HC-One Oval Limited

Priory Mews Care Home

Inspection report

Watling Street
Dartford
Kent
DA2 6EG

Tel: 01322292514

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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

Priory Mews Care Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service can accommodate up to 156 people. At the time of the inspection there were 136 people living at Priory Mews Care Home. The service comprises of five separate units adjacent to each other. Beaumont and Berkeley provide residential and nursing care for 30 and 14 people respectively; Marchall and Mountenay provide care for people with nursing dementia needs for 22 and 29 people respectively; and Cressenor House cares for 41 people with residential dementia requirements. A separate house accommodates the main reception, the kitchen, the senior management team, and the administration team.

The inspection was unannounced and took place on 10 and 11 January 2019.

The service was run by a registered manager and they were present on both days of the inspection visit. 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.

At the last inspection on 6 and 7 November 2017, the overall rating of the service was 'Requires Improvement'. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risks to people were not always minimised nor significant events safely responded to. Checks on the quality of the service were not sufficient to make necessary improvements. People were not always given their medicines as directed by their doctor. People were not always supported appropriately at mealtimes or treated with dignity. We required the provider to take action to make improvements. The provider sent us an action plan detailing how they planned to address the breaches of Regulations and said that this would be completed by 30 April 2018.

We also made four recommendations. These were about making sure there were enough staff available; the control of infections, adaptations to the environment and the range of activities available.

At this inspection, we found that that potential risks were assessed and managed to help keep people safe. Accidents and incidents were monitored, and lessons learned for the benefit of people. People were consistently treated with dignity and got the help they needed at mealtimes. There had been improvements to record keeping. However, shortfalls in the management of medicines remained as it could not be assured that everyone received their medicines as prescribed by their doctor. There were a number of discrepancies in medicines records including the use of 'only when needed' medicines prescribed for people with agitation.

This is the second time that the service has been rated as Requires Improvement.

The provider had addressed all good practice recommendations. Staffing levels were assessed and monitored to make sure there were enough staff deployed in each unit. Infection control practices minimised the spread of any infection. This included making sure each person who used a hoist had their own sling to prevent cross contamination. Changes had been made to the environment through a use of visual aids and decoration to help people living with dementia make sense of their surroundings. The activity team had been expanded so there were activity leads in each unit to undertake group and one to one activities with people to help improve their well-being.

Systems to monitor the quality of care had been strengthened but had not identified the shortfalls in the management of medicines.

A consistent staff practice had developed throughout the service whereby everyone was treated as an individual. People were treated with dignity and respected. People and their relatives told us staff were kind and caring and made people feel safe.

Staff received the training they needed to enable them to support people with a range of needs. Staff were suitably trained, received regular supervisions and felt well supported. The provider made sure the registered nurses had access to the training required to ensure their continuous professional development.

Health and safety checks helped make sure that the environment was safe and that equipment was in good working order. Recruitment practices were robust in ensuring only suitable staff were employed at the service.

People were supported to access health care services when needed. The provider worked in partnership with a range of healthcare professionals to ensure people received appropriate care and treatment. People had sufficient food and drink and were provided with choices and at mealtimes.

People were supported to have maximum choice and control of their lives in line with the principles of the Mental Capacity Act 2005. The provider had taken the necessary steps to ensure that people only received lawful care that was the least restrictive possible.

People's needs were assessed and people and their family members were involved in developing and reviewing care plans, which included people's choices and preferences.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

Feedback from people and their relatives was regularly sought and acted on so that the service improved for their benefit. People felt confident to raise any concern or complaint.

Records had improved so they were accurate and accessible which meant that appropriate guidance was available to staff.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management of medicines did not always ensure that people received their medicines as prescribed by their doctor.

The service learned lessons and made improvements when significant events occurred.

Potential risks to people's health and welfare were assessed and staff followed this guidance to keep people safe.

Checks made sure only suitable staff were employed.

The service was clean and staff practices ensured effective control of infections.

Is the service effective?

Good

The service had improved so that it was effective.

People's nutrition was monitored they received the support they needed at mealtimes.

Improvements had been made to the environment which took into consideration the needs of people living with dementia.

