Trustees of Honeywood House

Honeywood House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
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?	Good

Overall summary

Honeywood House Nursing home is a care home situated outside the village of Rowhook. The home is a large converted and adapted 18th century mansion house standing in 10 acres of park and woodland. It offers personal and nursing care to 25 older people, some of whom live with dementia. There is level access throughout with a shaft lift to the first floor.

The service has 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. In this service the registered manager is also the registered person.

We carried out an unannounced comprehensive inspection of Honeywood House Nursing Home on the 26

Summary of findings

August 2015. As part of this inspection we checked what action had been taken to address the breaches of legal requirements we had identified at our last inspection on the 8 and 16 January 2015. Following that inspection we issued warning notices stating the provider must take action in relation to management of people's medicines, the assessment of risk, the planning of person centred care and treatment, and obtaining people's lawful consent to care and treatment by the 2 May 2015. We also identified the provider was not meeting the requirements of the law in relation to staff recruitment, staff supervision, staff training and appraisals and good governance.

After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. At this inspection we found improvements had been made and all the breaches had been addressed. However further improvements are needed to be made in relation to the completion of medicine administration records (MAR).

The provider had taken action to improve the safe management of people's medicines. The arrangements in place for the ordering, storage and administration of people's medicines were safe and people received their medicines when they needed them. However some people's MAR charts contained gaps which meant that it could not be identified whether they had received their medicine as prescribed and intended. Without this information it is difficult for the effectiveness of medicines to be monitored and is an area of practice we assessed as needing to improve.

Improvements had been made to the safety and delivery of care people received and sustained. Risks had been appropriately identified and robustly addressed in relation to people's specific needs. For example assessments of people's risk of falls and developing pressure areas had taken place and strategies were in place to reduce these risks, Staff were aware of people's individual risk assessments and knew how to mitigate the risks.

Following the last inspection improvement had been made and sustained in relation to planning people's care. People and their representatives had been involved in the development of care plans which were person centred and detailed their likes and dislikes and where known, their personal histories.

The provider had made improvements to making sure they gained lawful consent from people for their care and treatment. Mental capacity assessments had been completed in line with legal requirements. Where people lacked the mental capacity to make decisions the management and staff were guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and how to submit one. Deprivations of Liberty Safeguards (DoLS) authorisations were in place and care plans clearly identified if someone was subject to a DoLS. The management team had been working with staff to raise awareness of DoLS and the impact DoLS had on people and this was evident from staff meeting minutes.

Staff recruitment had improved and all the relevant identity and security checks had been completed before staff were deployed to work at the service. Staffing levels had also improved and were based on the individual needs of people. People's level of need and the number of staff required to provide safe, effective and responsive care had been assessed and the relevant number of staff had been deployed. Staff were seen spending individual time with people and responding to call bells and requests for assistance quickly. One person explained that on her "bad days" when she preferred to remain in bed, staff responded to her call bell very quickly.

Staff training had improved. Staff had completed training that was relevant to their roles and which provided them with the skills they needed to meet people's needs. For example staff had completed training in the administration of medicines and supporting people living with dementia. One person told us "They (the staff) certainly seem to know what they are doing; I've no complaints about them what so ever". Staff felt they were well supported had received formal supervision on a regular basis at which they could speak in confidence with their line manager about their personal development or any issues of concern they may have.

Summary of findings

One staff member said "We do have supervision but I don't have to wait for that to ask for training. We can ask for that anytime". They also had an annual appraisal of their performance and the opportunity to complete nationally recognised qualifications in care.

Everyone we met with spoke highly of the delivery of care and of the caring nature of the staff that worked there. One person told us "They are lovely (the staff)." They explained they had never heard staff raising their voices to anyone or with each other and that they always let them do things at their own pace. People felt well looked after and supported by caring staff. We observed friendly relationships had developed between people and staff. One relative told us "We are greeted like family when we come here; it's a real homely place". A staff member said "We're just one big family here". Another explained "I would be happy for my mother to be here". An agency nurse told us "This is the nicest and most caring home I've worked in".

People's dignity and privacy was protected. For example we saw staff knocked on people's doors and waiting for a response before entering their rooms. Doors were shut when staff supported people with personal care and made sure they were appropriately covered when lifting them in a hoist.

