self-administered some of their medicines following the completion of a risk enablement assessment.

The administration of medicines was recorded using medicines administration records (MARs). We examined a number of people's MARs with the head of care. We found that handwritten transcription of prescriptions was recorded without signatures from two registered nurses. This meant people were at risk of medicines errors if one staff member made a mistake with the transfer of information. In the MARs where medicines were not given, the reasons for non-administration were not documented.

Some people who used the service had 'as required' medicines orders (PRN). These were for the purpose of medicines given on an infrequent basis, such as those for pain or constipation. Protocols for registered nurses were in existence, but the instructions were not clear, not regularly reviewed, and not specific to the person they were designed for. In addition, where creams or lotions were applied to the people's bodies by care workers, body maps and records of the applications were not appropriately recorded.

We were shown the most recent medicines audit from the pharmacy which was completed in April 2016. This had noted similar concerns to those we had identified during the inspection. Although we found the head of care had devised an action plan after the pharmacist audit and report, steps were not completed and signed off to demonstrate risks were mitigated. This meant people were at risk of harm from unsatisfactory medicines safety. We provided information to the provider about suitable places to seek additional ongoing support from a pharmacist.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had completed a comprehensive infection control audit and identified areas for improvement. An action plan was generated and the actions were documented as completed. The care home was clean and tidy in most areas. Cleaners were unable to demonstrate how they documented what cleaning they completed on a daily, weekly or monthly basis. We also found that the service was not in adherence with national standards for cleaning practices. Part of the guidance requires certain coloured mops, cloths and buckets to be used for particular tasks. This decreases the risk of cross-contamination of cleaning materials. In addition, access to substances hazardous to health (COSHH) was not satisfactory, with unrestricted access to chemicals and pesticides. We brought these matters to the attention of staff who took remedial action to ensure people's safety.

Is the service effective?

Our findings

During the course of the inspection, we spoke with a range of staff that performed different roles in the location. This included staff that provided care, such as registered nurses and care workers and also staff that performed support functions. There was mixed feedback from staff we spoke with regarding their training and development. All of the staff we spoke with confirmed that they received some training in various relevant subjects specific to their role. However, when we questioned staff about the frequency of subjects like safeguarding vulnerable adults, moving and handling and fire safety, they were unsure when they last undertook the training or future scheduled dates for their attendance. When we asked the registered manager about training, at the time of the inspection they were unable to produce satisfactory evidence regarding staff training. We asked the provider to send this information to us following the inspection and we received records of staff training.

The provider gave evidence of a staff training matrix of mandatory courses and some topics that were good practice to have completed. We saw the records indicated the course name and content. The matrix did not show the required frequency of the training or the delivery method of the training. At the inspection the registered manager confirmed that training was primarily e-learning, with some aspects like practical skills, conducted via face to face teaching. The records provided showed that for most topics, staff had received recent training. There were some subjects where the percentage of staff that had completed the topic could have placed people at risk. For example, we saw that 14 staff required training for manual handling. After the inspection, the provider sent us a training programme which showed what planned and booked courses staff were to complete. This indicated that steps were taken to ensure staff had the ability to refresh their knowledge and skills in core topics to ensure people's safety.

Registered nurses and care workers we spoke with were either undertaking or had successfully completed a Diploma in Health and Social Care. Some care workers had progressed to a higher level of the qualification and the provider had supported them with their learning. Time was made available to ensure that staff could meet with representatives from external training organisations at the service and progression to completion of the courses was encouraged. There was evidence that the provider encouraged care workers to apply for, attend and complete appropriate qualifications. This was further confirmed by the provider following the inspection.

We recommend that the provider ensures that all staff have the qualifications, competence, skills and experience necessary for the roles they are employed to perform.

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.

We spoke with the registered manager regarding standard DoLS authorisations at the location. At the time of the inspection, 39 people lived at the care home. One person was subject to a standard DoLS authorisation. The registered manager informed us that applications for standard authorisations were submitted for another four people. This was confirmed by the local authority when we checked. The registered manager also told us they intended to make additional applications for three people.

