Drumconner Limited

Drumconner Lancing

Inspection report

13-21 Brighton Road, Lancing, West Sussex
BN15 8RJ
Tel: 01903 753516
Website: www.drumconner.co.uk

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Ratings

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

Overall summary

The inspection took place on the 18 November 2015 and was unannounced.

Drumconner Nursing Home provides nursing support for older people, some of whom have physical disabilities as well as other conditions such as diabetes and dementia. The service has been established for over 35 years and can accommodate up to 57 people. On the day of our inspection there were 46 people living at the home. The home is a large property situated on the south coast.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was not available on the day of our inspection. The service had a manager who was responsible for the day to day running of the home, they had been in post since July 2015.

Consent was gained before supporting people with any tasks, staff were observed asking people if they needed support and how they wanted to be assisted. People were happy with the support provided, one person told us "It's marvellous and the staff are wonderful, they do anything for you." For people who lacked capacity the

Summary of findings

home had followed correct practice by undertaking mental capacity assessments and had made applications for the deprivation of liberty safeguards. However they had failed to notify the CQC about the authorisations for the deprivation of liberty safeguards, this is required to ensure that CQC have oversight and can assess that appropriate action has been taken. This is an area of concern.

People at risk of developing pressure ulcers had been assessed and plans put in place to either liaise with relevant external professionals or treat the pressure ulcer by providing nursing care at the home. However there was insufficient monitoring and recording of pressure area care for people who had pressure ulcers or were at risk of developing them. Staff were not recording information in care records to state when dressings had been changed or when people had been supported to reposition to reduce the effects of pressure.

The lack of effective records to ensure that staff were aware of each other's actions and people's condition monitored for improvements or deterioration was an area of concern.

People were happy with the choice and quality of food. One person told us "It's rather nice, we are fed well and they help if you need it." People had their nutritional needs met, however for people at risk of malnutrition there were insufficient systems to record a person's hydration and nutritional intake on a daily basis and therefore there was a lack of oversight of what people were consuming.

Peoples health needs were assessed and relevant health professionals were involved to ensure that people's health needs were met. However for people who had long-term health needs such as diabetes there was a lack of monitoring and planning around how to manage the condition.

People were supported by trained nurses and care staff who had received basic, mandatory training and who had achieved or were working towards Diplomas in Health and Social Care. However staff had not received training to meet people's specialist needs such as diabetes, dementia or wound care. Therefore people's health and well-being could have been compromised as staff had not been given the relevant skills or knowledge to recognise changes in people's conditions in relation to certain health conditions. This is an area that needs to be improved.

People were able to be take part in activities, however felt that these didn't always meet their needs and interests. Within a person's responses to a questionnaire they said "It is very difficult to provide such a wide range of activities to meet everyone's preferences, perhaps we could have more puzzles, quizzes or listening to music."

Person-centred plans were in place to ensure that each person received care and support that was specific to them. People were able to continue to live in a way that they chose and their likes and interests were taken into consideration when supporting them. People's needs were documented in individual care plans, these had been reviewed by nursing staff to ensure that they were current and up to date. However people were not involved in the reviewing of care plans.

We have made a recommendation regarding the involvement of people in the care planning process.

People and staff were complementary about the management and feedback had been gained through the use of annual questionnaires. The quality of the service was monitored by the manager to ensure that it was effective and meeting people's needs. Regular audits had taken place and actions taken in response when improvements were needed. However these audits had failed to identify the shortfalls in record keeping. This is an area that needs improvement.

People felt safe living at the home and were cared for by sufficient numbers of staff, both nursing and care staff had undergone appropriate checks to ensure that they were safe to work within the health and social care industry. Staff were aware of what actions they needed to take if there were concerns over a person's safety and had received training in relation to safeguarding adults at risk. Staff received regular observed supervisions where nursing staff and managers observed their practice to identify areas of improvement. There were also annual appraisals for staff to help identify training and development needs.

People were able to take measured risks to ensure that their freedoms were not restricted and their independence maintained. Some people had kettles and

Summary of findings

fridges in their rooms so that they could have access to drinks and snacks when needed. People's physical needs were met as they had access to appropriate equipment to ensure that they could mobilise independently throughout the home. One person had a mobility scooter so that they could continue to access the local shops. Risk in relation to infection was minimised as the home was clean and tidy and had safe systems in place to ensure that infection control was maintained.