Dedicated activities coordinators were in post who were responsible for the oversight of stimulation, interaction and meaningful activities. People could choose how to spend their day and they took part in activities. People told us they enjoyed the activities, which included arts and crafts, exercises and being entertained by singers and musicians.

People had a choice of food at meal times and specialist diets were catered for. People who needed help to eat and drink were supported appropriately. People's weight was monitored and referrals were made for specialist health care support as needed. For example for Speech and Language Therapy and input from GP's.

People had been provided with a guide to the service and were aware of how to raise concerns and complaints and felt able to do so. Relative and resident meetings had been held and people were able to contribute to these meetings and suggestions for how to improve the service had been acted on. For example how improvements could be made to the menu on offer and the activities provided.

People and staff told us the registered manager and management team were approachable, open and transparent. Improvements had been made to the quality assurance systems in place and internal audits the results of which were used to help drive improvements in the service. Accidents and incidents were recorded and the results analysed to identify and emerging themes and patterns, and action had been taken to reduce the risk of re-occurrence.

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?

Requires improvement

The service was not always safe.

People received their medicines safely and medicines were obtained, stored and disposed of appropriately. However improvements were needed to be made in relation to the accurate completion of medicine administration records.

There were sufficient numbers of staff on duty to keep people safe. Staff knew what action to take if they suspected abuse was taking place and the provider had systems in place to respond to concerns raised.

Recruitment systems ensured staff were suitable to work at the service.

Risks to people's safety were minimised and accident and incidents were recorded and responded to appropriately.

Is the service effective?

Good

The service was effective.

Staff supported people with their health care needs and associated services and liaised with healthcare professionals as required.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people.

Staff understood and applied the requirements under the Mental Capacity Act (MCA) 2005 and their responsibilities with regard to Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People were supported to be as independent as possible by kind and caring staff.

People were treated with dignity and respect, encouraged to express their views and to be involved in decisions about their care.

Is the service responsive?

Good

The service was responsive.

People were supported to live the lifestyle of their choice and visitors were welcomed into the home

Summary of findings

Personal centred plans provided staff with information about how to support people in a person-centred way. Staff were knowledgeable about people's support needs, interests and preferences and supported them to participate in activities that they enjoyed.

There were systems in place to respond to complaints.

Is the service well-led?

Good

The service was well led.

The registered manager and staff were fully aware of their responsibilities under legislation that came into force in April 2015.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable raising concerns.

The registered manager monitored the quality of the service provided and regularly checked people were happy with the service they were receiving.

Honeywood House Nursing Home

Detailed findings

Background to this inspection

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

We undertook an unannounced comprehensive inspection of Honeywood House Nursing Home on the 26 August 2015. As part of this inspection we checked that improvements to meet legal requirements planned by the provider after our comprehensive inspection of the 8 and 16 January 2015 at which breaches of legal requirements were found and enforcement action was taken.

After our last comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements. As part of the planning for this inspection we reviewed all the information we held about the service including notifications that had been sent.

The inspection team was made up of two inspectors, a pharmacist inspector and a specialist advisor in nursing care. During the inspection we spoke with 10 people who use the service and four relatives. We also spoke with five health care assistants, two nurses the registered manager the general manager and the secretary.

We viewed five people's care files in detail and some other records such as fluid, observation, mattress checking, and service user turning checks. We also observed care being delivered. We looked at medicine administration records, five staff recruitment files, staff training, compliments and complaints records, accident and incident records, the service's quality assurance audits, minutes of staff meetings, resident and relatives meetings, the newsletter and records relating to activities.

Requires improvement

Is the service safe?

Our findings

At the last inspection in January 2015 we found people were at significant risk of not receiving safe care. We identified the provider was not meeting the requirements of the law because they had breached the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 in respect of the Regulation 12 the management of medicines and the assessment of risk, Regulation 18 in relation to staffing levels and Regulation 19 in relation to staff recruitment.

We issued warning notices stating the provider must take action in relation to management of people's medicines and the assessment of risk by the 2 May 2015. We also issued requirement actions requiring the provider to resolve the breaches identified in relation to staff recruitment and staffing levels. Following that inspection the provider sent us an action plan detailing how they intended to ensure they met the requirements of the law and by when. At this inspection we found improvements had been made and the breaches had been resolved. However further improvements are needed to be made in relation to the completion of Medicine Administration Records (MAR) in order to ensure they accurately the medicines administered.

