Mr & Mrs B Clarke and Mrs C Mills

Threeways Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 11, 12 and 14 June 2018 and was unannounced.

We carried out an inspection at Threeways Nursing Home on 11 and 13 August 2015 where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not met the regulations in relation to safeguarding people from abuse and improper treatment and, had not ensured complete and accurate contemporaneous records in respect of people needs were in place.

At the last inspection on 13 and 14 December 2016 we found the provider had taken action and had met the regulations in relation to safeguarding people from abuse and improper treatment. However, they had not addressed the breach in relation to ensuring complete and accurate contemporaneous records in respect of people were available.We also found a new breach of regulation. The provider had not ensured safe care and treatment for people. We took enforcement action for these breaches.

We found a third breach in that the provider had not ensured that staff had the information required to meet people's individual needs and we asked the provider to send us an action plan to inform us how they would meet the regulations. The provider sent us an action plan to advise they had met the regulation.

We undertook this unannounced comprehensive inspection to look at all aspects of the service and confirm that the service now met legal requirements. We found improvements had been made and the provider had met the legal requirements. Although, we identified some areas that needed time to be embedded into day to day practice the overall rating had improved to Good.

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

The home is registered to provide nursing and personal care and accommodation for up to 45 older people and people with disabilities. At the time of the inspection there were 41 people living there. Some people required continual nursing care due to complex health care needs; including end of life care. Other people needed support with personal care and assistance to move around the home safely due to frailty or medical conditions, such as diabetes, stroke and Parkinson's and, some people were living with dementia.

The registered manager was present during the inspection. 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 quality assurance system had been reviewed and areas for change had been identified and prioritised

to drive improvement. The care planning process had been changed and a new care plan format had been introduced. Nurses were responsible for reviewing the care plans and daily records and, although some of these were up to date with clear guidance for staff we also found information that was not clear or had not been updated. Staff were aware records were not consistently up to date and the changes in the care planning process would take time to be embedded into day to day practice.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Staff were not fully aware of what these changes meant.

We recommend that the provider seek advice and guidance from a reputable source, about Accessible Information Standards (AIS) to ensure staff are aware of their responsibilities.

Staff were supported to develop their knowledge and professional practice through regular supervision and yearly appraisals. Relevant training had been provided, including safeguarding, fire training and medicines, Staff knew how to protect people from harm and what action they would take if they had any concerns.

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The management and staff had attended training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware of current guidance to ensure people were protected. DoLS applications had been when requested to ensure people were safe and the registered manager was waiting for a response from local authority.

Risk had been assessed and people were support to the independent in a safe way, with appropriate walking aids and assistance from staff to support people to move around the home. Staff were aware of their roles and responsibilities and followed the provider's infection control policies to protect people, visitors and staff. The home was well maintained with regular environmental checks and emergency procedures were in place to support people if they had to leave the building.

People were encouraged to make decisions about the care provided. Staff had a good understanding of people's needs and enabled them to be independent and make choices. There was a choice of food and drinks throughout the day and people were supported to eat a nutritious diet and drink enough fluids. Staff monitored people's health and ensured people could access healthcare professionals and services, to maintain their health and well-being.

A range of group and one to one activities had been developed with the involvement of people living in the home and, feedback was consistently sought from people and relatives about the services provided. Through monthly meetings and day to day conversations.

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.

Risks had been assessed to protect people whilst enabling them to be independent.

The management of medicines was safe and people received their prescribed medicines when they needed them.

Staff understood the safeguarding procedures to protect people from the risk of abuse and how to make a referral if they had any concerns.

There were sufficient staff employed to provide the support and care people needed. Robust recruitment procedures ensured only suitable staff worked at the home.

The home was well maintained with effective policies to keep people safe from the risk of infection.

Is the service effective?

Good

The service was effective.

Staff had received relevant training and provided appropriate support to meet people's needs.

Staff had completed training for Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had a clear understanding of current guidelines and their responsibilities.

People were supported to have a healthy diet, choices were provided and staff assisted people as required.

Staff ensured people could access to healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

People were supported to be actively involved in decisions about

their care and make choices about all aspects of their day to day lives.

Staff knew people very well and communication between people, visitors and staff was friendly and relaxed. People were treated with respect and support was provided in a kind and caring way.

People were encouraged to maintain relationships with relatives and friends and visitors were made to feel very welcome.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into the home and they received support that was personalised in line with their wishes and preferences.

People decided how and where they spent their time and range of group and one to one activities were provided for people to participate in if they wished.

People and visitors knew how to make a complaint or raise concern.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance and monitoring systems were used to identify areas to drive improvement. However, there were areas where further improvement was needed to ensure changes were part of day to day practice.

Staff were aware of their roles and responsibilities and felt all of the staff worked well together as a team.

Feedback about the service provided was consistently sought from people, relatives and staff.

Threeways Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on the 11, 12 and 14 June 2018 and was unannounced. The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service, including safeguarding's and notifications which had been sent to us. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 15 people living in the home and seven visitors. We spoke with 14 staff including the provider, registered manager, deputy manager, nurses, care staff, housekeeping and maintenance staff and the cook.