People said that they received their medicines on time and were offered pain relief if they were experiencing discomfort. Nursing staff dispensed and administered medication and there were safe systems in place for its storage and disposal.

People were cared for by kind and compassionate staff. People told us that their dignity and privacy were respected at all times and staff were observed knocking on people's doors before entering to ensure that their privacy was maintained. People were involved in the running of the home, there were regular meetings so that people were able to make their views known, records showed that these had been listened to and action taken as a result. Staff adapted their communication to meet people's needs, one relative told us "The staff are very kind and caring my relative cannot wear hearing aids because they caused ear infections, however staff make sure they talk in their good ear so they can hear."

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

The home was clean, systems were in place to reduce the spread of infection. Risks were assessed and the premises was safe and well maintained.

People received their medicines on time, these were dispensed by trained nurses and there were safe systems in place for the storing and disposal of medicines.

Is the service effective?

Requires improvement

The service was not consistently effective.

Staff had received basic, mandatory training, however some staff had not received training to meet people's specialist needs, therefore there was the potential that some staff lacked the knowledge and skills to be able to care and support people with certain conditions effectively.

People's nutritional needs were met and they were happy with the food provided. People had access to health professionals to meet their health needs. People's right to make decisions was respected and consent was gained before offering support to them. For people who lacked capacity appropriate measures had been taken to ensure that decisions made on their behalf were in accordance with legislative requirements.

People's physical needs were met, the home was undergoing refurbishment to provide adaptations to the environment to meet people's needs. People were assessed and provided with appropriate equipment to meet their physical and mobility needs.

Is the service caring?

Good

The service was caring.

People were support by staff who were compassionate and kind.

People were involved in decisions that effected their lives and care and support needs.

People's privacy and dignity was maintained and their independence was promoted.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Summary of findings

The service was responsive to people's needs and wishes. Individual care plans provided staff with information about people's preferences, their health and medical needs. However people were not always involved in the development or reviewing of their care plans.

People had access to a range of activities, however felt that these didn't meet their needs.

There was a system in place to manage comments and complaints. People felt able to raise concerns and make a complaint and felt confident that they would be listened to.

Is the service well-led?

Requires improvement 

The service was not consistently well-led.

Records were not always completed to ensure that people's health was monitored effectively and information about people's conditions shared with staff. Quality monitoring audits were carried out in the home but didn't highlight the shortfalls in record keeping.

There was a friendly and welcoming atmosphere in the home. People and staff felt that they could approach the management team if they had any concerns or comments and that they would be listened to.

Staff felt well supported by the management team and were positive about the leadership of the home.

Drumconner Lancing

Detailed findings

Background to this inspection

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

The inspection took place on the 18 November 2015 and was unannounced.

The inspection team consisted of two inspectors 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.

On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection we checked the information that we held about the service and the service provider. We used this information to decide which areas to focus on during our inspection. During our inspection we spoke with seven people, seven relatives and visitors, eight members of staff and the manager, the registered manager was not available on the day of the inspection.

We reviewed a range of records about people's care and how the service was managed. These included the care records for seven people, medicine administration record (MAR) sheets, three staff training and support and employment records, quality assurance audits, incident reports and records relating to the management of the service. We observed care and support in the communal lounges and dining areas during the day. We spoke with seven people. We also spent time observing the lunchtime experience people had and a member of staff administering medicines.

The service was last inspected in April 2014 and no concerns were identified.

Good

Is the service safe?

Our findings

People told us that the home was a safe and secure place to live. One person who was staying at the home for a short time told us "I wish I could stay here forever, I have never felt so safe."

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing staff's suitability to work in the health and social care sector had been checked, identity and security checks had been completed and their employment history gained. Documentation confirmed that nurses employed all had current registrations with the Nursing and Midwifery Council (NMC). People we spoke with told us they felt safe in the home, one person told us, "I am happy, safe and I'm looked after well." Relatives did not have any concerns about their relative's safety. One relative told us "You can tell it's safe by comparison, my relative had to spend a night in hospital, they desperately wanted to get back to their home in Drumconner, they feel safe and secure here."

There were sufficient staff to ensure that people were safe and cared for. Staff we spoke with told us they thought there was sufficient staff on duty to meet the people's assessed needs. One staff member told us, "There is enough staff and the manager helps out if needed." Another member of staff told us "We have enough staff and I do extra shifts if needed." People we spoke with told us there were enough staff to meet their needs. One person told us, "There is always someone about, no –one needs to feel nervous." People's individual care plans showed that a dependency tool had been used to identify their needs and the amount of support required. The manager confirmed that this was used to inform the staffing levels and told us that these were increased if people were unwell or needed additional support, for example if they were at the end of their life.