We reviewed the care documentation of eight people who used the service to determine whether the location assessed and recorded consent and mental capacity in accordance with the law. The service used an electronic care recording system which staff accessed through computer terminals and mobile phones. We saw a 'best interests decision' form for one person that recorded information relating to the ability of the service user to understand, retain and weigh up information. These were consistent with the MCA codes of practice. However, there was one further factor referred to as follows: 'believe information given in good faith'. This is not a relevant factor. The factor which the form should have covered (and did not) was the ability of the person to communicate their decision. We reviewed the person's DoLS authorisation. The authorisation was granted on 24 May 2016 and was due to expire on 21 November 2016. We saw there was one condition to the standard authorisation requiring the service to complete a behaviour chart in respect of the resident. The condition was not recorded in the electronic care record although when we spoke with the registered manager they told us that they were aware of the condition. The manager confirmed to us that the condition had not yet been implemented. The condition was imposed nearly three weeks previously. The DoLS Code of Practice states that "the managing authority must comply with any conditions attached to the authorisation." Another 'best interests decision' form for a person had a section which included the words: 'service user lacks capacity because they are unable to ... (tick any that apply)'. However, none of the four factors specified in the MCA code of practice were recorded.

We found four people's care records indicated that they may have lacked capacity to consent to remain in the home for the purposes of receiving care or treatment. The people may therefore have been subject to an unauthorised deprivation of liberty. The restriction was that for their own safety, the people would not have been allowed to leave the service by themselves. The relevant application had not been made or an authorisation approved to allow these people to be deprived of their liberty. We also looked at the training records for the service. This showed six staff had training regarding the MCA and seven staff had participated in training about DoLS. When we spoke with registered nurses, they indicated they had received training in relevant areas, but care workers stated they had not received training and had limited knowledge. All staff involved in mental capacity assessment or obtaining consent decisions must understand and display compliance with the MCA and associated codes of practice.

We recommend that the provider reviews the requirements of the Mental Capacity Act 2005 and implements measures to ensure compliance.

We saw that the appearance of meals prepared and delivered to people was appetising. There was a varied menu. We observed that people enjoyed their meals and this was a social experience with people talking with each other at dining tables and staff interacting calmly and politely with people. One person told us, "The food here is excellent. My favourite food is sweet puddings and you get a good choice of menu." Another person felt that, "The food is very good here; not once have I had to complain in 16 years." People were satisfied with the menu.

We reviewed records related to people's nutrition and hydration. The location used the malnutrition universal screening tool (MUST) as the method of determining risk of malnutrition. Electronic care records were present for all people whose care records were reviewed. Care workers could access electronic care records using mobile telephones. Some recording of information about people's nutrition was paper-based. Paper records showed that most people were weighed monthly, and arm circumferences were measured and recorded for six people who could not be weighed. Arm circumferences are used to determine the risk of malnutrition for people who are unable to be weighed. There were unexplained gaps in some people's weight and arm circumference records including those already identified as at medium or high risk of malnutrition.

Within the electronic care record system, MUST appeared to have been completed regularly, but through reviewing some care records and talking with two registered nurses it was evident that many MUST scores were neither up to date nor correct. For example, one person's MUST score was dated 26 May 2016 but the last weight recorded on the electronic care records was dated 29 February 2016. The MUST score on was therefore not up to date as it was based on a weight recorded three months previously. The paper based weight chart showed that the person was last weighed in April 2016 when a 14% weight loss in 2 months was apparent. This meant that in April 2016 the person was actually at high risk of malnutrition according to MUST. No further weights were recorded for this person after April 2016.

One registered nurse we spoke with explained they received training on measurement of arm circumferences in a previous job. Another registered nurse reported being behind on inputting people's weights into the electronic care records. This registered nurse recognised that belated documentation meant that people at risk of malnutrition could be missed. The registered nurse correctly described what an arm circumference measurement meant and understood that this meant the person was at medium or high risk of malnutrition. The registered nurse reported that the electronic care record did not allow arm circumferences to be recorded and that this meant the resulting MUST score was also incorrect. We reviewed six people's arm circumference measurements for a six month period. Five out of six showed the measurement decreased in that time, which meant people were at risk of malnutrition. Three out of six measurements in April 2016 were incorrect but this was not identified by the nursing staff.

We found nutrition care plans in the electronic care records contained many similarly- worded statements which were automatically generated by a person's MUST score. For people at medium or high risk of malnutrition according to MUST, care plans focussed on people's access to food but did not mention people's nutritional needs or ways to increase nutritional intake.