Staff felt well supported and had the skills and knowledge they required for their role.

People gave consent to care and support. Staff supported people in line with the principles of the Mental Capacity Act 2005 and the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service had improved so that it was caring.

Staff had built positive and caring relationships with people and this approach was consistent throughout the service.

People were treated respectfully or and supported in a way that

was caring and upheld their dignity.

Is the service responsive?

Good

The service had improved so that it was responsive.

People's needs were assessed and support plans gave guidance to staff about how to provide their care.

People were offered a range of individual and group activities to help enhance their well-being.

People were supported at the end of their life to have a comfortable, dignified and pain-free death.

People and their relatives knew how to raise concerns and complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Although quality assurance systems had improved and strengthened, shortfalls in the management of medicines remained.

Record were easily accessible and their content had improved so that they reflected people's care and treatment.

The views of people and relatives were sought and acted on.

People benefitted from a staff team who were well supported and clear about their roles and responsibilities.

Priory Mews Care 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 10 and 11 January 2019 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor, medicines inspector and two experts by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members.

Before the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service. We also asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was informed by feedback from twenty-four people and eleven relatives. We observed lunchtime in each unit and 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 also obtained feedback from two commissioners of the service, a tissue viability nurse and a chiropodist. The views from people, relatives and health care professionals is contained in detail in the main body of the report.

We spoke with the registered manager, deputy manager, clinical lead, four unit leaders, three nurses, four senior care staff, seven care staff, the activity lead, an activity coordinator, the administrator, chef, housekeeper and area director. We also viewed several records including sixteen care plans; the management of medicines; the recruitment files of five staff recently employed at the service; staff training records; health and safety records; complaints and compliments; accidents and incidents and quality monitoring audits.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 6 and 7 November 2017, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People could not be assured they would receive care in a safe way as the service was not doing all that was practicable to respond to significant events and mitigate assessed risks. The administration and recording of medicines did not always ensure people were given their medicines as directed by their doctor.

At this inspection on 10 and 11 January 2018, we found that risk management had been strengthened but all necessary actions had not been taken to make sure that people received their prescribed medicines at the right time and in the right way.

There was inconsistency in the recording of the administration of medicines. One person had not been given their prescribed medicine used in the management of seizures, when they had gone out for the day with relatives. Some people were prescribed medicines to be given 'only when needed' (PRN) or to be used only under specific circumstances. Protocols for these medicines gave information to staff to help them make decisions as to when to give these medicines so people were given their medicines when they needed them and in a way that was both safe and consistent. We checked the stock balances of five people who were prescribed PRN medicines to calm and relax them when they became agitated. For each person we found there were between four and seven tablets of medicine less in stock than the balance indicated on the medicines administration record. The provider investigated and told us that registered nurses had given people the right medicines but not recorded this on the medicine administration record. As a result of our concerns, registered nurses received an additional supervision to remind them of their roles and responsibilities, in line with the provider's protocol. The provider was rolling out new medicines training for all staff who administered medicines which included a competency assessment. However, insufficient time had passed to make sure that this additional training and support had been embedded. These medicines used for people who are agitated are 'high risk medicines' which means that they have a high chance of causing harm if they are misused or used in error.

The provider had failed to make sure that people were given their medicines as directed by their doctor. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider was working towards making sure there were not excess stocks of medicines. An additional trolley had been purchased for one unit, so people received their medicines at the right time. Medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately and kept at the correct temperature, so they were fit for use. Bottled medicines were dated when opened to make sure they were used within the correct time period. Guidance was available to staff about to which part of a person's body they should apply prescribed creams. Staff recorded when patches for pain relief were applied to people's skin and when they were rotated to ensure they were regularly moved to maintain people's skin.