Staff we spoke with had an understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures, these were accessible to staff and they were aware of how to raise concerns regarding people's safety and well-being.

Positive risk taking enables people to live their lives how they want to and promotes their rights and freedoms.

People were supported to undertake positive risks, we observed people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. A visitor told us about their friend who, after risks had been assessed and suitable equipment obtained, was able to independently access the shops in the local community. Risk assessments recognised people's physical and psychological needs as well as environmental hazards and were reviewed regularly. They took into consideration the perceived extent of the risk, the likelihood of the risk occurring and the measures in place to minimise the risk, as well as the number of staff needed and equipment required to assist the person. For example, one person had been assessed as being at a high risk of developing pressure ulcers due to their medical condition, this person's psychological needs had also been taken into consideration as they were refusing to mobilise and therefore this had increased their risk of developing a pressure ulcer. Appropriate equipment such as an air mattress had been provided and referrals to relevant health professionals had taken place to ensure that the risk was reduced and the person's health and welfare maintained.

Suitable measures had been taken to ensure that people were safe but their freedom was not restricted, unless the person lacked capacity to make decisions about their safety. One visitor told us "I know risk assessments take place and are taken seriously, when the person I visit first arrived at the home, they began walking around at night, the staff acted immediately to ensure their safety and they were asked if they'd be happy to move to a room nearer to the nurses so that they could be observed for their safety."

People had access to call bells in their rooms, these were on people's walls and were also available as pendants that people could wear so that they could call for assistance wherever they were in the building. One person told us "If we want help during the night we have a buzzer and they come straight away." Records of call bell timings confirmed that call bells were answered promptly. Accidents and incidents that had occurred were recorded and action had been taken to reduce the risk of the accident occurring again. For example, risk assessments and care plans had been updated to reflect changes in people's needs or support requirements.

People were assisted to have their medication by trained nurses, this was in accordance with the home's medication policy which stated that only registered nurses were able to

Good

Is the service safe?

dispense and administer medication. A copy of the National Institute for Health and Care Excellence (NICE) guidelines had been stored in each medicine folder for staff to access if needed, this informed them of the guidance that needed to be followed to ensure safe medicine administration. People's consent was gained and they were supported to take their medicine in their preferred way, for example one person liked the nurse to assist them to take the tablet out of the medicine pot and assist them to put it towards their mouth, whilst other people preferred to be more independent when taking their medicine. Safe procedures were followed when medicines were being dispensed. So as not to be interrupted the nurse responsible for dispensing and administering the medicines wore a red tabard, this made everyone aware that they weren't to be disturbed, therefore minimising the risk of any medication errors occurring.

People were asked if they were experiencing any pain and were offered pain relief if required, this complied with the home's policy for the administration of 'as and when' required medicines. Medicine records showed that each person had a medicine administration record (MAR) sheet which contained information on their medicines as well as any known allergies, these had been completed correctly and confirmed that medicines were administered appropriately and on time. Medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. People confirmed they received their medicines and that they had these on time, one person told us "I have a condition and they give me medicine for the pain or other medicine if I am unwell."

People were protected by the prevention and control of infection. Staff had undertaken infection control training and there was an infection control lead responsible for providing updates to staff regarding infection control. There were safe systems in place to ensure that the environment was kept hygienically clean, cleaning rotas showed that regular cleaning was undertaken and staff were informed of what colour cloths and mops to use for each environment to minimise the risk of cross contamination. Staff were observed undertaking safe infection control practices, they wore protective clothing and equipment and disposed of waste in appropriate clinical waste receptacles.

Requires improvement

Is the service effective?

Our findings

People told us that they enjoyed the food, one person told us "The cook is excellent and the food is fantastic." People felt that the staff were skilled and experienced. One visitor told us "There is a good feeling of professionalism amongst the care staff." Another person told us "Basic training is very good." However despite these positive comments we found areas of practice that need to improve.

Staff were regularly observed undertaking tasks to ensure that their practice was competent, if there were areas of concern these had been discussed and addressed and another observation had taken place to ensure that their practice had improved. Annual appraisals took place to enable people to identify further development needs. Most staff had either completed Diplomas in Health and Social Care or were working towards them. Staff said that they were adequately supported. One member of staff told us "I like working here, I feel really supported, and the manager is always popping in."