We observed the care and support provided and interaction between people, visitors and staff throughout the inspection. We looked around the home and observed medicines being given out.

We looked at a range of documents related to the care provided and the management of the home. These included four care plans, medicine records, four staff files, accident/incidents, complaints and quality assurance audits.

We asked the registered manager to send us copies of records after the inspection including policies and procedures for equality and diversity, safeguarding and infection control. These were sent to us as requested.

Good

Is the service safe?

Our findings

We have inspected this key question to follow up the concerns found during our inspection in December 2017. At that inspection we found a breach of the legal requirements. This was because the provider had not ensured safe care and treatment for people. For example, risk assessments had not been updated when people's needs changed and the management of medicines was not consistently safe.

At this inspection we found improvements had been made, they now met the previous legal breach and the rating had improved to Good.

At the inspection in December 2017 people's needs had been assessed and areas of risk identified, with guidance in the care plans for staff to refer to and reduce the risk as much as possible. For example, for the risk of pressure damage and falls. However, the risk assessments had not been reviewed when people's needs changed; which meant there was no up to date guidance for staff to follow and people were at risk of harm or injury.

Following the last inspection the care planning process had been reviewed and a new care plan format introduced. The care plans included clear information about risk, with guidance for staff to follow to reduce the risk, whilst encouraging people to be independent and make choices. These included skin integrity and risk of pressure damage; people's mobility and risk of falls and dietary needs; including risk of choking and swallowing difficulties.

People said they felt very comfortable at Threeways Nursing Home. One person told us, "I like being here yes, it is safe and very good." Another person said, "They are absolutely wonderful, anything you want you get it straight away, I only have praise for them." Relatives were equally positive and were confident their family members were in a safe and caring environment. One relative told us, "I do feel Mum is safe here, they always ring to tell me if something is not right with her, it's like they are planning ahead to avoid any problems arising." People, relatives, visitors and staff said there were enough staff working in the home to provide the care and support people wanted and needed.

The registered manager and nurses said they had reviewed their practice with regard to skin integrity and pressure damage. The National Institute for Health and Care Excellence (NICE) Guidelines (2014) were available for staff to refer to and were included as part of the training for wound care/pressure area care. Staff spoke knowledgeably about they systems that were in place to reduce the risk of pressure damage. One member of staff said, "We have no residents with pressure sores at the moment and we do a number of things to try and prevent them, like helping people who are in bed to change their position. They have pressure relieving mattresses and cushions as well, which we check daily." Records showed changes in people's position were recorded and the mattress and cushion settings were appropriate for each person's weight. People said staff reminded them to move around if they remained in their room and, "Always check that we are comfortable and safe."

Staff demonstrated a good understanding of risk to people with regard to moving around the home safely

and, how they supported people to be as independent as possible. For example, using walking aids, such as walking sticks and zimmers. One person told us, "I need a bit of help to get around I use the walker and staff always ask if I can manage, sometimes I use the wheelchair." A member of staff said, "We assess residents every time they are getting up, sometimes they can use the zimmer and other times we help with a wheelchair, depends how they are feeling and changes day by day." Another member of staff told us, "Each resident has been assessed and depending on their needs we assist them to mobilize as much as possible. Although assessments also show if people are unable to stand on their own, then we use the stand aid or hoists so that they can still join in activities, use the dining room or go in the garden, if they can't walk." And "We have had the falls team in to check we are doing everything we can and not restricting residents." One person said, "They use the hoist, doesn't worry me, I have got used to it." Another person told us, "They care about my welfare, they make sure you don't injure yourself." A relative said they were confident their family member was is in a safe and caring environment. The staff were trained to use the hoist to assist with mobility and, they provided assistance with a wheelchair when they went out of the home.

At the inspection in December 2017 we found improvements were needed with regard to the application of medicine patches and topical creams to people's skin. Staff explained the management of medicines had been reviewed; a 'Champion' had been appointed to take responsibility for ordering and checking that medicines were available and records evidenced they had been given, or applied as prescribed, safely. A body map sheet had been added to the medicine administration record (MAR) for staff to record where each medicine patch had been applied; with a date and signature to show that the sites were regularly changed to prevent the risk of tissues damage. Care plans included information about prescribed topical skin creams. A body map was used to show which creams were to be used, where they should be applied and how much. This information had been added to each person's profile and kept in the folders in their rooms, for staff to refer to and sign, after the cream had been applied. Staff explained which creams were used to prevent a rash or soreness caused by incontinence and, which were applied when a person's skin was dry. One member of staff told us, "There are a range of creams used for residents, depending on their specific needs and these are all recorded in their folders. I think it works really well, all the day to day information is in their rooms, the residents know it is there and have agreed to it." Another member of staff told us, "The nurse checks the folders each day to ensure we have filled them in. We are allocated to support a group of residents so they know which of us is responsible for each folder and they remind us, but I think we have got used to it now and there are rarely any gaps." The nurses agreed that the records had usually been completed. Gaps were generally due to staff being called away to assist another person and staff were reminded before they went off duty to complete and sign the records. The registered manager said if there were ongoing errors, like gaps, it would be discussed as part of the supervision process and extra training would be provided.