At our last inspection we found there were errors in each person's MAR charts and staff frequently changed entries on them. At this inspection we found that, whilst improvements had been made and most of the MAR charts were accurate and complete, some were not. For example, reminder memorandums had been issued to nursing staff to ensure they each had received the information about changes in practice that had come about following our last inspection. One such memorandum instructed staff to monitor the pulse of one person before giving a certain medicine. We found on some occasions the person's pulse had not been recorded as measured by the nurse. Therefore staff were not following the providers own medicine administration procedures to ensure that this medicine was administered safely. Most of the MAR charts were fully complete however there were some blank spaces where there should be initials to confirm that medicines had been administered or a code entered to indicate the reason for why they had not. Hand written information had been added to some MAR charts which had not been authenticated by the person making these changes. Therefore it was not clear who had made the changes. Whilst we did not assess this as having had a negative impact on people, in order to reduce any risk of miss-recording the prescribed instructions, we have identified that improvements are needed to make sure each person's MAR is fully complete and accurate.

At our last inspection we found concerns relating to the safe storage and management of medicines that have variable dosages. At this inspection the provider had followed their action plan and these issues had now been addressed.

People received their medicines when they needed them. Medicine administration was completed by registered nurses who were assessed as competent to do so and records confirmed this. Medicines were administered from a trolley in which they were stored securely. When not in use the trolley was stored securely in a locked room. However we saw seven pill crushers and cutters that had medicine residue from previous use. Therefore there was a risk this residue would be passed onto the next tablet that was cut or crushed. Staff explained they would always clean these tools before using them. However this is an area of practice we identified as needing to improve.

Medicine administration was recorded on individual MAR charts. Each MAR chart had a photograph of the person it applied to, supporting staff such as agency staff who may not have been familiar with the person. Each person had their own dedicated blister pack of medicines with a small number of general medicines being for communal use. The medicines recorded on the MAR charts matched that recorded on the dispensing blister packs. There was a written guidance for in what circumstances people who may need medicines that have a variable dose For example a medicine that required regular blood test was managed well and the dose changes following this blood test were actioned as indicated by the blood test results. Pain assessment guidance documents were available in the care plan to assist staff in assessing when as required pain relieving medicines should be administered. Each person had a body map to indicate where on a person's body to apply topical creams and the nursing staff monitored and signed on the MAR chart when the cream had been applied, for example topical creams applied to prevent incontinence rash. The arrangement for the disposal of medicines was safe.

Requires improvement

Is the service safe?

At our last inspection we found that risk assessments were not always individualised and did not detail how risks to individuals should be minimised. At this inspection we found risks to people's safety had been assessed and planned for. Each person's care plan was supported by risk assessments which detailed the extent of the risk, when the risk might occur, and how to minimise the risk. For example a pressure ulcer risk assessment had been completed for everyone using the service. This assessment took account of risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. Additional risk assessments were added was needed such as, dementia, infection control, use of bed rails and wound charts. These allowed staff to assess the risks and then plan how to alleviate the risk for example ensuring that the correct mattress is made available to support pressure area care.

Steps had been taken to minimise risks to people wherever possible without restricting their freedom and to make sure the equipment people needed to keep them safe was available and safe to use. Bedrails were in place for some people who had been identified as being at risk of falling from bed. These were checked daily to ensure they were safely adjusted and inflated mattresses were checked to ensure they were set at the correct pressure and functioning correctly. One person was mobile but required to walk with the support of a walking frame. An environmental risk assessment had been carried out and a care plan put in place identifying how a clutter free environment was to be managed to aid their mobility.

Staff ensured people with mobility and stability issues were safe when moving around the building. We saw care plans directed staff to ensure people who moved around the home had support equipment with them. Care plans advised that some people forgot to use their walking frames which had been provided to prevent falls. We saw staff remind people to use their walking frames when they were seen without them, guiding them to the item. We saw people were assisted to the dining table at lunch time and provided with the equipment they needed to eat and drink safely and independently.