Where people had a risk of choking on fluids, a fluid thickener was used. We found fluid thickener was prescribed for six people. A registered nurse showed us a notice provided by one person's speech and language therapist (SALT) which advised the consistency of fluid required. However, the same information was not available for the other five people who had fluid thickeners. A registered nurse reported that although new staff were given informal training about people's need for thickened fluids, no record was maintained of this training. A care worker who provided drinks for people stated they sometimes used thickener for people that needed it but reported that they preferred registered nurses to add thickener to drinks. The staff member stated this was because they were unsure what consistency was needed and that other staff they asked did not know. Despite this, we found the care worker had considerable knowledge of people's different nutritional needs.

We spoke with the chef who reported they were informed of any food allergies or conditions such as diabetes or coeliac disease when residents were admitted, and that they were informed when people needed soft or pureed food. We found the chef demonstrated good understanding that pureed food need to

be made with high calorie liquids and they reported providing pureed snacks between meals. However, for those residents for whom pureed food is provided, the chef did not know whether the people had swallowing difficulties or whether this was personal preference. The chef was unable to state what a MUST score was and was not aware whether any people in the home were at risk of malnutrition, suggesting that communication of MUST scores from clinical staff to the kitchen did not occur.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported by the service to attend all necessary medical and healthcare appointments away from the care home. Examples of good support to people related to healthcare included assistance with GP visits and helping people to understand correspondence they had received about appointments or blood tests. Where additional time was required to help with health appointments, the service provided escorts for people, if required. Staff we spoke with were knowledgeable about people's ongoing health matters, especially for illnesses or diseases where appropriate external healthcare was necessary. A GP and chiropodist regularly visited the care home to review people's needs.

Is the service caring?

Our findings

We asked people if staff were kind and caring. One person's feedback included, "Yes they are. I'm very chirpy and open, but they treat me with kindness and respect. They always knock on my door and I had a cuddle by the girl that's leaving." We also asked whether the service placed any restrictions on people. One person told us, "No there are no restrictions. My family can come and go as and when they like." Another person stated, "No, there's no restriction where I can go in the home. My daughters come and take me out when they like, and my daughters can come and go as and when they like". One relative's feedback echoed the sentiments of people we spoke with. They said, "I am over the moon with the place. My mother's condition has 'improved beyond belief'. Staff in the home had encouraged my mother to eat and now she 'eats normal food'. The relative went on to say staff were caring towards their mother and listen to their needs. The relative said that the staff always made them feel welcome when they visit the home. This meant the people we spoke with were satisfied that the support they received from the service was caring.

The registered manager explained the provider conduct annual satisfaction surveys with people who use the service. We looked at the 20 feedback results from the 2015 questionnaire. The provider asked people and their relatives to rate areas of the service like the staffing, the care and the general atmosphere. We saw results indicated people surveyed felt the service was caring. For example, when asked about 'how people were treated', all respondents rated care as good, very good or excellent. People were satisfied with the care they received. The survey recorded people's positive feedback. A relative's comment was, "To thank [the registered manager] and the nursing staff for the care and attention my father receives on a daily basis, and appreciate sometimes that some days other resident's needs can disrupt the normal daily routines. My father and our family agree that Foxleigh Grove is the best place for him to be." Another person wrote, "Very pleased with the care received; cannot fault the nursing home." The survey also documented people's opinions on areas for improvement. The survey showed that people and their relatives had the ability to express their views.

During the inspection, our visual observations of people's interactions with staff were positive. People were addressed by their preferred names, staff were attentive to people's needs and staff acted professionally with relatives and visitors. We observed staff were attentive to people's needs. For example, at lunchtime a person's glasses had fallen from their face into their meal. We saw a staff member quickly respond and remedy the situation. The person was thankful and able to continue eating their meal.

We asked people whether they were involved in decision-making for their care and treatment. Some people told us they had not viewed their care plans. One person said, "There is one but I haven't seen it or as far as I know my daughters haven't seen it." Another person told us, "No, I don't really need to see it but I know what it is." A third person stated, "No I have never seen my care plan but I think my daughters might have... the three of us make all the decisions for me." Although people told us they had not viewed their care plans, there was evidence of involvement in their creation and review. We reviewed care records to determine people's level of involvement in planning, making choices and being able to change the care if they wanted. We found people who had the ability to were free to make changes if they desired. An example we found was that people had the ability to choose if they wanted a bed-bath, a bath or a shower. They were free to

change their mind when they wanted a different method for their hygiene. Where people's conditions meant they may not be as involved in the planning or receipt of care, we found relatives and healthcare professionals were consulted to ensure that the person received the best possible care. Best-interest decision making was less evident in care records, although we found occasions where decisions were made without considering what the best outcome would be. However, the service took into account people's personal preference, likes and dislikes and tried to embed these into the care that staff provided. We provided feedback to the registered manager regarding best-interest decision making following the inspection.