There were safe systems in place for the management of medicines. The medicine Champion was not available during the inspection, but staff explained the system used with regard to the ordering, receiving, checking, storing, disposal of and giving out medicines. One member of staff said, "We all know the process used, as we have to cover when staff are on holiday." Medicines were ordered monthly and checked in the week before they were needed to ensure they had received the correct ones. They were stored securely in the lockable medicine trollies and cupboards, in the clinical rooms on the ground and first floor. Fridges were available to use if needed and daily temperatures were taken to ensure the medicines stored were safe to use. Nurses were responsible for giving out medicines. They had all attended training and they had been assessed to ensure they were competent, before they were able to give out medicines.

The medicine administration record (MAR) contained photographs of people for identification purposes, their GP and contact details as well as any allergies they had. The MAR had been completed correctly. Staff said they checked the MAR when they gave out medicines to ensure there were no errors and this was also

done weekly as part of the providers audit system. Staff said if there were any errors they could identify who had made them by referring to the list of signatures at the front of the MAR folder. An incident form would be completed and if there were repeated errors the nurse would have to repeat the training, be assessed and would not be able to give out medicines until they could demonstrate their competence.

Risk assessments had been carried out to identify how much support people needed with their medicines. One person kept their medicines in their room. They had moved into the home for a period of respite following surgery and following an assessment chose to be responsible for their own medicines. Other people were given their medicines by staff. As required medicines (PRN) were available when people needed. For example, for pain relief. There was clear guidance for staff to follow in terms of what the medicines were for; the amount to be given and how often. Staff signed the form to state when they had been given and they observed and asked people if they felt better to ensure they had been effective. One member of staff said, "We check the PRN meds and if we have given them regularly over a couple of days we ask the GP to review them. May need to change them or give them regularly rather than PRN." Staff asked people if they were comfortable, in addition to the prescribed times for medicines and people said they were given their medicines when they needed them. The deputy manager told us all medicines had been recently reviewed by the community pharmacist and GPs, with the involvement of people and their relatives if appropriate. "To ensure the medicines were appropriate for each person. They advised a number of changes to our practice, which we have made and overall there has been a reduction in the amount of medicines prescribed for people."

At the last inspection there were concerns about the time it took for staff to respond to people when they used the call bells to request assistance. There was an effective system in place to check how long staff took to respond to the bells and these were checked regularly as part of the providers audit system. The registered manager said the response time was usually within two to three minutes and they found where this was above six or ten minutes it was because staff were supporting people whose needs had changed or there had been an emergency. The records for call bell response times showed they had improved, although staff were reminded regularly to be mindful of answering them. People told us staff responded promptly when they used the call bell. One person said, "The staff do come quickly" and, they showed us how they call bell worked. Another person felt there were more than enough staff and the call bell was responded to promptly, "Even during the night," if they were restless.

There were sufficient staff to ensure people received the support they wanted and needed. A dependency tool was used to assess each person's needs over a 24 hour period and staffing levels were calculated to provide appropriate care and support. Although staff said this was flexible so that if people's needs changed additional staffing would be provided. One member of staff said, "Sometimes we have to change things, if a resident wants to join in an activity or has an appointment, but we let people know what we are doing." A person told us, "I do feel there is adequate amount of staff, they often sit down and have a chat, I think they find me interesting."

Recruitment procedures were in place to ensure that only suitable staff worked at Threeways Nursing Home. Relevant checks on prospective staff's suitability had been completed; including completed application forms, two references, interview records, evidence of their residence in the UK and a Disclosure and Barring Service (DBS) check. The DBS check identifies if prospective staff had a criminal record or were barred from working with children or vulnerable adults.

People were protected from the risk of abuse because staff had attended training in safeguarding people and knew what steps to take if they thought someone was at risk of harm or abuse. Staff said they talked about the types of abuse, including neglect, as part of the training as well as the whistleblowing policy. The

contact details for the safeguarding team had been placed on the staff notice board and were easily accessible. One member of staff told us, "I wouldn't hesitate to tell the nurse or manager if I had any concerns and I am sure they would be dealt with. But if they weren't I would contact the team myself or you (CQC)."

The home was clean and well maintained. People said staff cleaned their rooms and the communal areas daily and they had no concerns. A relative told us they had never had cause for concern over cleanliness in the home and their family member's room, "Was immaculate." Staff had attended infection control training and 'Champions' had been appointed to ensure systems were in place to protect people, visitors and staff. Protective personal equipment (PPE), such as gloves and aprons were available and we saw staff used these when needed. Hand washing and hand sanitising facilities were available throughout the home and staff used these. Laundry facilities had equipment that was suitable to cleaned soiled washing and keep people safe.

