Hexon Limited

# Woodlands Nursing Home

**Inspection report**

Woodlands Nursing Home,8-14 Primrose Valley Road, Filey, North Yorkshire,YO14 9QR
Tel: 01723 513545

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## Ratings

| | |
|---|---|
| **Overall rating for this service** | Good |
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires improvement |

## Overall summary

Woodlands Nursing Home is a service which provides personal and nursing care for older people, some of whom are living with dementia. It is registered for 34 people, but on the day of inspection there were only 24 people living at the home. The home had agreed to a suspension of new admissions and then a phased admission of people, following concerns raised by the local authority in March 2015.

At our previous comprehensive inspection on 10 and 11 March 2015 we found a number of shortfalls in the quality of people's care and safety. For example, we found that the quality and safety of the service was inadequately assessed and monitored and that the home did not sufficiently protect people regarding infection control.

Some areas of the premises were not safe and the décor was not sufficiently adapted for the needs of people living with a dementia. There was a risk that people would not receive effective care which met their needs because staff did not receive adequate supervision of their work. People were not always given care that met their clinical care needs.

We carried out a focused inspection on 16 July 2015 where we followed up on the shortfalls in the quality of people's care and safety. We found that improvements had been made in all the areas where earlier shortfalls had been identified. However, it was too early to judge whether these improvements had been sustained and we

# Summary of findings

planned to return to check on this. Please refer to these earlier reports for details on the action we asked the provider to take and the improvements which were found at that time.

At this inspection on 24 November there was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed, and took up post on 16 March 2015, but had not yet registered with CQC. However, an application to be registered had been received by CQC.

At this comprehensive inspection on 24 November 2015 the premises were clean and hygienic. Laundry was well managed to comply with infection control best practice. Staff followed infection control best practice guidelines to protect people from the risk of cross infection. This meant that people were protected from the risk of cross infection.

The premises was well maintained and safe. Communal rooms, corridors and rooms for individual use had been redecorated and were bright and cheerful. Pictures had been replaced with new interesting ones, which would encourage discussion and reminiscence. Windows were safely restricted. Lighting had improved, particularly in the area of the home devoted to caring for people who were living with dementia. Chairs and other furniture had been replaced. Toilets and bathrooms had been redecorated and repaired. Some floor coverings had been replaced or deep cleaned. Outdoor steps had been highlighted with high visibility paint to reduce the risk of falls. Outdoor spaces had been attended to and now provided pleasant safe areas for people to enjoy.

People told us they felt safe at the home. Risks to people were managed well without placing undue restrictions upon them. Staff were trained in safeguarding and understood how to recognise and report abuse. Staffing levels were appropriate, which meant people were supported with their care and able to pursue interests of their choice. People received the right medicines at the right time and medicines were handled safely.

People told us that staff understood their individual care needs. We found that people were supported by staff who were well trained. All staff received mandatory training in addition to specific training they may need. The home had strong links with specialists and professional advisors and we saw evidence that the home was proactive in seeking their advice and acting on this.

People's needs were met in relation to food and drink and they received the health care support they required. People were enabled to make choices about their meals and snacks and their preferences around food and drink were listened to and acted on.

The home was clear about its responsibilities around the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and supported people to make informed decisions about their care.

Staff had developed positive, respectful relationships with people and were kind and caring in their approach. When this had not been the case, the manager was aware of this problem and was addressing it through supervision, monitoring and the home's disciplinary procedure. People were afforded choices in their daily routines and their privacy and dignity was respected.

People were consulted about their care. People told us that most staff understood their needs and what was important to them and made sure that they received the care they needed and preferred.

People were assisted to take part in activities and daily occupations which interested them. However, activities and pastimes were not always tailored for the individual needs of people who were living with dementia.

People were encouraged to complain or raise concerns, the home supported them to do this and concerns were resolved quickly. The home used lessons learned to improve the quality of care.

There was good leadership which promoted an open culture and which put people at the heart of the service. However, there was a vacancy for a deputy manager and the manager was fulfilling the clinical lead role. This meant that a large number of tasks fell to the manager alone. There was a risk that the quality of management would not be sustained without a senior team to strengthen the development of the management role within the home.