Staff had undertaken induction training upon commencing employment, records showed that mandatory training for care staff was up to date and covered topics such as manual handling and infection control. Measures had been taken by the manager to ensure that staff were provided with information that could improve their knowledge and awareness, these included folders of various articles and information sheets about various conditions that staff could access and read, there were also links with local hospices to share best practice. The manager explained that to increase staff attendance at training courses she had asked the staff for their feedback in relation to this. Staff had told her that they found that frequent, shorter training days were not effective as they often found it difficult to attend. The manager had taken this into consideration and had changed the way that training was delivered, this is now two full days of training so that as many staff as possible can attend and complete all of their mandatory training.

However, training to meet people's specialist needs had not always been provided. Staff we spoke with did not have training in diabetes, dementia, malnutrition and dehydration, wound and pressure area care, challenging behaviour, mental capacity and deprivation of liberty, records also confirmed this. This meant that there was the potential that staff hadn't been provided with the necessary skills to be able to meet the needs of the people they were providing care and support to or recognise any changing needs in relation to their condition. This is an area of practice that is in need of improvement.

People's skin integrity and their risk of developing pressure ulcers were assessed using a Waterlow Scoring Tool and a Malnutrition Universal Screening Tool (MUST), this took into consideration the person's build, their weight, skin type and areas of risk, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure ulcers. Care plans for these people showed that referrals had been made and measures had been taken to liaise with relevant professionals such as GPs and tissue viability nurses. For those people who had pressure ulcers wound assessment charts had been completed providing details of the wound and the treatment plan recommended, photographs of wounds had been taken to monitor their improvement or deterioration. For one person these photographs showed a significant improvement in the condition of their skin due to the treatment and wound management carried out by staff.

There were mechanisms in place to ensure that people at risk of developing pressure ulcers and those with physical disabilities had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses. People had been assessed to determine the type of cushions and mattress that was appropriate as well as the setting that the mattress was required to be. Records showed that daily checks to ensure that settings for mattresses were correct had been carried out and were further confirmed by our observations.

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, these people were weighed each month, unless they refused, to ensure that they were not losing any more weight. Records showed that referrals to health professionals had been made for people who were at risk of malnutrition, these included referrals to the GP, dietitians and nutritionists. Advice and guidance provided by the professionals had been followed, for example for one person who was at risk of malnutrition the nutritionist had advised that the person's food be fortified with products such as cream and cheese, records of the menu confirmed that meals had been fortified. Within the person's care plan was a letter

Requires improvement

Is the service effective?

from the nutritionist to the person's GP outlining all the positive work the home had implemented such as fortifying meals, offering snacks throughout the day and supplementing the person's diet with nutritional supplements, all of which had been refused by the person.

Communication for people who had communication difficulties was good, links with external professionals such as speech and language therapists had taken place. One relative told us "My mother is treated with care and compassion and staff understand her needs. She can understand them but cannot respond." Measures had been taken to enable people to communicate despite communication difficulties, for example for one person who had had a stroke a booklet had been provided that contained pictures to assist her to communicate with people. Staff adapted their approach to meet people's differing communication needs, they were observed speaking in a soft, quiet voice to a person who was unwell and then communicating with banter and jokes to a person who appeared to really enjoy this type of interaction.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the home was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. This related to two people who were unable to leave the home on their own due to risks to their safety and well-being. The manager fully understood the requirements of this legislation and had acted in accordance with it, therefore ensuring that people were not deprived of their liberty illegally.

Restrictive practice in regards to the use of bed rails had been discussed with people, risk assessments to ensure that the least restrictive practice had been taken and people had given consent for their use. The manager explained that if people were unable to give their consent then this would be discussed with their power of attorney or a deprivation of liberty safeguard application made. Staff had not received formal training in relation to mental capacity and deprivation of liberty safeguards, instead the manager had provided information to them informing them about it and the changes that had occurred since April 2015. We observed staff gaining people's consent before supporting them, asking them if they'd like their medicine or if they needed support to access the toilet facilities. Formal consent was also gained in people's care plans, these showed that people had been asked to give their consent to the use of lap belts for wheelchairs.