Environmental risk assessments and checks ensured the home was safe for people, visitors and staff. Records showed that checks had been completed for electrical equipment, water temperatures, the call bell system and emergency lighting. A gas safety record and electrical certificates were in place and checks had been completed on the lifts and hoists. Personal emergency evacuation plans (PEEPs) were available for each person; with details of the assistance people needed to leave the building. Fire alarm testing was carried out weekly and fire training was provided regularly for staff.

Good

Is the service effective?

Our findings

At the inspection in December 2017 we found the service was not consistently effective because staff had not always demonstrated their knowledge of mental capacity or an understanding of how to support people to maintain good health. At this inspection we found the service was effective. Staff had a clear understanding of mental capacity and how to meet people's needs and, the rating had improved to Good.

At the December 2017 inspection, staff had attended training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and demonstrated an understanding of capacity and enabling people to make choices and take risks. However, there were examples that people's right to take risks had not been properly assessed and mental capacity assessments had not been reviewed when people's needs had changed.

At this inspection staff demonstrated that they understood people's individual needs and consistently asked people for their consent before they offered assistance. People said the staff were well trained; they understood their needs and offered support without taking away their independence. One person told us, "They treat us how we treat them, there is no bossing about." Relatives were very positive and said, "She has her freedom but does need quite a lot of help but they don't seem to mind" and, "The staff are wonderful, they give the right balance between caring and independence, they encourage Mum to be independent but don't patronise her."

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 people 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. We checked whether the provider was working within the principles of the MCA. Best interest meetings had been arranged with health and social care professionals, to discuss people's specific needs and how these could be met when concerns had been identified.

Staff understood the importance of ensuring people made decisions and they were very clear that people made choices about all aspects of their day to day care. One person told us, "Everything they do here is in my best interests, and they always seek my permission to do anything." Staff said everyone living in the home could make some decisions, such as when to get up, what to eat and where they wanted to spend their time. They also discussed the specific care and support provided for people whose capacity was changeable and for people living with dementia or confusion. One member of staff said, "They are a bit forgetful and can try and use their bathroom without letting us know. They have the call bell, it is always nearby but they may forget to use it, so we pop by their room regularly to make sure they are ok. We don't want to stop them getting up and they certainly want to be independent, but they are at risk of falling." A relative told us, "It's their natural manner with people, gentle and kind, people with dementia can be challenging but they do not get irritated by this, they remain calm and kind." A member of staff said, "We

involve relatives when residents may not be able to make some decisions, we have arranged best interest meetings and discussed with the resident, relatives and GP or assessor, how we can enable people to make decisions and continue to be independent in a safe way." A relative told us their family members needs were met and, "They never want for anything."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Staff understood when an application should be made and the process or doing this. The registered manager said DoLS applications had been sent to the local authority as they were needed, in particular for the locked front door and the use of bed barriers. Information was recorded in the person's care plan if an application had been made and there was guidance in place for staff to follow for the use of bed barriers.

Appropriate training had been provided and staff were aware of their responsibilities. A member of staff said, "I think the training has been very good we have much more with the new manager. Another member of staff told us, "Staff know all the residents and their needs, so we all pick up on things if they are not quite right." A third member of staff said, "We have really good training now and we are supported by the nurses and management to have the right skills to look after the residents and their relatives; they are an important part of the care team as well." Staff had completed training in moving and handling, safeguarding, infection control, food hygiene, record keeping, continence management and equality and diversity. Specific training was also provided to meet people's individual needs, such as assisting residents with stroke, diabetes, Parkinson's and dementia awareness. Nurses attended additional training. For example, catheter care, medication training, including syringe driver training and wound care. A visitor said, "Staff appear to be well trained and caring."

New staff completed induction training and worked through the Care Certificate during their probation period, usually 12 weeks. The Care Certificate is a set of standards that social care and health workers demonstrate in their daily working life. The induction training meant new staff worked supernumery for at least two weeks if they had no previous experience of working in the care sector. They completed the fundamental training, such as moving and handling and safeguarding, in the first few days and worked with more experienced staff to understand their roles and responsibilities with regard to providing appropriate support and care. A new member of staff said they had worked different shifts with experienced staff and felt continually supported to develop the skills they needed to understand people's needs and to recognise when these changed. Their competency had been assessed throughout the first few weeks by the training manager and only when she felt confident and the training manager had assessed her as competent was she able to support people on a one to one basis. For example, assisting people with their meals. Staff said they had regular feedback from the nurses and management about their work, "Which makes us think about what we are doing and is very good. Keeps us on our toes. Excellent."

Regular supervision was provided to ensure staff were aware of their roles and responsibilities; that training had been effective and staff were supported to have the knowledge and skills to provide appropriate care and support. The registered manager said a programme of yearly appraisals had been planned and would commence in the next few months. Staff said the supervision was good, "We have a chance to talk about our work and if it is good enough, although I think if there were any problem we would know about that straight away. Also if we need any help and if there is any training we would like to do." Staff were supported to complete vocational qualifications and staff we spoke with had completed Level 2 and 3 in care.