The provider had taken steps to make sure the environment and the home's equipment was safe for people. A personal evacuation plan was in place for each person in case of an emergency. Safety checks had been completed for the home's equipment which had also been serviced as needed. There was a secure door entry system in place to ensure unauthorised people did not gain entry to the home. Accident and incidents had been recorded and an analysis had taken place to help identify any emerging themes or trends.

Staff demonstrated they had the skills they needed to use a hoist to lift and transfer people safely and understood some people felt anxious when being transferred in this way. We observed two members of staff supporting people to move from a chair to a wheel chair using a hoisting procedure. One person demonstrated anxiety and concern during the lift. We saw staff calm the person reassuring them they would be ok. We saw staff ensured this person was safe during the lift, advising them where to place their hands so they did not get trapped. The person responded positively to the reassurances from staff.

At the last inspection we found appropriate steps had not been taken to ensure that, at all times, there were sufficient numbers of skilled and experienced persons employed. At this inspection we found that this issue had been resolved. People and their visitors told us they felt there were enough staff to meet people's needs. People had call bells in their room which they could use to alert staff to the fact they needed assistance. We observed two call bells being answered within a couple of minutes of people calling. We discussed this with both people who explained that call bells were usually answered promptly. One person explained that on her "bad days" when she preferred to remain in bed, staff responded to her call bell very quickly.

The registered manager told us they based the number of staff deployed each shift is based on an assessment of people's needs and the skills staff needed to support them. They told us they oversaw the planning of the staff duty rotas and worked closely with the senior members of staff to make sure the staff skill mix and staff numbers deployed were sufficient to meet people's needs. We saw from the records there was a senior member of staff on duty and a member of the senior management team on call at all times. Domestic staff were employed to undertake cleaning and food preparation. Other staff were employed to complete the gardening and maintain the building and office staff were employed to complete administration tasks.

At the last inspection we identified appropriate recruitment checks had not always been completed before people started work at the service. Therefore there was a risk staff

Requires improvement

Is the service safe?

working at the service were not be suitable for the role. At this inspection we found this issue had been resolved and checks had been completed to make sure staff were suitable to work with people living there.

Staff recruitment processes included the completion of identity and security checks. At least two references were in place, one of which was from a previous employer, and all checks were completed before people started work. There were records in the service to confirm the skills and training completed by agency staff who worked there. The registered manager explained they obtained this information so that they could assess whether the agency staff had the skills they needed to meet the needs of the people who lived at the service.

People were protected against the risk of abuse. People and their visitors told us they felt safe and raised no concerns about their safety. They told us they felt they were able to speak to staff about any problems they had. Staff were aware of what constitutes abuse and had completed relevant training. They explained that they had completed training in how to recognise changes in behaviour, how to respond and how to escalate any concerns. The registered manager and staff had a good understanding of the protocols for making a safeguarding referral and had obtained a copy of the local guidance. Incidents that affected people's safety had been recorded and investigated. These records had been analysed to identify any themes or patterns emerging that could indicate people were at risk of abuse and action taken to reduce the risk of re-occurrence.

Good

Is the service effective?

Our findings

At the last inspection in January 2015 we had significant concerns that the care people were receiving was not effective. We identified the provider was not meeting the requirements of the law because they had breached the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 in respect of the Regulation 11 obtaining people's consent to care and treatment and Regulation 18 staff supervision, training and appraisal.

We issued a warning notice stating the provider must take action to address issues in relation obtaining people's lawful consent to care and treatment which had to be met by the 2 May 2015. We also issued a now requirement action requiring the provider to resolve the breaches identified in relation to the staff training, staff supervision and staff appraisals. Following that inspection the provider sent us an action plan detailing how they intended to ensure they met the requirements of the law and by when. At this inspection we found improvements had been made and the breaches had been addressed.

At our last inspection we found that although staff had received training on the Mental Capacity Act (MCA) they lacked knowledge to know how to apply the training when working with people. There was no information available for staff regarding assessing and detailing people's capacity to make decisions and give consent and legal documents were not always in place to ensure the next of kin had the legal authority to make decisions on people's behalf. At this inspection we found these shortfalls had been resolved.