Risks to people's safety had been assessed such as the risk of falling, developing pressure ulcers, choking

and receiving adequate nutrition. Staff knew how to follow the provider's procedures for witnessed and unwitnessed falls. During the inspection one person fell whilst being escorted by staff. Staff took immediate and prompt action to reassure the person and followed protocols to help the person to mobilise with the use of a hoist. For people at risk of falling risk management plans included the type of equipment and amount of staff support they needed to be moved safely. A relative told us, "Mum now has two pressure mats to alert staff when she gets out of bed. Staff respond quickly". There were risk management plans to guide staff of the actions they needed to take to reduce the risk of people developing pressure ulcers and to attend to people who had a wound. Wounds were assessed and any interventions recorded and monitored. Body maps were used to direct staff to any pressure areas people had and people were repositioned at frequent intervals to help keep people's skin healthy.

At the last inspection on 6 and 7 November 2017, we made a recommendation about the control of infections. This was because people did not have an individual sling for their hoist. At this inspection on 10 and 11 January 2018 we found that people who used a hoist to move had been issued with their own sling to avoid the risk of cross infection.

People and their relatives were satisfied with the cleanliness of the service. Housekeeping staff were allocated to each unit and worked hard to ensure the service was clean and free from unpleasant odours. Each person's room was deep cleaned regularly, as part of the 'resident of the day' programme'. Infection control audits were carried out and staff had access to and used personal protect equipment such as disposable gloves and aprons to prevent any cross infection. All these actions helped to minimise the spread of any infection should it occur.

At the last inspection on 6 and 7 November 2017, we made a recommendation about the deployment of staff. This was because in some units there were not enough staff to support people at mealtimes, with going to the toilet and with activities. At this inspection we found that there were sufficient staff available to meet people's personal care needs and to take part in things that they enjoyed.

People and their relatives said there were enough staff available to help them or their family member. They said that staff assisted them when they needed it and made sure they had a regular bath or shower. People who used a buzzer to summon help said that staff were usually quick to respond. A relative said, "He presses the buzzer all the time. Staff are very responsive and very patient with him". Some people said that staff did not always have time to stop for a chat as much as they would like. One person told us, "The staff are pretty good at coming to assist me. I may have to wait if they are busy". A relative commented, "Staff appear rushed off their feet, but my family member doesn't appear to suffer as she is usually up washed and dressed by the time I arrive".

The provider had obtained a specialist tool to assist them to assess the staffing levels required at the service. This tool used people's dependency levels, such as what tasks they need staff to support them with throughout the day, to determine how many staff are needed throughout the day and night. Staffing levels were adjusted according to the individual needs of each unit and regularly reviewed. Staff levels remained consistent throughout the day and reduced in the evening, when people retired to bed. Staff rotas were arranged in advance and agency staff used to cover any staff absences or vacancies.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role. This included obtaining a person's work references, a full employment history, checks on nurses' registration and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People and relatives told us that they or their relatives were safe living at the home. One person told us, "Oh yes, I feel safe and very well looked after. I always have two staff to hoist me out of bed, they know how much help I need". Another person said, "I am very nervous person. I feel safer here as there is always someone around to help me". Relatives were reassured by the presence of staff and security of the building that helped to keep their family member safe. One relative said, "She is safe here. There is plenty of room to wander about with the attention the staff give her and security". Another relative commented, "I know when he wanders about at night he is safe. The night staff are here to keep a check on him".

The service's safeguarding policy set out the definitions of different types of abuse, staff's responsibilities and how to report any concerns. Staff had received training in safeguarding and knew how to follow the service's policy to ensure people's safety. Staff knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith. Staff had access to the contact details of the local authority who are the lead agency in safeguarding investigations. Staff felt confident that the registered manager would act on any concerns but knew to contact the local authority of CQC if they did not do so.

Some people presented behaviours that may challenge themselves or others. Each person had a care plan which identified the nature of their behaviour, the potential triggers for the behaviour and guidance for staff on the appropriate action to take to minimise the occurrence. Staff knew how to follow guidance to keep people and themselves safe. A relative told us, "I have watched the staff being very patient and comforting another resident who was upset. Staff were able to distract them and calm them down". Another relative said, "If my family member is being difficult and doesn't want to wash or change staff remain very calm. There is no shouting. Staff come back later and try again". A staff member described how joint working with the person, family members and mental health team had had a positive impact on one person, leading to a reduction in their behaviours and improvement in their quality of life.