People were supported to have enough to eat and drink. People said the food was very good; they were

offered choices and could really have what they wanted. Their comments included, "It is pretty good food." "I am fitter and stronger than I was when I came here and that's down to good food." "You can have any food to your liking, it's very good food here." "The food is excellent, breakfast is my favourite and they all know I like the eggs and bacon" and, one person was at risk of choking and told us, "I have food mashed up." Relatives also said they food was good. They said, "She has a good choice of food and enjoys the food, she feels the home has a nice feel to it and the residents are all lovely." "Food is very good here, they have a good range of home cooked meals, cakes in the afternoon, it's good" and, "There is a good choice of food, she enjoys her meals, especially breakfast told me the food is good quality, a nutritious choice of meals and a decent portion size."

Mealtimes were relaxed and comfortable, people chatted with each other and staff in the dining room and the lounge, while others preferred to have meals in their rooms. One person said, "I am not restricted but I do prefer to stay in here (their room)." The dining table and trays were laid out with napkins and condiments, a range of cold drinks were offered and people said mealtimes were always very good. People told us they discussed the food provided during their residents meetings and if they had any suggestions they were picked up and changes were made. For example, one person had suggested that fruit should be an option in the afternoon when they had tea, as well as the homemade cake, and this had been agreed and fresh fruit was offered.

The cook said people could have what they wanted and had good knowledge of people's likes and dislikes. There were two main choices and people had requested other meals. Staff asked people each morning what they wanted for lunch and evening meal for that day and said if people changed their minds they offered other meals. We observed people telling staff they did not want the meal they had chosen earlier for lunch; staff suggested alternatives and their chosen meal was made. People's specific dietary needs were met, including diabetic diet and, soft and pureed meals were provided for people who had swallowing difficulties or were at risk of choking. Records were kept of people's diet, including the amount they ate and drank throughout the day, snacks and hot drinks were available at any time and people were supported to eat a nutritious diet. People were weighed regularly and advice was sought from GPs and dieticians if there were any concerns with weight loss or gain.

People were supported to be as healthy as possible. One person said the GP visited her at the home and he got on very well with the nurses. A relative told us that their family member was very poorly when they moved into Threeways Nursing Home and, "Is looking so well now, has really come through the other side." GPs visited the home when needed and requests were made for referrals to healthcare professionals, such as the tissue viability nurse if required. Visits were recorded in people's care plans, which were updated if there were any changes to meeting people's needs. Appointments were also arranged with chiropodists, usually six weekly and with optician and dentists as required. Advice had been sought from the speech and language team (SaLT) for people who had difficulties with swallowing and there was clear guidance for people to reduce the risk of choking, with soft or pureed meals and the use of thickener in drinks. Staff supported people to follow this guidance but were aware that people may refuse to do this. One member of staff said, "We know residents should follow the guidance from SaLT, but we have to respect their choices as well. A resident will not have a soft diet, the GP knows about this and the SaLT team have been informed and we support the person to make the best decisions about their meals as much as possible."

People's individual needs had been met by adaptations to the home. Equipment was provided to ensure they were as independent as possible and lifts enabled people to access all parts of the home. Walking aids were available for people to use if appropriate and we saw staff supported people to move around the home with zimmers and wheelchairs. Baths had been adapted to enable people to use them safely and showers had been maintained so that people could choose which facility to use. Gardens were well maintained and

people using walking aids and wheelchairs could access them.

Good

Is the service caring?

Our findings

At the inspection in December 2017 we found the service was not consistently caring because care was not centred on the individual and people were not well supported to express their views or make decisions about their care. At this inspection we found the service was caring; support was based on people's preferences and the rating had improved to Good.

Staff were kind and caring. People told us staff provided the support they needed. "It's like a family, everyone looks out for everyone else." "The staff are wonderful, they are so sympathetic" and, "I am very happy here, it's home." Relatives told us people were very well looked after. One relative said, "It is nice for me to go to sleep at night knowing she is safe, she was not safe living at home we both needed this." Staff told us they enjoyed working at the home and felt they involved people and their relatives in decisions about the care provided. One member of staff said, "If I make someone's day happier I feel content and have a good day."

Staff knew people very well and involved them in all aspects of planning the care provided. One person said they had a care plan and if there were any changes she was involved, "In all decisions and decide them with my family and the manager together." There was evidence in the care plans that people, or their relatives if appropriate, had discussed their needs and had agreed to their care plan. Staff said, and we observed, that they always talked to people about how they were, what they want to do and if they need assistance. One member of staff told us, "It is exactly what we are here for, to support the residents."

People said they were treated with respect and staff ensured their privacy was protected. Their comments included, "Absolute dignity, they are always very good and never make me feel ashamed or embarrassed." "They close the curtains and cover me when washing and dressing," to protect my dignity and, "The staff are well disposed, caring and soothing." A relative told us their family member was, "Treated very respectfully, needing a lot of help with everyday things, but they do this with respect and protect her dignity." People were asked if they had a preference for female or male carers. This was recorded in their care plans and we saw that those we looked at had stated they did not have a preference and signed the care plan to show they agreed with the statements.