People's capacity to make decisions had been completed when needed. There were a number of care plans which provided details of mental health and mental capacity assessment that had been undertaken to assess people's capacity to make decisions and give consent to their care and treatment. We saw consent had been sought by the people and relatives who had been appointed as their Lasting Power of Attorney (LPoA). An LPoA is someone who has been appointed by a person to make certain decisions on their behalf when they reach a point where they are no longer able to make decisions for themselves. A record of the involvement of the LPoA was in place. We saw one person was assessed as not having the capacity to consent to the use of bed rails and this had been agreed by their LPoA. Another person told us they had bed rails in place and had agreed to them being used themselves. We saw documents regarding people's decisions about whether or not they wanted to be resuscitated in the event of needing cardiopulmonary resuscitation (CPR). CPR is a lifesaving technique used in many emergencies, including heart attack, in which someone's breathing or heartbeat has stopped. We also saw documents relating to advanced care plans (ACP). An ACP documents a person's wishes in anticipation of deterioration in their condition in the future, with associated loss of capacity to make decisions and/or the ability to communicate their wishes to others. ACP's only come into effect if, and when, a person has lost such capacity.

Staff now demonstrated they had an understanding of the MCA including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They described to us circumstances in which a best interest decision should be made. They told us when people are assessed as not having the capacity to make specific decision and when there is no LPoA, a best interests decision would be made with the people who know the person including relevant professionals. Care plans had been updated to contain clear guidance for staff to follow and there was information available in relation to the assessment for decisions and what specific decisions a person could and could not make. We saw staff asking people for their consent throughout the day before delivering care. For example we saw staff moving one person with a hoist so that the bed linen could be changed. They explained what they were going to do and checked that the person understood and agreed to the process before they began. They provided re assurance to them throughout the procedure checking with them they remained happy with what was happening.

The Care Quality Commission (CQC) has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005). The purpose of DoLS is to ensure that a person who lacks the capacity to make their own decisions and, in this case, lives in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The registered manager had a good understanding of DoLS and staff described to us the implications of this for the

people they were supporting. People living at the service were being deprived of their liberty by way of locked doors, being under constant supervision and some people by way of the use of bed rails. Care plans indicated whether or not people had the capacity to consent to these restrictions and applications had been made for DoLS where applicable. We saw from the staff meeting minutes that DoLS had been discussed and staff informed of the need to report the death of any person who was under a DoLS to the coroner for investigation.

At our last inspection of the service we found that the provider had not ensured that staff received the training, supervision and appraisals they needed to make sure they obtained and maintained the skills they needed to undertake their roles. At this inspection we found that they had taken the action they needed to resolve this issue.

People told us they felt the staff were trained to be able to take care of their needs and staff told us they received training which enabled them to carry out their job role. One person told us "They (the staff) certainly seem to know what they are doing; I've no complaints about them what so ever". A relative said "From what I understand they do a lot of training and I've no concerns about their capabilities".

Staff received the training they needed. We saw that newly recruited staff completed an induction to working in the home and shadowed experienced staff before they worked unsupervised. All new staff completed the Care Certificate which is a nationally recognised certificate which involves the staff member completing work books to provide them with the competencies they need to prepare them to work in care. Staff told us they had undergone lots of training and training updates. They explained a lot of the training had been classroom based which enabled them to discuss the training and raise any questions they many have. We saw that training had been provided in subjects to help staff meet people's specialist needs such as dementia and the care of the dying. One staff member told us there were two people who had diabetes which was controlled by medicines and diet. They told us all the registered nurses employed had been trained in diabetic care and records confirmed this.

Staff were supported to maintain their competencies, develop as a worker and obtain qualifications. Staff told us they were supported to complete nationally recognised qualifications in care and to learn about subjects that interested them. They said they felt supported by the registered manager and management team. One staff member said "We do have supervision but I don't have to wait for that to ask for training. We can ask for that anytime". We saw supervision had been discussed at a staff meeting on the 11 March 2015 where staff had been informed that 'Alongside an annual appraisal you are required to have a further six staff supervision sessions. These will follow on from your training sessions ASAP and various areas will be discussed and questions asked. These again are mandatory.' Staff said they received supervision from their line manager at which they could speak to them in confidence about their personal development, training needs and performance. They said this usually took place every two months and that all staff including the nursing staff had six supervision meetings a year and these were recorded. The registered manager explained they were aiming for each staff member to have and annual appraisal of their performance. They told us they had not yet completed all the appraisals but were on track for this to be completed by the end of the year.