We found that people received care which was dignified and respectful. When we asked people whether their privacy and dignity was respected by staff they told us they agreed. For example, one person said, "Yes, they do always knock on my door even when I leave it open and when they wash me. They always close the curtains and close my door." When asked about privacy, another person told us, "Oh yes, the girls are lovely here and they always knock on my door before they come in..." Staff demonstrated respect of people's privacy when hygiene care was provided, by closing bedroom doors and curtains. We observed staff knock on people's bedroom doors when they were closed. We saw staff announced their presence and sought consent from people to enter their rooms.

Confidentiality in all formats was maintained, especially in electronic records. We noted computers required a user password again when they were not used for a period of time. We did not observe any instances of people's personal information being located at an inappropriate place within the building. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. This meant the provider ensured that confidential personal information was handled with sensitivity and complied with the legislation.

Is the service responsive?

Our findings

People we asked felt the care delivered was personalised and responsive to their needs. One person told us, "I can make all my own decisions on what happens to me and where I go". Another person stated, "I have full control of all my decisions whatever I do". We asked one person whether the service helped them to maintain their independence. They said, "Yes, sometimes I try to make my own bed but the staff always try to help me". People's comments suggested that person-centred care was present at the service.

We looked at a 13 people's care documentation to determine whether care from staff was responsive to their needs. We found people who used the service had their personal needs and preferences taken into account before care commenced and throughout the continuation of their stay. In each of the care records there was good evidence of pre-admission planning which in itself gave a picture of people's needs and also whether the service could meet those needs. We also looked at falls risks, general risk assessments, bed rail risk assessments, moving and handling risks and Waterlow scores. Waterlow scores determine a person's risk of developing a pressure ulcer.

The provider's care documentation system recorded specific information important to the person. For example, we saw people could state their cultural and religious preferences, likes and dislikes and end of life wishes. People's preferences were reviewed at regular intervals and we saw evidence of this in the care records we examined. People were free to choose what aspects of care they needed assistance with, and the service would allow people to remain as independent as possible. The registered manager explained that pre-admission assessments by the service ensured that questions were asked to ensure the person received person-centred care when they moved in. When we spoke with registered nurses, they stated that care changes were made to take people's views into account if they changed. This meant the service adapted to people's changing needs.

For people at high risk of pressure ulcers, strategies must be taken to prevent their skin breakdown. We saw Waterlow scores ranged from moderate to very high risk. We checked those people were nursed on pressure relieving mattresses, and found the service had implemented this as required. Although none of the mattresses were monitored by staff for the correct setting, this was not required as the mattresses were self-regulating. We found people were satisfactorily protected from pressure ulcer development. This corroborated with our evidence that the provider had not reported any pressure ulcers to us since the last inspection.

People's falls risk assessment scores ranged from low risk to very high risk and in all cases there was evidence of risk-reducing methods documented. Examples we saw included ensuring people wore correctly fitting footwear and the appropriate use of walking aids. Few of the care records examined had evidence of falls documented, however there was a space for copies of accident forms to be filed. One person's falls risk assessment identified that only one fall had occurred in the prior 12 months. However when we looked at the actual accident forms there was evidence of nine falls since January 2016. Staff had correctly identified and recorded that the person was at high risk of falls, but the risk assessment didn't reflect the increased falls rate.

We found allergies were noted within care plans and on the pre-admission assessments. We noted that in the care records of one person, an accident had caused blisters on their abdomen from apparently spilling tea. We did not find notes that actions were taken to prevent further recurrence. We did find however there was good recording of accident and incidents. This meant people's planned care was reviewed after incidents occurred and were documented, and care was amended if it was necessary.

People were encouraged to maintain an active lifestyle. The layout of the building meant that group activities were limited to the ground floor. However, expansive landscaped gardens surrounding the building promoted people going outside during pleasant weather. We found there was a ready supply of equipment and materials to support activities. Activities coordinators planned and carried out satisfactory entertainment and stimulating experiences. We saw this was easily displayed for people and contained a varied mix of activities. External trips away from the care home were also undertaken. We saw activities coordinators were part of the routine care at the service. They helped with personal care at some times of the day, for example at meal times. We saw there was a suitable activities programme and observed activities in progress during the inspection. One example of an activity we witnessed was a bingo session and a number of people attended and enjoyed. Amendments were made to ensure people who had difficulties could still participate. This meant people were socially stimulated and encouraged to maintain an independent lifestyle.