# Summary of findings

Staff understood their roles and responsibilities which helped the home to run smoothly. Communication was clear from the manager to all levels of staff within the home. Staff were encouraged to give their views. The manager understood the home's strengths, where improvements were needed and had plans in place to achieve these with timescales in place.

Systems were in place to assess and monitor the quality of the service and the focus was on continuous improvement.

# Summary of findings

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

We always ask the following five questions of services.

**Is the service safe?**

Good

The service was safe.

People were protected from the risks of acquiring infection because the home was clean and hygienic.

People were protected because of the way the building was maintained.

Risks to people's safety were assessed and acted on and risk plans included how to maximise freedom.

People were protected by sufficient staff, who had the skills and experience to offer appropriate care and were well deployed within the home.

Staff were safely recruited to protect people.

Medicines were safely handled.

**Is the service effective?**

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through supervision and appraisal and this meant people received good care.

The service met people's health care needs, including their needs in relation to nutrition, hydration and pressure care.

People benefitted from an environment which was adapted, decorated and which had signage for people who were living with dementia.

Staff received induction and appropriate training to protect people's welfare.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

**Is the service caring?**

Good

The service was caring.

People told us that staff were kind and caring.

We observed staff were kind and compassionate. Staff knew people well and we observed warm and affectionate conversation between people and staff.

Staff were on hand to diffuse situations and to reassure people when they became anxious or upset.

The way the home handled pain relief was tailored to individual needs.

# Summary of findings

**Is the service responsive?**

Good 

The service was responsive to people's needs.

People were consulted about their care.

Staff had information about people's likes, dislikes, their lives and interests to ensure staff had the information they needed to offer person centred care.

Activities and daily pastimes responded to people's interests but not always sufficiently focused on meeting the needs of people living with memory impairment or dementia.

**Is the service well-led?**

Requires improvement 

The service was well led.

The current manager was not registered with the Care Quality Commission, however an application had been received. Prior to their appointment the home had a long history of being reactive to requirements placed upon it rather than being proactive to improve quality.

The management of the service was effective, however there was a risk this may not be sustained. A large number of management tasks fell to the manager alone.

People told us that they enjoyed living at the home and that they liked the manager. The manager explained things to them and consulted with them about improvements in the home.

People benefitted from the effective quality assessment and monitoring of the service.

# Woodlands Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 24 November 2015 and was carried out by one adult social care inspector, a pharmacy inspector who was on induction with CQC and was shadowing the inspection and a specialist nurse advisor. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority safeguarding team and the hospice at home team which operates from St Catherine's hospice in Scarborough to provide outreach support. Before the inspection we would usually ask 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. On this occasion, as this was an inspection to provide a rerating following up on previous concerns, we did not request the PIR. However we gathered the information we required during the inspection visit.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with five people who lived at the home, two visitors and four members of staff including the manager. We also spoke with a visiting health care professional and a health and social care professional who were visiting the home during the inspection visit.

We looked at all areas of the home, including people's bedrooms with their permission where this was possible. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at six care records and associated documentation. This included records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for two members of staff. We also observed the lunchtime experience and interactions between staff and people living at Woodlands Nursing Home.

Good

# Is the service safe?

## Our findings

People told us that they felt safe at the home. One person said, "I didn't feel so comfortable upstairs, as there were a couple of people who made a fair amount of noise, which unsettled me. I asked if I could change rooms and they sorted it out straight away." Another person told us, "There are always staff about so I know they are near if I need any help." Another person said, "Yes, I feel very safe." A visitor told us that they felt their relative who lived in the home was, "Very safe".

At our previous comprehensive inspection of Woodlands Nursing Home on 10 and 11 March 2015 we found that the home was not clean or hygienic. At our focused inspection on 16 July 2015 we found that the cleanliness of the building had substantially improved. Cleaning schedules and records were in place with regular documented cleaning checks to ensure that cleanliness standards were maintained. Mattress audits were in place and we saw that a number of mattresses had been replaced. Old and stained bed linen had been disposed of and new bed linen was in use.