People's health care needs were met and care and treatment was delivered in line with their preferences and care plan. One person was noted to be on monitoring programmes for temperature, pulse and respiration and blood pressure so that any changes in their condition could be identified and the appropriate action taken. All others had routine three monthly recording of these observations. Each person's weight was monitored monthly and more often if they had been identified as at risk of malnutrition. People who spent the majority of their day in bed were monitored by staff some required hourly checks, changing of position, barrier creams applied to prevent rashes and pressure ulcers. Staff were observed carrying out these checks, explaining the process to the person and completing records to ensure the care plan had been followed correctly. Staff told us they had completed training which helped them to recognise deteriorating conditions and how to monitor vital signs and administer oxygen as required.

Changes to people's care needs and condition had been documented and monitored. For example daily records were completed for day and night shifts, and provided a satisfactory account of how people's needs had been met. They detailed the assistance people had been given with personal care; if the person had eaten and drank sufficiently; what their mood was like; and if they had taken part in any social activities. One person had moved into the

Good

Is the service effective?

service with a pressure ulcer. Records identified the dressings staff should use, and body maps and charts, recording the healing progress over time, had been completed.

Staff were aware of people's health needs and called in the GP and other health professionals as required. Referrals had been made to people such as dieticians, speech and language therapists, and physiotherapists and their recommendations had been included in the care plans. Professional support from the GP was sought on a regular basis for one person who had a catheter. Records detailed the daily catheter care that had been carried out for this person and their fluid intake and output.

People were supported to eat and drink sufficient quantities. Most people were able to eat and drink independently. Nutritional risk assessments were supported by individual care plans identifying if the person needed help or encouragement to eat and drink or required a pureed or soft textured diet. Records identified that soups and custards should be fortified with milk and cream for people at risk of malnutrition. Where concerns had been identified about a person's weight, nutrition, diet or swallowing difficulties a referral had been made to the relevant health care professional. Any advice they had given had been documented and was being followed. We heard the staff who had worked the morning informing the afternoon staff that some individuals had not eaten adequately that morning and would need encouragement to eat sufficient that afternoon.

A choice of home cooked food was available at each meal time and homemade cakes and pastries were available between meals. People told us and we saw they enjoyed the food and that they could always request something different it they did not want any of the choices on offer. Hot and cold drinks were available at regular intervals throughout the day and people could request additional drinks and snacks as they chose. People could choose for themselves where to eat. Some people ate in the dining room whilst others less mobile had lunch in the various sitting rooms or in their own rooms. We saw people who needed help to eat receiving support from staff at lunch time.

Good

Is the service caring?

Our findings

formed a good relationship with them. Two visitors explained their relative was nursed in bed and was very well looked after. They said they regularly visited and found their relative to be well cared for and comfortable. "We are greeted like family when we come here; it's a real homely place". Everyone we met with spoke highly of the delivery of care and of the caring nature of the staff that worked there. One person told us "They are lovely (the staff)." They explained they had never heard staff raising their voices to anyone or with each other and that they always let them do things at their own pace. One staff member said "We're just one big family here". Another told us they believed the care to be extremely good and explained that "I would be happy for my mother to be here". An agency nurse explained "This is the nicest and most caring home I've worked in".

All the relatives we spoke with told us they were happy with the service and the care their family member received. They told us they were able to visit when they chose and staff were always friendly and kind to their family member when they saw them. Relatives told us they did not need to call in advance; they could arrive, sign in and carry out their visit. They told us whenever they visited staff were available to talk to if they needed to. Our observations confirmed visitors were able to come and go as they chose. We observed staff had formed positive relationships with relatives recognising who they were and who they had come to visit.