People told us that they were happy with the food and that they were offered lots of choice. We observed that the chef asked people what they wanted to eat before each meal, the chef told us "People living here can have whatever they want." People were able to confirm this as they told us "The meals are very nice and there's always a choice. I'm a very fussy eater and they always make something for me." Another person told us "The food is good. I'm not fussy but if you don't like it they will bring you something else, if I want my porridge in the evening instead of the morning they will do it for me."

People could choose where they ate their meals, some people chose to eat in the main dining room whilst others preferred to stay in their rooms. People confirmed this and one person told us "I like to stay in my room so they bring meals to me." The dining room was arranged so as to create a social environment, people were able to sit with their friends and we observed people engaging in conversations with one another over their lunch. Food was presented nicely and people were asked if they'd like condiments to season and flavour their food. There was a choice of drinks for people, some chose to have soft drinks whilst others were observed enjoying a glass of wine with their meal. The menu sheet included information relating to the size of meals people preferred as well as their dietary requirements to ensure that their health needs were addressed. For example, soft, pureed, thickened or fortified diets. We observed people being suported to eat pureed food, this was presented nicely and staff showed patience and supported people in a calm and dignified manner. Staff informed people of what was on each spoonful and ensured that people were supported at an appropriate pace.

Requires improvement

Is the service effective?

People had access to health care professionals, people told us that they were supported to make and attend external hospital appointments if needed but could also do this independently if they were able to and that they had access to GPs who visited the home regularly. One person told us that they had an eye condition that required annual checks, they explained that an optician visited the home once a year to undertake the required checks on their eye. Records showed that referrals had been made in a timely manner to ensure that people had access to relevant health professionals, these included referrals to Occupational Therapists, Tissue Viability Nurses, Speech and Language Therapists and Diabetic teams. This demonstrated that the provider was aware of the importance of making referrals and ensuring that people had access to the appropriate professional to meet their health needs.

People's physical needs had been taken into consideration. Most rooms were large, with en-suite facilities, they were on one level to ensure people with mobility needs could navigate their rooms safely and easily and had overhead hoists so that if people needed support to transfer from their bed to their wheelchair they could be supported in a safe way and with minimal discomfort. The home was in the process of refurbishing rooms to ensure that they all offered the same specification. Ramps and handrails were in place to enable people to access the garden safely and people told us that they enjoyed using the garden in warmer weather.

Good

Is the service caring?

Our findings

People felt that they were well cared for, one person told us "It's not bad at all, I am looked after very well." A relative who was visiting a person in the home told us "I am very happy with the care and all the staff are lovely."

People were treated with kindness and compassion. It was apparent that staff knew people well, they took time to talk and listen to people about their feelings and concerns and staff confirmed that the most effective way to get to know someone was to sit and talk with them. There was a friendly, relaxed and sociable atmosphere in the home, staff and people were observed having fun together, sharing jokes and interactions. One person confirmed this and told us "They all like me and I like them." Another person told us "They never force you to do anything. It's a lovely place and the staff have a joke." Staff adapted their approach and communication according to people's needs, for example showing sensitivity and compassion to a person who was feeling unwell. Staff enabled the person to explain how they were feeling and offered appropriate support to them to make them feel more comfortable and relaxed.

We observed interactions between people over lunch, staff told us that people were able to choose where they sat and were encouraged to sit with others so that they could enjoy conversations with one another. One person confirmed this as they told us "I like to come in here and have a chat rather than sitting on my own in the room." People were observed showing compassion for one another's well-being, asking how each other was feeling that day and if they were okay.

Maintaining relationships with family and friends outside of the home was seen as a priority and this was encouraged, people's visitors and relatives could visit them whenever they chose to. Visitors and relatives had also been encouraged to take part and be included in events at the home. One person told us "I come every week and it's very pleasant. I am made to feel welcome and it's a homely atmosphere." Another person told us "We have a party tea on special occasions and families can visit anytime." Relatives and visitors were able to share and enjoy meals with people, one person told us "I can share fish and chips and a can of beer every Friday evening with my husband and enjoy lunch with him on a Sunday, I can also spend Christmas day here with him."

Independence was encouraged within the home, people's differences were acknowledged and respected and efforts to ensure people were treated equally had been taken. People had access to various pieces of equipment and aids that enabled them to be independent and support themselves, for example mobility aids and adapted equipment were provided so that people could mobilise and eat and drink independently. One person had a telephone in their room and was able to arrange their social life and visitors. When we asked the manager about the importance of promoting and maintaining people's independence, they told us, "If someone has been doing something for years, who are we to say they can't do it, we try to keep their lifestyle the same as it was when they lived in their own home."