At this inspection on 23 November 2015, the cleanliness and safe infection control practice of the home had been sustained and further improved. All areas of the home which included communal rooms and people's individual bedrooms were clean and smelled fresh. New disposable sanitising gel pouches were available in toilets and communal areas throughout the home. This minimised the risk of cross infection and is recommended good practice. Old furniture with hard and soft surface damage had been replaced with new, which minimised the risk of cross infection. The laundry had been refurbished and reconfigured to provide a clear flow of laundry through dirty to clean. The laundry room was free from stored items. However, the floor needed treatment to ensure it was impervious to minimise the risk of cross infection. The medicine storage room was clean and hygienic. Sluice rooms and equipment were clean and cleaning equipment was colour coded to minimise the risk of cross infection. Cleaning staff told us that they worked to schedules, the cleaning hours had increased and the cleaning team had expanded from one member of staff to three. People commented to us on how clean and bright the home was.

At our previous comprehensive inspection on 10 and 11 March 2015 there had been inadequate risk assessment of the environment. We had noted a number of risks to people as we toured the building. At our focused inspection on 16 July 2015 we found that the safety of the environment had improved.

At this inspection on 24 November 2015 improvements to the safety of the environment had been sustained and further improvements had been made. Window restrictors had been replaced in the home to ensure that people were protected from the risk of falling from windows. The home was well lit and lighting had been upgraded in the section of the home which specialised in caring for people who were living with dementia. The steps to the outside of the building were defined with high visibility paint to minimise the risk of people falling and injuring themselves. However, this paint was beginning to wear away. New risk assessments for the environment had been drawn up to ensure that risks were identified and addressed.

At our previous comprehensive inspection on 10 and 11 March 2015 staff were not well deployed throughout the home which meant people had been at risk of harm. At our focused inspection on 16 July 2015 we found that improvements had been made to staff deployment, so that staff were available when needed.

At this inspection on 24 November 2015 we found the improvements to staff deployment had been sustained and further improved. The staff rota showed that inexperienced staff were placed on shift with more experienced staff who could support and guide them and which minimised the risk of unsafe care. The manager had recruited staff with a view to balancing the mix of experience and skills, so that they were in a better position to offer safe care across each shift. For example, two new nurses had been employed as permanent staff so that the home did not rely so heavily on agency nursing staff. This improved continuity of care.

Staffing levels were planned in response to people's dependency. Staff told us that the home had one nurse on duty and five care workers each day time shift. This reduced to one nurse and two care workers each night. This was to care for twenty four people and records confirmed these staffing levels were in place. Staff told us there were sufficient staff on duty to give the care people needed safely and without rushing. Observations throughout the day showed that staff were well deployed, staffing was organised to ensure people were safe and that staff had time to give care without rushing.

Good

# Is the service safe?

At our previous comprehensive inspection on 10 and 11 March 2015 there were shortfalls in the way that medicines were handled. At our focused inspection on 16 July 2015 we found that improvements had been made to ensure medicines were handled safely.

At this comprehensive inspection on 24 November 2015 we found that the improvements to medicine handling had been sustained and further improved. Medicines were safely handled. The home had a policy on the safe handling of medicines and nurses, who were the only staff to handle medicines, told us they were aware of this. The home used a Monitored Dosage System (MDS) with medicines supplied by on a 28 day cycle (A MDS is where medicines are pre-packaged for each person). Medicines were stored in a locked medicine trolley within a locked treatment room. This conformed to the manufacturers recommendations for storage. Controlled drugs were stored safely. We observed that prescribed medicines were correctly dispensed by a registered nurse. Photographs were included in the medication chart to aid recognition. Medicine administration records were correctly completed, including the right codes (for example when people refused their medicine). Medicine disposal and clinical waste complied with legal requirements. A fridge was provided to store certain medicines and the fridge temperature was monitored regularly and recorded in a handbook.

Safeguarding training for staff was up to date with a clear timescale in place for when updates were required. When we spoke with staff about this they were able to describe different types of abuse and the correct action they would take to protect people if they observed an incident of abuse or became aware of an allegation. Staff told us they felt the team would recognise unsafe practice and report it to the manager. Staff told us they would expect safeguarding to be dealt with by the local authority or the police, depending on the nature of the concerns. This gave us evidence that staff had the knowledge to protect people appropriately.

Staff told us that people's behaviour which others might find challenging was managed with a positive attitude. One member of staff told us, "We consult with the Community Mental Health team to give us guidance on managing people's behaviour in a positive way." All staff had received induction training in how to deal with behaviour which may challenge and had been trained on a one to one basis on individual people's needs in this area. We observed that staff were skilled in calming situations when people became upset or angry.