Staff knocked on people's doors and asked if they could enter before they walked in. People told us staff never just walked into their room. One person said, "I have my door closed and staff knock, open if a little and ask if they can come in if they don't hear me, very polite." Another person told us, "I sit here near the window and can see when staff are around and they can see me, but they still knock, say hello and ask to come in." A visitor said, "That is very good, because this is their home and I wouldn't like people just walking into mine uninvited, even if I knew who they were."

People and relatives said they general atmosphere was pleasant and comfortable. Communication between people, relatives, visitors and staff was relaxed and friendly, with staff using people's preferred name, including their title if that is what they had requested. One member of staff said, "It is up to them and we respect their choices." Another member of staff said, "We are keyworker for residents as well so we get to

know the families and friends. We would contact them if a resident needed anything, like toiletries. We also check on resident's nails and hair and see if they have any appointments due. It is nice to sit and talk to residents in addition to when we are supporting them at other times."

Staff respected people's equality and diversity and offered support based on their individual preferences. They spoke knowledgeably about people's lives before they moved into Threeways Nursing Home, their relatives, friends, interests and hobbies. This had been recorded in each person's life story in their care plan and was reflected in 'My life in pictures' on their bedroom walls. This included information about their choices and preferences and had been agreed by each person or their relatives. For example, a picture of a person's football team and other areas of interest, such as animals and walking.

People were supported to maintain their personal relationships and relatives and friends said they were welcome to visit at any time. Their comments included, The staff are lovely, it's like we are part of their family, they are so welcoming" and, "We visit weekly at least and bring the dog to say hello, it is very good here." People told us, "My friends who visit are treated with respect" and, "I use the telephone in my room and family and friends can visit when they like." Visitors clearly knew the staff, they chatted as they arrived and asked where their family member or friend was. Staff offered them a drink and directed them to the lounge or the person's room.

Confidentiality procedures were in place and staff said they had to sign to show they had read and understood them. They were very careful to discuss people's needs in private with each other and said if relatives wanted to discuss something more than, "A chat and catch up," they suggested they spoke to the nurse or registered manager.

Good

Is the service responsive?

Our findings

We have inspected this key question to follow up the concerns found during our inspection in December 2017. At that inspection we found a breach of the legal requirements. This was because the provider had not ensured that staff had the information required to meet people's individual needs, as care plans were not personalised and did not show that people were supported to be independent.

At this inspection we found improvements had been made. People had been involved in developing their care plan; they were based on people's preferences and enabled them to be independent and, the rating had improved to Good.

People told us they were involved in decisions about the care they received, because staff listened to them and supported them to make choices. One person said, "The staff are a great team." Another person told us, "The staff are wonderful, they are so sympathetic. When I was poorly they helped me feed myself and encouraged me to do it myself as I started to get better. I feed myself now I am stronger." Relatives were also positive about people's involvement in planning their care. One relative said, "The staff always involve residents in decisions about everything, from activities, to meals and especially the care they receive. Gives me confidence in what they do." A range of group and individual activities were available to participate in if people wished and these were planned and developed from discussions with people living in the home.

People said they had chosen Threeways Nursing Home or their relatives had visited and chosen for them. One person told us, "I am quite comfortable and they came to talk to me about what I wanted and what they provide before I moved in. So decided together I suppose. No complaints now I am here." The registered manager and nurses said people's needs were assessed before they were offered a place at the home; to ensure their needs could be met and, that the services provided were appropriate to what each person wanted.

The information in the assessments had been used as the basis of the care plans, which were developed and updated with the involvement of people living in the home and their relatives, if appropriate. The registered manager said the care plan format had changed since the last inspection and they had introduced individual folders kept in people's rooms, with their permission. Records showed that people, or their relatives, had given their consent for the care and support provided; the photographs in the care plan and MAR, sharing of information with external professionals and the use of bed rails. If they had capacity and a DoLS was not required.

Care plans were personalized and identified people's individual needs. A residents profile was at the front of each care plan and the individual folders. This was a precis of people's specific needs, including their medical and social history; their medicines and specific needs including communication, personal care, diet and mobility with risk of falls and aids used. Staff said this information was easily accessible because it was kept in the folders in people's rooms. If they had been absent from work they could catch up quickly with any changes by discussing the records with people, or their relatives. One member of staff told us, "The folders are really good, they are reviewed regularly and when people's needs change and they keep us up to

date with the support people want and they or their relatives agree to the information." People said they knew about the folders. One person told us, "Yes it is all in there, but I don't worry about it." "Another person told us, "Yes the information is there for staff and I talk to my nurse about my needs to make sure the plan is up to date and what I want. Works well I think." A relative said they visited several times a week and spent time with their family member in their room. They had seen that the meals were appropriate, medicines being given out and the care provided was, "In line with the agreed plan."