People were treated with dignity and respect and their privacy was maintained. When staff offered support to a person to go to the toilet, they asked them discreetly, the person didn't hear and so the member of staff remained patient and repeated themselves to ensure the person understood. People had been asked if they preferred female or male care staff when they first moved into the home, when we asked people about how their preferences had been taken into consideration when receiving support from staff they were able to confirm that these had been respected, informing us that they could choose if they were supported by a male or female member of staff and that staff knocked on their doors and waited for a reply before entering.

Personal information about the person's care and support needs was kept confidential, records were stored in lockable cupboards and therefore their privacy maintained. A handover meeting took place so that staff who had worked the morning shift could hand over relevant information about each person to staff coming on duty, this was conducted in a private room with the door closed to ensure that other people couldn't overhear and therefore people's privacy and confidentiality maintained. Discussions during the handover meeting also demonstrated staffs approach to treating people with dignity and showing respect.

An advocate had recently been employed for people and staff, the manager explained that they could offer support with any concerns that people or staff had. People and their relatives had been informed of this person's role as

Good

Is the service caring?

they had been sent a letter advising them of this. The manager also explained that any member of staff would be able to support a person if the person felt more comfortable talking to them.

People were able to stay at the home until the end of their life, the manager explained to us that people's nursing needs outweighed their psychological needs and they would be able to stay at the home to ensure that their nursing and care and support needs were met. Registered nurses had received training and development in relation to end of life care and were encouraged to share their knowledge with other staff so that they were aware of how to care and support someone at the end of their life in the best way. Advanced care plans were put in place for people nearing the end of their lives so that staff knew their wishes and could support them in accordance with these. There were plans in place to build a relative's room that people could use to spend time in or stay the night if they wanted to be near to someone when they were at the end of their life. The manager told us "The room will provide relatives and friends with a place to go to relax, make drinks, have a shower etc, we obviously care for them when they come and visit now but this will create a space for them to provide them with more privacy."

Requires improvement

Is the service responsive?

Our findings

People were positive about living at the home, one person told us "We are very fortunate to be here when you compare it with other places, they are so kind and helpful." Another person told us "We can go to bed or get up whenever we want." The home's statement of purpose states that they run the home for the benefit of the people as it is their home, and that they ensure that the resources, activities and services are person-led. However despite this statement and people's positive comments, we found areas of practice that need to improve.

The National Institute for Care and Health Excellence (NICE) recommends that older people should be encouraged to construct daily routines to help improve or maintain their mental well-being. Social needs were addressed through the implementation of various activities. These included keep fit, what's going on in the world, bingo, gardening, games, art and craft and a shop that people could visit to purchase items of their choosing. Responses from the relative's survey were positive about the activities. One relative said "The activities co-ordinator has an amazing talent with the people and the weekly programme of entertainment is well constructed and takes into account people's wishes."

However despite the relative's positive comments there was a mixed reaction to the activities from people who lived in the home. One person told us "There is not much activity and no trips out." Another said that the arts and crafts was "too childlike" and told us "That is why you see people falling asleep watching TV in the lounge." Staff confirmed that although staffing levels were sufficient to meet people's physical and health needs, that staffing levels did not allow them to support people to go out regularly and that this was sometimes the responsibility of family and friends and that people who did not have this social network would sometimes be unable to be supported to go out. There was a minibus that could be used, however people explained that this was mainly used to assist them to health appointments. People felt that there was a lack of activities to meet their individual needs. This is an area that needs to be improved upon.

On admission to the home each person had their health, medical and social needs assessed, individual care plans were devised to meet people's needs. Each care plan was specific to the needs of that person and was person centred. It contained information about the person's likes and dislikes, their interests and hobbies as well as their past employment history. One person who used to work in the classical music industry was supported to listen to classical music and also enjoyed attending an external music group, they were able to tell us how much they enjoyed this. Another person used to be a fisherman, this person had been able to have a sea view room as this was important to them and was offered fresh fish as this was something that they enjoyed eating. Another person used to be a long distance lorry driver at night, this meant that the person was used to sleeping during the day, measures had been taken to enable this person to continue with this lifestyle to a certain degree and meals or snacks were offered to him during the night.