Records of care planning reviews confirmed that medicines were suitable and safe for current needs. Staff were knowledgeable about individual's needs around medicines and any associated risks. For example they told us about pain relief medicines and how these were managed to make sure people received effective pain relief whenever needed.

Care plans identified a person's level of risk and plans were detailed and specific to each individual. These were centred on the needs of each person and included consultation with people or their representatives. They considered people's level of independence and what support was needed to ensure independence was promoted. Risk assessments covered how to maximise people's freedom.

Accident and incident records showed that the manager had analysed these and had put action plans in place to address issues as they arose. For example, one person had suffered a number of falls. Staff had recorded where these falls were taking place, to assess whether there were any trends which could point to a preventable cause. External professional advice had been sought to reduce the risk, sensors were in place in key areas of the home and a 'crash mat' was in use close to the person's bed. This ensured that the person was not unduly restricted and had freedom to move about the home, while minimising the risk of falls.

Staff told us that their approach to risk was responsive to people's changing needs and mental capacity. They told us that the home had an open and positive approach towards managing risk. For example, one member of staff told us, "We have supported people to go outside and use the washing line, and to go outside to the flower tubs to carry out gardening." Another member of staff told us, "We assessed the risk associated with supporting a person for a walk to the lake and chose a time when they were calm and relaxed. It went well."

We checked recruitment practices within the home. Staff application forms recorded the applicant's employment history, reasons for employment gaps, the names of two employment referees and any relevant training. We saw that a Disclosure and Barring Service (DBS) check had been

Good

# Is the service safe?

obtained prior to commencing work at the home and that employment references had also been received on all staff files we looked at. A DBS check helps to ensure that people who are known to be unsuitable to work with vulnerable people are not employed.

The home had a policy and procedure on staff discipline and the manager explained how they had used this in the last year to ensure people received safe and appropriate care. The home had a policy and procedure on whistle blowing, which was to support staff to raise a concern. Staff told us that they had confidence to raise concerns through whistle blowing and that they felt confidentiality would be protected.

During our observation we saw staff using a hoist to assist a person move into an arm chair. Staff used the equipment safely and with confidence. This meant that the person being hoisted was calm and relaxed whilst the process was undertaken.

We undertook an observation during a meal time. We saw that staff were careful to ensure people were seated comfortably and that they were supported to move safely from one part of the home to another.

Good

# Is the service effective?

## Our findings

People told us they were regularly asked for their consent to care. We observed that staff routinely asked for people's consent before giving assistance and that they waited for a response. When people declined, staff were respectful and returned to try again later if necessary.

People told us that the staff were quick to contact a GP or other health care professional when required. One person told us, "They often pop in to ask how I am. They have called the GP and got me in touch with a chiropodist when I asked for one." Another person told us, "The food is great, I really enjoy it, there is choice and they would make you something different if you wanted." Another person told us, "I really like how they never take away your own control of your life. Even when I was happy for them to make decisions for me, they encouraged me to think things through for myself."

At our previous comprehensive inspection on 10 and 11 March 2015 we found that staff were not receiving regular supervision or appraisal of their work, which meant the manager could not be sure that people received the care they needed. At our focused inspection on 16 July 2015 we found improvements had been made to staff supervision.

At this comprehensive inspection on 24 November 2015 improvements to staff supervision had been sustained and further improved. Staff told us they were receiving supervision and support in their role. Records confirmed that all staff had received monthly supervision meetings since the last inspection with notes on areas for development and evidence of discussions about support needs. Appraisals had also begun, where staff were encouraged to review their performance over the year and to commit to develop their practice to improve people's quality of care. This meant that staff were receiving the support and guidance they needed to ensure people received effective care.

At our comprehensive inspection on 10 and 11 March 2015 there were a number of shortfalls in the way people clinical care needs were addressed. This meant people were at risk of not having their needs met. At our focused inspection on 16 July 2015 we found improvements had been to ensure people received the clinical care they needed.