A record was made of any accident or incident which included a description of what had occurred, any treatment given and who was informed such as the next of kin. The registered manager reviewed all significant events to see if there had been any common themes or patterns and that the appropriate action had been taken. Accidents and incidents were also discussed at health and safety meetings and reviewed by the provider's quality lead. There were systems and processes to make improvements when things had gone wrong. A root cause analysis had been undertaken for serious falls and fractures and pressure ulcers which looked at any contributing factors and concluded with any additional action that could be taken. For example, when looking at possible factors as to why a person fell it was noted that the person was on pain relief. A medication review was recommended to make sure that their pain relief was sufficient and had not contributed to them falling unexpectedly.

The provider had assessed the environment and carried out actions to make sure that it was safe for people who lived and worked at the service. Regular checks on the premises and equipment took place including the servicing of fire-fighting equipment, gas and electricity supply, air mattresses and moving and handling equipment. Maintenance personnel were employed to attend to repairs and make sure they were dealt with in a timely manner. Each person had a personal emergency evacuation plan which identified the individual support and/or equipment people needed to be evacuated in the event of a fire. Day and night staff had taken part in fire training and drills so that they knew what to do in the event of a fire.

Good

Is the service effective?

Our findings

At the last inspection on 6 and 7 November 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always supported appropriately at mealtimes.

At this inspection on 10 and 11 January 2018, we found staff had received training and guidance in supporting people with dignity at mealtimes and that this had had a direct impact on people's experiences.

People and their relatives were complimentary about the food choices available. One person told us, "I am a vegetarian and staff prepare me a vegetarian curry and rice at lunchtime". The chef was passionate about preparing food for people and had a good knowledge of people's likes, dislikes and specialist diets such food texture. The chef understood people's cultural needs and described how one person liked their rice cooked in a particular way. They regularly liaised with staff and attended meetings to help ensure people were being provided with meals that they liked.

Everyone said that staff encouraged people to make sure they had sufficient to eat. One person told us, "When I came out of hospital I didn't want to eat. Staff coaxed me to try and eat and offered me dishes I liked. I had a lovely cooked breakfast this morning". A relative commented, "If mum refuses to open her mouth for food staff will try and tempt her by putting a little bit on her lips to get her to taste and often she will then eat some food". At lunchtime people were asked what they wanted to eat and how much they would like to be served. People who required help to decide were shown a platted option of each meal. When people changed their mind about their meal choice, this was respected. Staff sat next to people who required assistance to eat and supported people to eat at their own pace. Specialist cutlery had been sought for people who needed it, so they could eat independently. Staff made sure that people who wandered during mealtimes were given a meal.

People were offered drinks and snacks throughout the day, so they did not have to wait long between meals. Staff knew which people were at risk of poor nutrition and who was at risk of choking and needed close supervision at mealtimes to keep them safe. For people who had difficulty with swallowing, guidance had been sought from the speech and language therapist. Care plans included the consistency of people's food and fluids and the safest position for them to be in when being supported to eat. Staff followed this guidance at mealtimes. Food and fluid charts were kept when necessary to make sure that people had sufficient to eat and drink. People were weighed regularly and their weights monitored so that action could be taken if people gained or lost significant amounts that may affect their health.

At the last inspection on 6 and 7 November 2017, we made a recommendation about adapting the environment for the needs of the people living with dementia. At this inspection we found that the provider had acted to make improvements to the environment, which benefitted people.

There was signage to orientate people to bathrooms and toilets. To help people identify their bedroom some people had a distinctive door colour and other people had a box of photos or things that were

important to them. The walls were decorated with people's art work, pictures and posters. Sensory boxes were available on tables where people sat and we saw that some people enjoyed exploring them. These included soft toys, balls and mood lights. Dressing up costumes and books were also available to help stimulate people. There were wide corridors so that people who liked to walk during the day had the opportunity to do so safely. For people with mobility difficulties, equipment was in place, so people could use bathrooms and toilets.