The Social Care Institute for Excellence (SCIE) states that involving people in decisions about their care is essential and should be evident in every single care plan. It states that research on well-being demonstrates that involvement leads to improved service outcomes and enhances people's well-being, that people who use services, and their relatives are experts by experience and their knowledge and ideas can provide a fresh perspective on how their care and support needs can be met. Reviews of the care plan had taken place, registered nurses were allocated a number of people to oversee and would review their care plans each month. People were unsure if they were involved in the planning or reviewing of care and there was no evidence in the care plans to show how people had been involved. Relatives had some involvement in the review process as they confirmed they were shown a copy of the care plan after the review and the manager explained to us that meetings had been arranged in the past between staff, people and their relatives if they had ever raised any concerns following a review.

We recommend that the provider seeks advice and guidance in relation to involving people in the review of their care plans.

People were encouraged to be as independent as possible. Dependent on people's needs and abilities people were able to have kettles and fridges in their rooms so that they could make drinks and have access to snacks. One person who had recently moved into the home, missed going to

Requires improvement

Is the service responsive?

the local shops and to see their friends. A friend of the person told us "The home has supported the person to purchase a mobility scooter so that they can still access the shops independently."

People were treated as individuals, they were able to choose how they spent their time, what clothes they wore and how to decorate their rooms. People were also able to continue to live the lifestyle they had before they moved into the home. For example, one person always used to enjoy a glass of whiskey at a certain time of day, we were able to see that this person was offered a glass of whiskey at the preferred time and a relative who was visiting the person told us "Staff are very good they know they (person) likes their drink at this time and they never forget however busy they are."

People felt comfortable and at ease discussing issues and care needs with the staff and managers. Comments from people who used the service and relatives we spoke with included, "I wouldn't change anything," and "I couldn't wish for anything better". There was a complaints policy, this was clearly displayed for people to see and we found that complaints had been handled appropriately and within the time frame set out in the policy. Action in response to the complaint had been taken and these were used to improve practice and drive improvement.

Requires improvement

Is the service well-led?

Our findings

People were positive about the leadership in the home. One person told us, "It's wonderful in here, I wish I'd come in sooner." They told us they knew the manager well and they were responsive to any requests. One person said, "You want anything you ask the manager and they go and get it for you." There were variable responses from relatives regarding the management of the home, however most feedback was positive. Despite peoples positive comments we found areas of practice that required improvement.

Part of a registered persons responsibilities under their registration with the Care Quality Commission is to have regard, read and consider guidance that is provided in relation to the regulated activities that they provide, as it will assist them to understand what they need to do to meet the regulations. One of these regulations relates to the registered manager's responsibility to notify CQC of certain events or information. The registered manager had followed correct practice by ensuring that people who lived at the service had their capacity assessed in accordance with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However providers are required to inform CQC of these assessments and applications, to help ensure that we have oversight of these and can assess if appropriate action has been taken, this had not happened. When we raised this with the registered manager she was unaware that she needed to notify us of these.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Accurate records were not always being maintained in order to help ensure that people's needs were being addressed. Guidance produced by the National Institute for Health and Care Excellence (NICE) recommends that people, who have been assessed as being at risk of developing pressure ulcers, should be encouraged to change their position regularly and at least every four - six hours. It states that if people are unable to reposition themselves then assistance should be provided and this should be documented. For some people who had reduced mobility, were at an increased risk of developing pressure ulcers and spent most of their time in bed there were some records that documented the frequency that they had been assisted to reposition. However there was a lack of consistency in these records, for example some had not been completed and for one person who was assessed as needing to be repositioned every two hours their records had not been completed for five days, despite them receiving continued treatment for pressure ulcers. This meant that staff were not provided with accurate information about the care people had received in relation to repositioning and that there was a potential risk that people were not supported to reposition frequently enough or to be positioned correctly to reduce their risk of developing pressure ulcers.

Other records showed that staff had signed the records but had not recorded sufficient information informing other staff of how the person was repositioned so that this could be alternated each time to relieve pressure. When we asked a registered nurse about the use of repositioning record charts they told us that these are only used if they are recommended by an external health professional, if a person has a pressure ulcer or if they are at the end of their life. However most people who spent a majority of their time in bed and were at risk of developing pressure ulcers did not have repositioning record charts, this could potentially mean that people were not being repositioned frequently enough and therefore were more at risk of developing pressure ulcers or their pressure ulcers worsening, this was not in accordance the guidance produced by NICE in relation to pressure area care.