At this comprehensive inspection on 24 November 2015 improvements to clinical care had been sustained and further improved. Staff were regularly using the Malnutrition Universal Screening Tool (MUST) to identify and manage people's nutrition and hydration needs. When people could not be weighed, staff had used other methods of estimating weight which meant that changes in weight were appropriately monitored. Body maps were consistently used to monitor skin integrity and a system had been devised to differentiate between differing types of skin damage which reduced the potential for confusion. Turning charts were used, though there were occasional gaps in recording. The service was proactive in referring to the tissue viability nurse, speech and language therapy team (SALT) and accessing the correct pressure relieving mattresses and profiling beds to assist effective pressure care. We spoke with a health care professional who offered support from the local hospice and they told us that the home had contacted them appropriately and had followed their advice. The manager told us that no people had pressure ulcers at the time of this inspection visit and that the three wounds which were being treated were recorded on wound progress documentation.

We spoke to the cook and they told us they had systems to ensure food was prepared as people needed it to be. They showed us that for some people where swallowing was a risk, the home had engaged with SALT to undertake an assessment of people's ability. The cook told us that they knew about people's likes, dislikes or any allergies regarding food and that they knew when foods needed to be fortified, pureed or prepared as a soft diet. They told us that there were usually two choices at meal times, but that people could request something different and they could usually provide this.

Copies of choking risk assessments were on file which gave instructions on how food needed to be prepared. We saw some people needed thickeners in their drinks, whilst other's needed food to be finely chopped or pureed. This information was displayed in records for staff and the kitchen staff to follow. The manager told us that those people who were at risk of malnutrition or dehydration had their intake recorded on a chart. This gave details of the quantity people had eaten or drunk so that their wellbeing in this area could be monitored and acted upon.

We observed the care given over lunchtime. People who needed adaptations to support them to eat independently had these. Those who required support from staff were given this in a well-paced way. The meal looked appetising

and people had chosen different meals and drinks according to their preferences. At other times of day people were regularly offered drinks and snacks and people had drinks of water and juice close to them at all times, both in the communal areas of the home and in their individual rooms.

At our previous comprehensive inspection on 10 and 11 March 2015 the décor of the building did not lend itself to effective dementia care. At our focused inspection on 16 July 2015 we found improvements had been made to better support people living with dementia.

At this comprehensive inspection on 24 November 2015 the improvements had been sustained and further improved. The manager had held a residents meeting about this where people's views had been sought and acted upon. Walls had been painted and damaged chairs were replaced with attractive, comfortable furnishings. The signage around the home had improved with pictorial prompts to guide people towards important rooms such as toilets. People's individual room doors had been repainted in fresh colours and a poster with the person's name and a picture relevant to each individual was on each door. Corridors were well lit to assist people with orientation around the home. In the communal areas of the home pictures and photographs decorated the walls which would promote conversation and reminiscence. One wall had been decorated with a scene of beach huts which were colourful and cheerful.

Outside, a courtyard had been cleared and turned into an attractive outdoor space, with flowers in tubs which staff told us that people tended in the summer months. To the front of the building the lawns had been tidied and a washing line had been erected so that people could assist with hanging washing out to dry.

At our previous comprehensive inspection on 10 and 11 March 2015 there were shortfalls in staff training around the Mental Capacity Act (2005) and DoLS which meant people may not have been protected around this area of their care. At our focused inspection on 16 July 2015 we found improvements had been made to ensure the principles of the MCA were applied.

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).

At this comprehensive inspection on 24 November 2015 improvements had been sustained and further improved. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff told us that they had received training in the MCA and DoLS and could correctly tell us the main principles. The manager told us that a number of staff had received this training and that all staff had received a briefing in the five main principles of the MCA and DoLS. More training was planned in the month following the inspection visit. This meant staff had the information they needed about the MCA to ensure people were cared for according to its principles.

The MCA, DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. The manager had made a number of DoLS applications to the local authority, (The 'Supervisory Body') and at the time of the inspection visit two people had been assessed and the DoLS authorised. Care planning was in place to ensure that the provider was complying with the conditions applied to the authorisations.

People's consent to care and treatment was recorded along with their capacity to make decisions about their care. Where appropriate Do Not Attempt Resuscitation consent forms were correctly completed with the relevant signatures. Information about advocacy services was available to people in the lobby of the home. The support people required to maximise their independence in decision making was recorded, including the support of informal advocates and Independent Mental Capacity Advocates (IMCAs). This ensured people were cared for in line with the principles of the MCA.