Staff felt well supported by their colleagues, senior staff and the management team. A health care professional told us, "There is good team work and interaction amongst the staff teams on each unit". Staff said they received supervision, attended staff meetings and had a yearly appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

New staff completed an in-house induction which included reading policies and procedures, shadowing staff and undertaking training essential to their role. Staff were encouraged to undertake a Diploma in health and social care level two or above. To achieve this qualification, staff must prove that they have the ability and competence to carry out their job to the required standard. A staff training matrix was used to identify when staff training needed to be refreshed so that staff's knowledge was kept up to date. Training for staff included essential areas such as health and safety, fire and moving and handling. Most topics areas were taught through e-learning with a check in place that staff knowledge met a specified requirement. Face to face training was provided to staff in dignity in dining as part of dementia awareness and moving and handling. We observed that staff were skilled in moving and handling techniques when transferring and moving people. Nursing staff completed additional courses to make sure they continually validated their nursing qualification with the Nursing and Midwifery Council (NMC).

People and their relatives told us that they felt the staff had the right skills and specialist knowledge to assist them and others. One person told us, "All the staff have been well trained. They give me time and help me the way I want. They know how to put on my oxygen mask to help me breathe when I need it". Another person said, "The staff are knowledgeable and know to clean my tracheotomy tube regularly". A relative commented, "The staff really understand and know what mum likes. I am impressed with their knowledge and training". Another relative described how staff were responsive to their family member's medical need. "I was walking around the corridor when my family member had a seizure. Staff responded quickly to make sure she didn't hit her head. They were very reassuring. Afterwards they sat her down in one of the recliner where staff were able to keep an eye on her".

People's health care was managed by registered nurses and care staff in liaison with a range of health care professionals. A health care professional told us, "This home has a supportive clinical manager with whom I link with following referrals and who then ensure that any advice is acted upon. My visits are always well supported, and staff assist with reviews". People said they had access to health care services such as the chiropodist, dentist and doctor when needed. The optician was visiting at the time of the inspection. One person said, "I think a doctor is here every week and you can always ask to see other people. The staff are very good, they organise all that". A relative told us, "When mum had a chest infection, the doctor was called straight away". A health care professional told us staff were quick to seek input from the district nursing team when they saw that a person's skin had started to deteriorate. They also said, "If I have needed staff to redress certain wounds if tender, staff have been very thorough to follow through".

Guidance with regards to people's health needs was detailed in their care plans. For people with diabetes guidance was available to staff about the warning signs to look out for and action if a person had too much or too little sugar in their blood. One person told us, "I am a diabetic so have regular blood sugar tests and get weighed weekly". For people with a catheter staff were advised when to change and empty the bag and

the signs to look out for which may indicate the person had an infection. A catheter is a tube in the bladder for removing fluid. For people with a radiologically inserted gastrostomy (RIG) staff had liaised with specialist support including the speech and language therapist and dietician. A RIG is a way of introducing food, fluids and medicines directly in to the stomach by inserting a thin tube through the skin and into the stomach. The person's care plan included how the person should be positioned to be fed and actions to identify and minimise any infections.

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. Staff understood the main principles of the MCA and how to put them into practice. People's capacity had been assessed and information about this was available in people's care records.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes are hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority for people who may be restricted in their freedom. The registered manager monitored DoLS authorisations and had a planner in place. This was so they knew when to resubmitted applications before they expired to ensure that they only restricted people's liberty when it had been assessed as lawful to do so.

Good

Is the service caring?

Our findings

At the last inspection on 6 and 7 November 2017, we identified a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not always treated in a dignified or respectful manner.

At this inspection on 10 and 11 January 2018, we found that inconsistencies between units in how people were treated had been addressed so that everyone's dignity was respected.

People and relatives told us that staff always treated people with dignity and respect. One person said, "Staff do treat me with respect. The staff here think about what they are doing. They are very careful and caring". A relative commented, "I can see real dignity for the residents here. They really do treat my dad with respect. It is lovely to watch and helps me not to worry". People's bedrooms doors were closed when they received personal care. One person told us, "My curtains and door are closed until they have finished my personal care and I am fully dressed".