Five people we spoke with told us they felt comfortable to make a complaint if they wanted to. Out of the five, some said they had provided feedback to the registered manager which was acted upon. The provider had a complaints policy and procedure. We observed a copy was easily available for people, relatives and staff to access. We also observed that complaints posters were displayed in various locations around the home if people or relatives needed details. Staff we spoke with knew about the policy and the steps they would take if a person or relative wanted to make a complaint. The policy and procedure contained the information for various staff members regarding their role in listening to and managing complaints. There was the ability to escalate complaints within the organisation if people felt their complaint was not handled well. There were no complaints since our last inspection. The registered manager demonstrated they preferred to deal with concerns immediately before they escalated into formal complaints. This was in line with the provider's complaint policy. The service maintained that people had the right to make contact with other regulators regarding complaints. This meant that people's complaints would be handled seriously and professionally.

Is the service well-led?

Our findings

We asked people whether they felt Foxleigh Grove Nursing Home was well-led. The comments we received indicated people were satisfied with how the service was operated. One person said, "Yes, I've met the owner and her son and yes I think they are trying to do a good job. The staff here are very nice and they always talk to me." Another person commented, "Yes, I think it's run well and I always get to speak to the owner. The staff, yes I think they're alright and they do a good job." Another person said, "Yes, I think [the registered manager] does a very good job here".

Staff we spoke with also agreed that they enjoyed working at the service. They felt there was a positive culture which resulted in good care provided to people. One staff member stated, "I have been here for five years. I really love it and all of the residents. I love coming to work we have had lots of training." Another staff member said, "I have been here for 3 years. I have a diploma in health and social care. I love to come to work; everyone is really friendly." The chef told us, "I love cooking and if there are any problems, I can talk to the manager." We found the registered manager and head of care approachable and dedicated to their roles. They interacted well with people who used the service, staff and relatives. Everyone we spoke with as part of the inspection had positive opinions regarding the management and staff.

We spoke with a visiting health professional to gather their opinion about the management of the service. The health professional said they considered that the management and staff were knowledgeable, confident and competent in their approach. They told us that a person needed a syringe driver for their pain. This was in order to manage the needs of person with end of life requirements. The person was unwell when they were admitted to the service. However, the health professional considered the person's wellness had been enhanced after they moved in. The health professional told us, "In a nutshell they are very professional staff, proactive and consistently look at the psychological needs of this client group."

The registered manager and head of care ensured that people had the ability to be involved in the running of the service. Quarterly 'residents' meetings were held and we saw the last meeting occurred in May 2016. The service was able to disseminate key information to people about any changes to the service and listen to their feedback. Staff were also involved in the running of the service. Meetings were held with staff to listen to their opinions and undertake joint problem-solving. We saw that a staff meeting was held in April 2016 and the next scheduled meeting was October 2016. Outside of these meetings, staff felt comfortable approaching management with any concerns. One staff member told us, "This is a family home. Staff are part of the family. The owners come in often." Another staff member said, "[The head of care] takes action personally. She is not on her own. She has 'stepped up'. [The registered manager] is brilliant, and 'comes down on you' when needed. We are completely supported."

The quality of people's care was checked by the staff and registered manager. Accidents and incidents were recorded by staff and reviewed by the head of care or registered manager. Where necessary investigations occurred to determine the cause of incidents and whether recurrence could be prevented. Due to legislative requirements, there are times that the service needs to notify us of certain events which occur at the service. Our records showed that the service reported certain issues to us, as required by the regulations. We found

the management complied with the requirement to notify us regarding the running of the service, and always provided accurate, detailed information without delay. When we spoke with the registered manager, they were able to explain the circumstances under which they would send notifications to us. This meant that on every occasion, events which impacted on people's care were reported to relevant parties for monitoring.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity. The management were familiar with the requirements of the duty of candour and were able to clearly explain their legal obligations in the duty of candour process. The provider did not yet have an occasion where the duty of candour requirements needed to be utilised at this service. At the time of the inspection, the service had a duty of candour policy dated May 2016. The policy clearly set out the steps for the registered manager to follow if the duty of candour requirement was triggered.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Care and treatment was not provided in a safe way for service users. The registered person had not done all that was reasonably practicable to mitigate risks to the health and safety of service users. The registered person did not ensure the proper and safe management of medicines</p>