People living with dementia were supported to make decisions about the support provided. One person liked to spend time in the lounge and used the dining room; they were independent as much as possible and needed to use a walking aid to move around. We saw staff reminded them quietly not to forget their aid and supported them to access the bathroom safely, as they were at risk of falling. Their care plan stated that they were forgetful and there was guidance for staff to ensure the person made choices about the support provided and they were involved in decisions about how they spent their time.

Staff said they were kept up to date with changes in people's needs and the services provided through the handovers at the beginning of each shift. We joined staff at one handover. They were clearly used to keep staff informed about people's needs, how they felt, if they had had a good night's sleep and if there had been any changes in health care needs. Staff told us, "The handovers are very good; even if we have been off we can catch up with how people are as we can ask questions and see if residents need more support." Another member of staff said, "There is also a communication book to record appointments, visits by health professionals and any tests that are due. Like for urine infection. We check them when we start each day so we can plan residents care."

People were supported to spend time doing what they enjoyed and this was not necessarily activities arranged in the home. One person chose to remain in their room and said, "I enjoy football, cricket, bowls, and all sports on TV really" and, staff respected this. The activity co-ordinator gave people a copy of the activity timetable and told us, "But it is really up to them if they want to join in. The programme is developed by them, with just a bit of help from me as I type it up, but it is all theirs really." One person said, "I really enjoy the activities here and we choose between us what to create." Another person told us, "Activities are meaningful, they are chosen by residents and the activity coordinator is excellent."

There was an activity programme which included group and one to one sessions. These included regular external visitors such as the hairdresser, singers, Pat a dog, yoga and massage and a range of internal activities. For example, bingo, arts and crafts, games, knit and natter and a monthly residents committee meeting to discuss how they wanted to spend their time. An activity and wellbeing questionnaire had recently been given to people and the responses had been reviewed to find out how people wanted to spend their time. People put forward suggestions about what they would like to do and fed back what they had not enjoyed. The results a number of issues and actions were listed to address them. For example, some people were physically unable to do some of their hobbies; because of painful joints or difficulty mobilising. The action from this was for the activity co-ordinator to look for alternative support systems that would enable people to continue with their hobbies. People needed assistance to sit in the garden or go out of the home and the action was for nurses and management to increase staff awareness that some residents require assistance to go out and further training in person centred care was needed. The feedback from the questionnaire was that people who chose to remain in their rooms were very positive about the one to one time; with 93% saying they enjoyed the time and found it worthwhile. Whilst seven people responded that they preferred not to participate in their hobbies.

Activities were also based on specific celebrations. In June they planned to celebrate the Queen's birthday and an indoor football game had been organised for Father's Day. The activity co-ordinator and people had

been building a facsimile of the 'Orient Express'. To go on 'holiday' and stop at some of the destinations along the route. People were looking forward to putting together information about the towns they would be stopping at and there was clearly a considerable amount of research and work involved in providing this. There was also a magazine the 'Weekly Sparkle' that had information from previous years for people to reminisce about with a quiz at the rear to test their memory. We observed activities throughout the inspection; people clearly enjoyed the quiz, yoga and arts and crafts, they took part or watched other people taking part. The activities were very sociable, people were relaxed, and there was laughter and joking between people, relatives and staff.

Links with the community were encouraged, local churches visited people regularly and the activity co-ordinator was developing the links with local schools so that they came to the home more often. A fete had been arranged for August, for people, their relatives, friends and neighbours to attend; with the proceeds going towards local charities.

Staff said they had attended end of life training and had supported people, their relatives and friends at this time. End of life care plans were in place for people who chose to record their wishes, these included do not resuscitate (DNR) forms and staff were also aware that people may choose not to discuss this. Medicines were available if people's health needs changed quickly and staff said they could call the palliative care nurses if needed. One person told us she had been asked about her end of life plan and it had been agreed with her and her family to sign the DNR. A relative spoke very positively about the support they and their family member had received. They told us the nurses treated them all with the greatest respect. They were supportive and caring her and always on the end of the phone for updates and, "Even in his final hours the nurses were having a giggle with him, he was always joking around."

Technology was available in the home for people to communicate internally with staff using the call bell system and externally using landlines or mobiles to talk to and receive calls from relatives and friends. There was a broadband system in place and people used this to contact relatives using skype and emails.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Although most people at the home had full capacity and could communicate their needs, additional support was needed to support some people. For example, for sensory loss such as poor eyesight and for people living with dementia. The registered manager was aware of the AIS and information had been included in the care plans in terms of how to support people who may have difficulties communicating. However, staff were not fully aware of what these changes meant.

We recommend that the provider seek advice and guidance from a reputable source, about Accessible Information Standards (AIS) to ensure staff are aware of their responsibilities

People and relatives knew that there was a complaints procedure. A poster explaining how to make a complaint was displayed on the notice board in the entrance hall and information had also been included in the information folder in people's rooms. The three complaints raised in the previous year had been responded to in line with the provider's procedure. People said if they had any concerns they would talk to the staff. One person told us, "I would tell a nurse if I was worried or concerned about anything" and, another person said, "I've not had reason to complain but if I did I would speak to a superior." There were a considerable number of thank you cards also on the notice board, which thanked staff for their kindness and the care provided.