Treating people with respect permeated in the whole staff team. We saw many examples of this from care staff and non-care staff such as housekeeping staff. People were addressed respectfully staff, using their preferred names. Attention was paid to people's appearance including their clothes and ensuring that people who liked to dress smartly were enabled to do so. A relative said, "Mum always liked to look clean and smart. Her finger nails are always clean and painted regularly and she is always well-dressed when we visit". One person's care plan identified that it was very important to them to have their make up on and that they carried a bag containing perfume, a comb and make-up. Staff helped this person with their make up and asked if they would like any perfume. Staff informed the person that they looked, "Beautiful", when they asked about their appearance.

A health care professional told us, "I do feel that the home generally has a good ethos and that they are caring". The registered manager was introducing a dignity champions to put dignity at the centre of the service. A dignity champion challenges poor care practice, acts as a role model and educates and informs staff working with them.

People described staff as kind and caring with a commitment to help them. Comments from people included, "Staff are beautiful: They look after me"; "Staff are outstanding. They have a caring attitude. I always have a laugh and joke with them"; and "Staff treat me very well. They care about what they are doing for you and put themselves out to help you". Relatives also told us that the way staff interacted with people had a positive impact on their wellbeing. Comments from relatives included, "Staff have a very good bedside manner"; "Mum's face lights up when she sees the staff. When she was in hospital one of the staff visited. When I came back to pick up some clothes, staff showed their concern for mum asking me how she was getting on"; and "Staff are brilliant. They go above and beyond".

The provider had received compliments from relatives about the caring nature of the service to them and their family member. One relative commented, "The staff are always kind and considerate of my family

member's needs. They support us a family". Another relative reported, "We both appreciate the high standard of care given, so much hard work and kindness received from the staff and the empathy shown for our situation with thanks for all your help".

People and staff had developed positive relationships. Staff promoted a non-discriminatory atmosphere where people were valued. This resulted in people feeling comfortable and relaxed.
When speaking to people, staff sat next to the person or knelt, so they were at the same level and had direct eye contact. Staff interacted well and this resulted in smiles and laughter. Staff used touch appropriately to engage with people. A staff member said hello to a person using their name and also gently touched their shoulder. The person responded with a big smile.

People and relatives said that when people become upset or anxious staff were good at reassuring them. One person told us, "I have noticed that staff are good at coaxing people and comforting them. They will put their arm around them to give them a hug. They never leave people in distress". Another person said, "I got upset when my mother died. Staff stayed with me, held my hand and chatted. It was very comforting". A relative commented, "If mum has been upset, the staff sit and comfort her. They are also very reassuring and comforting to the family when mum has been very poorly". One person was worried about when their family would be visited and a staff member offered to call their relative to check when they were visiting. Later this person lost their mobile phone and staff reassured them that it was somewhere around until they found it for them.

People and their relatives said they had been involved in developing their or their families care plan. A 'resident of the day' programme operated to make sure people's care plans were reviewed regularly. These reviews took into consideration the views of people and their family members. One person told us, "Nurses come and discuss my care plan with me". A relative said, "I am fully involved in any discussion about family members care. I am always asked if I want to attend the meeting".□

Care plans contained information about people's likes, dislikes, life history, interests and choices. One person told us, "If I don't want to get out of bed, I don't get out of bed. Staff let me decide". Another person said, "I don't like to use the hoist as I found it was too uncomfortable for me. I prefer to be moved to the side of the bed and then use my walking frame. It is a bit of a struggle for me but it is my choice". People and relatives said that staff knew them well and how to meet their individual characteristics. One relative said, "Staff know mum doesn't like a lot of noise and help her to move to a quiet corner or back to her room when she ask them". Another relative told us, "Mum hates being touched. Staff seem to know how to move her without causing her distress".

Staff understood the important of promoting people's independence. A relative told us, "He likes to do as much as he can for himself and then ask for help when he needs it. He likes the staff to shave him as his hands are a bit shaky". During the inspection one person helped staff push the drink trolley around the corridor.

Some people had family members to support them and other people required advocates to help them air their views. Information was available about lay and independent mental capacity advocates and their services had been accessed when they were needed. Advocates are independent of the service. They can support people to express their needs and wishes and weight up and take decisions about the options available for people.