We saw that care plans took account of when a best interests decision was needed. They recorded that best interests decisions had to be carried out by a multidisciplinary team in line with the MCA.

Good

# Is the service effective?

We looked at staff induction and training records. Staff told us that they had received induction before they began their mandatory training. During this time they told us they developed a good understanding of each individual's care needs and the philosophy of the home. Staff were knowledgeable about the needs of people they supported and knew how their needs should be met.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone. This was to make sure they understood people's individual needs and how risks were managed.

Staff had received the full range of mandatory training. Updates were planned to ensure staff knowledge was refreshed and in line with best practice. Staff had also received training in areas of care that were specific to the needs of people at the home. For example, fortified foods training, care for people when they were reaching the end of their lives, dementia care and managing falls. Training was planned in such areas as care for people with Parkinson's disease, and appropriate activities for people who were living with dementia. This meant staff were trained to offer people the care they needed.

Good

# Is the service caring?

## Our findings

People told us that all the staff and the manager were kind to them and that staff gave them time and listened to them. For example one person told us, "The staff are kind, they are always checking on me." Another person told us, "The staff are really lovely." Another person said, "They are so thoughtful. They take the time to talk things through."

We spent some time with people in communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff and there was kindness between them as they chatted. We saw that staff encouraged people to express their views and listened with interest and patience to their responses. Staff gave the impression that they had time and spoke with people who were sitting so that they were on eye level with them.

The way staff spoke with people demonstrated how well they understood individual needs and abilities. All were respectful in their interactions with residents and any visitors. Staff took time and care when they carried out care tasks and activities. Staff explained what they were doing and why and ensured that each person was comfortable when assisting them. We observed that staff visited people who spent most of their time in their bedrooms to ensure that they were comfortable, to offer drinks or snacks or carry out personal care activities.

Staff we spoke with told us that they enjoyed working at Woodlands Nursing Home and spoke with respect and affection for the people they were supporting. We observed staff who were assisting people with their meals. They were focused upon the person, sat by their side and paced their assistance so that people were relaxed about the eating experience. We observed staff supporting a person whose sight and hearing was severely impaired to enjoy a clothes party. Staff interacted with them in a kind and encouraging way and the person was clearly enjoying feeling the texture of clothes and jewellery. One member of staff told us. "We have time to chat with people. It is much more relaxed than it was." One member of staff told us, "We treat people like we would treat out own family." Another member of staff told us, "We take an interest in people's lives."

Staff who were giving personal care in people's private rooms placed a 'dignity daisy' on the outside of the door. This was a laminated card which showed other people and staff that they should not enter, so that people's dignity could be promoted.

The home had a dignity charter, and the manager had implemented a 'dignity slip', where staff were periodically encouraged to write down and reflect on times when they had respected and promoted a person's dignity. Staff told us this focused their attention and helped them to think about care from the persons' point of view. The manager had also begun to draw up a set of ten golden rules for each person who lived at the home, which gave staff instructions for each individual about how to place dignity at the front of their thinking when giving care. We saw a completed set of ten golden rules which highlighted the main ways that the person experienced respect and regard to their dignity in their care. Staff told us that these initiatives had been discussed with them in meetings and that they supported them to give thoughtful and respectful care.

The staff and people we spoke with told us that the home encouraged visitors and we observed that a number of visitors were greeted by staff in a friendly way. Visitors told us that the staff always offered them refreshment and that they were made to feel welcome.

A health care professional told us, "The staff really are kind. They understand people's care and it shows in the good communication they have with people."

The manager told us that they regarded the recruitment process to be very important in assessing potential staff for kindness and compassion. They told us that those who did not appear to have a good sense of empathy were not employed.

At our previous comprehensive inspection on 10 and 11 March 2015 we noted that those people who would benefit from pain relief administered by syringe driver did not have this option open to them, as the nurses did not all have syringe driver training. At our focused inspection on 16 July 2015 we found improvements to this had been made. At this comprehensive inspection on 24 November 2015 these improvements had been sustained. Nurses were now trained to administer pain relief by syringe drive and so this option of pain relief was available for people who needed this.

Good

# Is the service responsive?

## Our findings

People told us that the staff knew them well and responded to their needs. One person told us, "If I had anything to complain about then I would talk about any problem with the manager." Another person said, "They have been wonderful, It is a haven for me here. As I have got better they have adjusted the support they give."