One person had a pressure ulcer, they had a wound assessment chart that identified that they needed their dressing changed twice each week, however we were unable to find any information in records that showed that this had taken place and therefore there was insufficient information recorded and available for staff to know if the person's dressings had been changed.

For people at risk of malnutrition food and fluid record charts can provide essential information that forms the basis of a nutritional assessment and helps determine subsequent treatment plans. There was an inconsistency in the use of fluid or food charts for the people that were at risk of malnutrition, some people did not have food and fluid charts, whereas other people had these in place but they were not completed correctly. Therefore for those that were losing weight there was no monitoring or oversight of what a person was eating or drinking on a daily basis. Nutrition and hydration intake should be monitored and recorded to prevent unnecessary dehydration or weight loss.

Requires improvement

Is the service well-led?

Diabetes UK states that a key requirement for effective diabetes care is a documented individualised care plan for each person and recommends that all people with Diabetes should have a diabetic care plan to assist them to manage their condition, that this should be written and contain information about the key roles and responsibilities, targets and outcome measures, annual review procedures and arrangements for specialist reviews. There were nine people who had diabetes in the home, however not all people had a diabetic care plan. Due to a lack of care planning for people's condition their diabetic needs had not been adequately assessed or monitored and there was not a formal plan in regards to the delivery of their care for their condition.

There were insufficient records to monitor and record the actions of staff and the progress or deterioration of people's health needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a mission statement that stated that the provider's aim was to enable people to live as fully as possible with skilled care in an environment that fosters dignity, self-respect, independence, comfort and security. People and our observations confirmed that they had experienced this and one visitor told us "It's very pleasant with a homely atmosphere. Book me in when it's my turn." Staff spoke highly of the manager and the rest of the management team, they told us there was an open and inclusive atmosphere in the home, that the management were supportive and approachable and they were able to speak freely and make suggestions and felt that their ideas were listened to.

We observed the manager supporting people and directing staff where needed if a task needed completing. One member of staff told us "I would not be here if I felt people were not well looked after, it's lovely here, if it wasn't I would leave." Another member of staff told us "It's a good team, we're like a family, and the team work well together." A visitor told us "There is a good chain of command. All very efficient and approachable." The manager told us "The home puts the person at the centre, this stems from the approach from the owner and is filtered down amongst other staff." They went on to tell us that the owner was very involved in the running of the home and really cared about the people living in it and the experience that they had.

There were good links with the local community and partnership working with other organisations. Records showed that there were links with local hospices for staff to attend training and development to improve their knowledge and skills and share practice. There were close links with the hospital avoidance manager and liaised with them regularly to ensure that the staff were providing suitable and effective care to minimise the chances of people being admitted to hospital. People's care plans demonstrated that partnership working ensured that people had access to the relevant specialists when needed and that staff were pro-active in ensuring that referrals to them were made promptly to ensure that the correct treatment was provided in a timely manner.

People were involved in the running of the home. There were regular meetings for people to be kept informed of what was happening in the home, it also provided an opportunity for people to share their views and opinions, minutes of the meetings showed that people felt that the activities offered needed to be improved, as a result new activities had been implemented. People and their relatives were asked to complete annual questionnaires to seek their opinion on various aspects of the home and of the support provided. Feedback from both was positive, one person said "Staff are helpful and polite, cheerful and caring." Another person said "Everything has been done to make the changes from moving from my home to here as easy as possible, the staff are so friendly." People and their relatives were kept informed about the home as there was a regular newsletter produced informing people of events that had taken place as well as forthcoming events that they might like to attend.

Regular audits of the quality and safety of the service were carried out by the manager. Action plans were developed where needed to address any issues identified during the audits. One audit identified that improvements were required to the storing of controlled drugs and more room was required for staff to be able to undertake audits of the controlled drugs. As a result a new medicines cabinet was ordered and a new medication room provided to ensure that medicines were stored appropriately and staff had adequate space to work safely. However these audits had not identified the shortfalls in effective record keeping and appropriate action hadn't been taken to ensure that there were sufficient records in place. This is an area that needs to be improved upon.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014. Good governance **Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.** **The registered person had not ensured that accurate, complete and contemporaneous records were kept for each service user, to include a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents Regulation 18 Care Quality Commission (Registration) Regulations 2009 Notification of other incidents. **Regulation 18 (4A) (a) (b) (4B) (a) (b) of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.** **The registered persons had not notified the commission of any application or authorisations made in relation to depriving a service user of their liberty.**