Arrangements had been made to ensure that private information was kept confidential and secure. Care staff had been given training and guidance about how to manage information in the right way so that it was

only disclosed to people when necessary. Written records that contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff.

Good

Is the service responsive?

Our findings

At the last inspection on 6 and 7 November 2017, we made a recommendation about the provider reviewing the way activities were provided so that they met the needs of people in each unit. At this inspection we found that there was an activity lead for each unit so that people were regularly offered a range of group and one to one activities.

People and their relative said there were things going on each day which they could join in with. One person told us, "There is always something to do. Staff come and chat to me in my room and show me things: I never get bored". The activity lead was enthusiastic and imaginative, with a clear understanding of how different activities would benefit people with different capacities. A list of activities was displayed in each unit, but people were also supported to go to another unit to take part in sessions that they were interested in. During the inspection some people went to a unit where a 'music for health' session was occurring by an external provider. People were helped to put their coats on and staff escorted them so that it was a trip out. During the 'music for health' each person was included irrespective of their ability and staff aided the session, so people got maximum enjoyment.

One to one sessions took place including chats, card games and puzzles. These included people who spent time in their rooms. The sessions varied in length and noise level depending on people's individual personality and concentration levels. An activity staff member described how they adapted one to one sessions, so they were individual and meaningful to the person. One person was very knowledgeable and enthusiastic about trains but did not want to engage in a conversation on this topic. The activity staff found that if they started to talk to this person about a journey they had made, the person then told them about the station nearby and this developed into a conversation.

People told us about the things they liked to do. Comments from people and relatives included, "I love dogs and when there is a dog show on or the staff bring their own dogs along to see me in my room"; "I am hard of hearing so prefer the activities lady to come to my room. We often have a chat over a cup of tea whilst she does my nails"; "I have done painting, played indoor bowls and had a go at making pancakes on pancake day. We have had some good shows here. The Wizard of Oz was great"; "My family member likes to walk around the home. Staff will walk along chatting to her"; and "He loves watering the plants in the garden at summer time. He goes around to the pub room to watch the football or boxing".

Each staff member wore a badge which gave their name and a few words about what they liked to do such as "I like to dance", or "I love to walk the dogs". When people read staff's badge, this could start a conversation about what staff liked to do with their time and lead on to people talking about what they liked to do.

Care staff understood the importance of promoting equality and diversity. This included arrangements that could be made if people wished to meet their spiritual needs by religious observance. People were supported to follow their faith and the service had developed a relationship with a local church. A church service was held each month. Special events such as Christmas and Easter were celebrated.

An initial assessment was undertaken before people moved to the service to check the service could meet the person's care and support needs. Assessments included nationally recognised specialist tools with regards to identifying people at risk of pressure ulcers and malnutrition. This information was used to develop a care plan that covered all aspects of people's care and support needs. The provider's care plan framework gave clear guidance to staff to make sure that each person had a detailed care plan setting out their health, social and personal care needs. People and their family members were involved in the development and regular review of their care plan. The 'resident of the day' programme included reviewing the persons care plan and speaking to them about their food choices and activities.

People and their relatives said all staff were approachable and they could speak to a carer, nurse or the unit manager if they had a concern or complaint. People and their relatives said they had not needed to make a complaint as any problems were addressed and communication was good. One relative told us, "I would speak to any of the staff or if I needed to, I would speak to the house manager or the overall home manager. They are all around if you need to. The staff are so good here at keeping you informed that there is really no need to complain". Another relative told us, "One day I came in and mum had no socks on. I spoke to the manager on duty at the time. She listened, wrote it down and it's never been an issue since. I have found that small issues are dealt with straight away". Information about how to make a complaint was displayed at the service. The complaints policy set out how a complaint would be investigated and the timescales for response. All complaints had been taken investigated and a record kept detailing all actions and progress of the complaint investigation.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider was looking at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. An example of this was that one person preferred to communicate by writing things down and so were provided with pen and paper to do so.