At our previous comprehensive inspection on 10 and 11 March 2015 we found that care plans were not personalised sufficiently to give staff the information they needed to give care that was centred on each individual. At our focused inspection on 16 July 2015 we found improvements to care planning practices had been made.

At this comprehensive inspection on 24 November 2015 the improvements had been sustained and further improved. Each person's care plan contained details of clinical, social, cultural and recreational needs and were based on a holistic assessment of each person's care needs. Information about people's personal histories, their likes, dislikes, important relationships and interests had been compiled and used to produce personalised care plans.

Care plans identified people's goals which were identified in consultation with them. We spoke with a person who told us they had discussed their future care options with the manager and was impressed by how supportive and understanding they were. They told us that they had supported them to explore options and to tackle a range of advice to make an informed decision.

One care plan included details of a person's interest in football, another person's interest in pets and singing, another in gardening, with guidance on how to engage people in conversation about these topics. Personal preferences were recorded, for example, one care plan recorded the person's love of farms and farming. Another stated "enjoys talking about football." Family and friends were named, with significant dates recorded.

People were provided with individual objects of interest and comfort to them when this was appropriate. This included a variety of soft toys and dolls, magazines, jewellery and accessories such as hats and scarves. We observed that people were enjoying having these objects nearby and that they provided a point of conversation with staff and promoted interaction.

The manager had conducted residents meetings where food choices, outings and activities were discussed among other things and people had been consulted for their views.

Staff had responded to a survey of their views. One had written, "the activities that have been introduced are encouraging." Staff told us that they had more time to engage with people in one to one activities, such as supporting people on walks out to the lake, baking, doing jigsaws, playing skittles, singing, dancing, reading newspapers, books and magazines, quizzes and carrying out individual interests such as painting and drawing. The home engaged a number of external entertainments. For example they had a regular visit from a person who engaged people in motivational exercise, music and other stimulating activities.

On the day of inspection the home was hosting a clothes party which people enjoyed. The manager told us that the home had formed a staff and resident choir and that they were practising for the carol concert. The manager told us that they were aware that there was more work to be done to address the specific needs of people who were living with dementia. However, staff were able to talk about people's preferences, who was significant in people's lives and what their interests were. We observed staff reminiscing with people about their lives and talking about life histories and families with them.

At our previous comprehensive inspection on 10 and 11 March 2015 we found that people were at risk of being isolated in their rooms as staff did not have time to visit them to engage in social interaction. At this comprehensive inspection on 24 November 2015 we observed that staff had time to visit people in their rooms and to chat with them. One person who spent most of their time in their room told us that staff often popped in and had time to talk with them. This meant that people were at less risk of social isolation.

Staff told us about the resident of the day initiative. This focused on one person each day of the month, who would have their care reviewed with their involvement, their room deep cleaned, a particular focus on their choice for food and drink and any activity they may wish to pursue, for example a trip out to a cafe. They told us that this did not always take place every day but it did happen regularly.

Good

# Is the service responsive?

This was a good way of making sure people had a regular review of their needs and it was an important time to feel special and cared for. This meant that the service was responsive to individual needs.

Staff regularly recorded information about people's wellbeing and any concerns in daily written records. This meant staff had information to help them to offer care which was responsive to people's needs. Staff could tell us about people's care needs and how these had changed. Records confirmed what they told us. Some people gave us a clear account of the care they had agreed to. Others told us they knew about their care plans but did not know what was written in them. Some people had signed care plans and we saw that written plans were regularly reviewed. This showed that people were consulted about their care.

People told us they would feel confident telling the staff if they had any concerns and felt that these would be taken seriously. The service had a complaints procedure and the registered manager told us they followed this to ensure people's complaints were appropriately dealt with. We saw two records of complaints which had been responded to appropriately and within the timescale set out in the policy and procedure. We spoke with a person who had raised a complaint, and they told us that it had been quickly and kindly addressed and that they were now very happy with the care.

The manager held resident meetings and also encouraged people to give their views individually. When a number of new admissions took place at once, the manager arranged to meet with the residents and those who they cared about most to gain their views about the care and to answer any questions they may have.