Requires Improvement

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our inspection in August 2015 and December 2017. At those inspections we found a breach of the legal requirements. This was because the provider had not ensured that an effective quality assurance system was in place and the provider had not maintained complete and contemporaneous records in respect of each person.

At this inspection we found improvements had been made and the provider met the legal requirements. However, additional work was needed to ensure the improvements were embedded into day to day practice.

People said Threeways Nursing Home was very comfortable and staff provided the care and support they needed. One person said, "This is my home, I am quite happy." People and relatives said the staff and management were approachable and they could talk to them at any time. Relatives told us, "If we have any questions or we want to check on anything there is always staff around to talk to" and, "When we visit staff always ask us if everything is ok, if we want a drink and if they can do anything. We see staff and the manager talking to residents and checking that they are ok." People said, "Staff come in to just say hello and see how we are quite often" and, "They check that we have everything we need." Staff told us they worked really well together as a team, "Including the manager" and they were confident they provided the care and support people needed.

The quality assurance system had been reviewed and a number of audits had been introduced to assess the services provided and drive improvements. Weekly and monthly audits had been completed to look at all aspects of the services provided. These included care plans, medicines, accident and incidents, complaints, catering, housekeeping and maintenance. We found overall the audits had identified areas where improvements were needed and action had been taken to rectify these. However, reviewing and updating the care plans was one area where additional work was needed. We found some of the information was not consistent and had not been updated promptly when people's needs changed. For example, in one person's profile it stated they were 'Able to use call bell to ask for assistance', but in the care plan it stated they 'Cannot reliably use the call bell' due to memory loss. In another care plan it was not clear how many staff were needed to support a person to transfer safely, and whether the stand aid or hoist should be used. The impact on people's care at the time of the inspection was low; because staff demonstrated a very good understanding of people's specific needs and spoke knowledgeably about how they supported the people whose care plans had not contained clear guidance for staff.

Nurses were responsible for reviewing a number of care plans each month and they said the lack of up to date records was in part due to the recent changes in the nursing team. One full time nurse had left; nurse's shifts had been reviewed and some changes had been made to ensure there were sufficient nurses on each shift. The registered manager said they had actively advertised for nurses and were interviewing prospective staff. However, the changes had meant nurses had not had the time to review and update the care plans they were responsible for regularly and when people's needs changed. Staff were aware this was an area that needed to improve and discussed how they could allocate time to ensure records were up to date. The

most promising suggestion was for the named nurse and keyworker to sit and discuss each person's needs with the person concerned. This would enable people to be actively involved in decisions about their care and in writing the care plan and, could also be used as part of the supervision process to support care staff. Nurses planned to introduce this as soon as possible.

There were clear lines of accountability and staff were aware of their colleagues and their own roles and responsibilities. One member of staff said, "We work really well together, each of us knows what we have to do on each shift and we also know what our colleagues are doing. If we needs to we can use the walkie talkie to contact the nurses or staff if we have any concerns or need someone to help us." Another member of staff told us, "The nurses and manager are very good; I feel I can talk to them and one is on call out of hours if we need advice." The keyworker and named nurse process had only recently been introduced. The care staff had a good understanding of the specific support they now provided for people and additional advice was available for nurses to ensure they developed their roles in this process.

Senior staff were quite clear about their responsibilities and there were regular 'team' meetings to keep staff up to date. For example, there were separate quarterly meetings for housekeeping staff, catering staff, care staff and nursing staff to look at their roles and responsibilities and put forward suggestions for improvements. Staff said they meetings were really helpful. "They keep us up to date with what is going on, although we generally know because we discuss things daily, and we can suggest things." Staff discussed how useful it would be to have meetings that involved all of the staff working in the home. This would make sure they were aware of each member of staffs area of responsibility; how this could possibly impact on other staffs work, discuss any issues and ensure that all staff worked together as a team to ensure the services provided were appropriate and met people's needs.

Feedback was regularly sought from people living in the home and their relatives and representative. The activity co-ordinator arranged monthly meetings, one for the residents committee and another for residents and relatives. They were planned to include afternoon tea time; one had taken place on the first day of the inspection and was well attended. The registered manager said they also planned to send out satisfaction questionnaires to relatives and external professionals.

The provider had notified CQC of significant events which had occurred in line with their legal obligations. The registered manager was aware of their responsibilities under Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to, it requires providers to be open and transparent and sets out specific guidelines providers must follow if things go wrong. Staff told us they were open about all aspects of the support provided and they contacted relatives or their representatives, with people's permission, to inform them of any concerns they might have. For example, if a person's health needs had changed and their GP had been contacted.

The registered manager had an understanding of General Data Protection Regulation (GDPR) which came into effect in May 2018. GDPR was designed to ensure privacy laws were in place to protect and change the way organisations approach data privacy. Staff said they were currently reviewing their record keeping and were seeking advice on how to best make the changes required under this legislation.