The provider understood the importance of consulting people and their family members about a person's end of life wishes. Advance care plans (ACP) set out people's future decisions and choices about where and how they would like to spend their time at the end of their lives. Where people had an ACP in place and were nearing the end of their lives, these plans were being followed in accordance with people's wishes. Liaison and training took place with the local hospice to ensure that people received a pain free and comfortable death.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 6 and 7 November 2017, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems in place for assessing, monitoring and improving the service were not robust. Also, people's care and treatment records were not always accurate or accessible.

At this inspection on 10 and 11 January 2018, we found that although quality monitoring systems had been strengthened there remained shortfalls in the management of medicines. Improvements had been made to record keeping ensuring people received the care they required.

The provider had introduced a structured programme of audits and checks to monitor the quality of service delivery. A member of the management team walked around each unit twice a day to test out people's care experience. Daily, weekly and monthly meetings took place to monitor what was happening in each unit to gain a strategic oversight of the service. Quality and compliance audits were also carried out by the area director and any shortfalls identified, developed into a service improvement plan. Daily and monthly checks were carried out on the administration and recording of medicines. When shortfalls had been found, staff had received additional supervision and guidance. However, there remained shortfalls in medicines administration which meant that it could not be assured that people received their medicines as prescribed.

People and relatives said told us they found the management team approachable and helpful. One person said, "The registered manager is quite a nice woman. She comes around and sometimes sits and has a chat. She always asks if everything is okay". Another person commented, "The unit manager is very good. Very hands on and always willing to help out if short-staffed". The registered manager understood their roles and responsibilities and when to notify the Care Quality Commission of important events that took place in the service. The registered manager had got to know a large proportion of people who lived at the service and developed positive relationships with them. The management team and staff were clear about the aims and values of the service and how to put these into practice. There had been several changes at the service as the provider, who had been responsible for the service for just over a year, had embedded new ways of working and report writing. Although this had been unsettling for staff, the overwhelming majority were happy and proud to work for the organisation and said they worked well as a team. One staff member had received the providers 'Kindness in Care' award. This is awarded to staff who go above and beyond what is expected. This staff member was nominated by a relative because of their compassion.

A range of meetings were held to aid communication in the service and ensure people's needs were being met. These included short daily meetings with nursing, care, housekeeping, catering and maintenance staff to discuss any issues. This gave the registered manager an overview of the service and enabled them to monitor the progress of any actions taken. Clinical meetings were held with the clinical lead and nursing staff to share best practice and develop learning. Staff meetings were held in each unit and in key areas such as health and safety.

Overall people were satisfied with the level of care they received and said they would recommend the service to others. Comments from people and relatives included, "I am happy here"; "I was able to bring bits and pieces from my own home. It is always warm, plenty of food, very comfortable and someone does the cleaning for me"; "There are people to chat to here. I like a chat. I would recommend this place to anyone"; "He settled in so well. Staff are very caring. There is big enough space for him to wander around and no restrictions"; and, "Staff are brilliant and very welcoming. They are more like friends now. A very relaxed atmosphere. As a relative I can turn up at any time to visit. This is mum's home".

People and their relatives said that they had the opportunity to make their views know about the service through chatting with staff, relative and resident's meetings and surveys. One person commented, "I am quite happy here. It's well run so I don't feel the need to attend the relative and resident's meeting". Another person said, "I go to the meetings. They always ask what we think of the home and ask for suggestions for activities and meals". In May 2018, ten people had taken part in a short survey and reported that although staff were king and caring, there was dissatisfaction with the food provided. Because of the survey, changes had been made to meals. One person had fed back to the service, "Very pleased with the changes seen since being taken over by HC-One. Presentation of food improved". The provider had a programme of surveys for staff, people and relatives that had begun to be rolled out.

The provider worked in partnership with other agencies to enable people to receive 'joined-up' care. This included working with commissioners and health and social care professionals. The service was part of the NHS 'red bag' scheme. This helps people in care homes who are being admitted to hospital be discharged quicker. The bags, which contain key paperwork, medication and personal items like glasses, slippers and dentures, are handed to ambulance crews by care staff and travel with people to hospital where they are then handed to the doctor.

The provider understood their responsibility in displaying their CQC inspection report rating at the service when a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The administration and recording of medicines did not always ensure people were given their medicines as directed by their doctor.