Requires improvement

# Is the service well-led?

## Our findings

People were very complimentary about the way the home was managed and about the manager. One person said, "They work alongside the staff and know everything that is going on." Another person said, "The manager is lovely, they come and have a talk with you." Another person said, "They have made this into a place of comfort and peace for me. They are just wonderful." A social care professional said, "They have definitely taken the wheel and are sailing the ship in the right direction."

At our previous comprehensive inspection on 10 and 11 March 2015 the systems for assessing and monitoring the quality of service were not adequate and there was little evidence of people's involvement in developing the service. At our focused inspection on 16 July 2015 we found improvements had been made.

At this comprehensive inspection on 24 November 2015 the improvements had been sustained and further improved. There was no registered manager for the home. However, there was a manager, who had taken up their role on 16 March 2015. They had submitted an application to CQC to become the registered manager. The manager told us that their role was time consuming as there was a vacancy for a deputy manager. This meant that a large number of tasks which could otherwise have been shared with other senior staff fell to the manager to complete. The provider had plans to employ a deputy and provide more supernumerary nursing time on rota, which would provide eighteen hours a week when a nurse would be available to carry out care planning, ensure charts and other clinical monitoring records were kept up to date, and take over some of the responsibility for supervision and appraisal of staff. The manager was carrying out all supervisions and appraisals, all audits and completing all care planning records and reviews. They did this while also sometimes needing to work a shift as a nurse on rota. This meant that they were working long hours to improve the quality of care in the home. While the overall quality of leadership in the home had improved since March 2015 and again since July 2015 there was a risk that this may not be sustained due to the number of tasks which were the responsibility of the manager alone.

The manager carried out a range of audits on areas of quality and safety within the home which were recorded. We saw audits for such areas as care planning records, medicine handling, wound management record keeping, falls, infection control, activities and treating people with dignity. The results of audits were analysed for trends and to discover action points. Plans to improve practice were drawn up using the results of audits and shared with staff during meetings and supervision sessions.

The manager was visible about the home and people told us that they were approachable and helpful when consulted. Staff reported that lines of communication to and from the manager were good and that the new 'ten at ten' initiative was a goal they were working towards, though sometimes this did not happen when they were busy. This was a commitment to taking ten minutes at ten o'clock each morning to speak with all staff for a quick update and to share concerns and comments. Staff told us that the manager was always available for advice and support at any time they were free. We observed that staff approached the manager throughout the day of inspection in this way.

Records of recent staff surveys showed that staff felt they were involved in decisions and informed about developments in the home. One member of staff had written, "The home is in the best state it has been for a number of years." Another member of staff had written, "It has now become a very enjoyable place to work." Staff told us that staff morale had improved and that staff had attended meetings where their views were listened to and acted on. Records of staff meetings confirmed that staff views were recorded with plans in place for these to be acted upon.

Records of recent friends and relatives surveys showed that they felt the home had improved under new management. One person had written, "Pleased with the new manager." We spoke with some relatives of a person who lived at the service. One relative told us that the manager had been, "Fantastic about sorting things out and really cared about how the move into the home affected the whole family". They told us the manager had gone out of their way to support them emotionally and offer practical advice which had been very helpful. A visitor told us that the manager had been open and honest about some of the challenges that had faced the service recently and that they were happy that the home was in 'good hands'. A meeting for relatives and friends had been planned in the summer but

Requires improvement

# Is the service well-led?

no relatives had attended. The manager told us that they had arranged another meeting, and that a small number of relatives had attended who had been consulted for their views.

The manager consulted with people on a one to one basis regularly and during reviews, and recorded any areas where people felt improvements could be made. These were discussed in staff meetings so that the overall quality of care could be improved.

The manager and staff spoke about looking for ways to improve the quality of life for the people who lived at the home. For example, they spoke about developing the range of activities on offer to reflect people's interests and the needs of some people who were living with dementia. Staff told us they felt valued and that their opinions were respected. The manager told us that staff had taken on board the need for change and spoke about the staff team with respect and pride.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the home to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support.

The manager told us how they updated their knowledge and practice with information from organisations recognised for advising on best practice. This had contributed to the personalised approach to care planning, however, work towards this goal was in the early stages.

Notifications had been sent to the Care Quality Commission by the service as required.

**We recommend that the registered provider consults best practice guidance on developing a supportive management team for the service.**