People and their relatives were involved in making decisions about things that mattered to them. People's care plans were individualised and had been written in consultation with the person and their relatives. This helped to ensure that staff had the guidance they needed to provide personalised care in a consistent way. Three people we spoke confirmed they regularly met with staff to go over their care plans. One person told us "They do speak to me about it but my daughter knows more about it, she deals with a lot of the paper work side of things for me." Care plans were kept in people's own rooms and included their social history, likes and dislikes, social, cultural and religious preferences. There were "life story books" available for relatives and staff to complete, some of these were in progress and others not yet completed. The registered manager explained this was an ongoing process and they continued to ask relatives for their support to complete this document. Staff told us the 'life story books' helped them to get to know people, particularly those people who lived with dementia. They explained how knowing about someone's past gave them insight into why people did certain things or mistook them for people they once knew and helped them to respond to them appropriately.

Staff demonstrated respect when delivering personal care to people. For example when supporting a person who was nursed in bed they ensured the door was kept closed when attending to their needs and covering them with a sheet whilst washing them. They talked to the person explaining what was happening in a kind and gentle manner even though they the person was not responding to them. Staff knocked on people's doors and waited for a response before entering and addressed people by their preferred name.

We saw staff were kind and respectful when interacting with people treating people with dignity and communicating with people in a manner which was appropriate. They gave people time and space to respond to questions, and were patient when people wanted to speak and struggled to say what they needed. We observed they had formed strong bonds with people and were able to tell us about their history, their family, previous jobs they had held and their likes and dislikes. For example one person came in the conservatory on several occasions when we were talking with staff and looking at records. Each time the person came into the room staff greeted this person in a friendly manner and reassured them it was ok to sit down and join us. They explained the person had previously been a teacher and gave them a file to look at. This clearly pleased the person who chatted away to staff about 'work' and the birds in the garden for a while before leaving the room.

One person told us they preferred to eat lunch in her room occasionally. They said when they did this staff were very supportive and regularly checked that they had all they wanted. "If I want specific food such as a particular yogurt they will talk to the kitchen and they will buy them for me".

We observed staff respond in a kind and calm manner towards people who became agitated. For example when a person became anxious we saw them respond positively to staffs interventions, reassurances and support.

Good

Is the service caring?

The atmosphere in the home was calm and relaxing. Throughout the day people were spending time as they chose in their bedrooms and the communal areas. Staff were regularly checking on people ensuring they were comfortable. We saw staff sitting and interacting with people and checking on their well-being. People looked comfortable and they were supported to maintain their personal and physical appearance. For example, people were well dressed and groomed and wore jewellery. People told us and showed us they had brought their own belongings, such as photographs and ornaments, to personalise their rooms and help them feel at home.

Good

Is the service responsive?

Our findings

At the last inspection in January 2015 we assessed that the service was not responsive to peoples' needs. We identified the provider was not meeting the requirements of the law because they had breached the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 in respect of the Regulation 9 in relation to the planning of person centred care and treatment. We issued a warning notice in relation this breach which stated the provider must take steps to ensure they resolved the breach by the 2 May 2015. At this inspection we found provider had taken steps to make the improvements needed to meet the requirements of the law and the breach had been addressed.

People's needs had been assessed before they moved into the service and care plans had been developed allowing staff easy access to information and guidance as required. The care plans were person centred and each designed to address individual needs. They detailed how a person should be supported and the rational for these directions. They included the activities of daily living such as communication, people's personal hygiene needs, continence, moving and mobility, nutrition and hydration, breathing, pain control, sleeping, medication and mental health needs. They highlighted to staff whether people were living with dementia and whether they needed reminding about things such as the date and time. They provided guidance for staff to follow for how to deliver care to people in line with their preferences and prompted them to assess, plan, evaluate, record and review people's care as required. Plans had been reviewed and updated on a monthly basis, involving professional support where required for example input from a physiotherapist or dietician and any changes to the care plan as a result of this review had been recorded.

Care plans reflected people's preferences and were kept up to date. All care plans included a preferred activities plan identifying individual preferences for activities such as listening to the radio, reading the newspaper or just talking to other people. People who were incontinent had individualised care plans identifying their needs for example the type and number of pads to be used, how often they required assistance with personal hygiene and what topical creams were to be applied to help prevent incontinence rash. Other care plans included details about the support people required with their personal hygiene care such as brushing their teeth, cleaning their dentures, brushing their hair, shaving, wearing spectacles and dressing. We saw in the minutes of a residents meeting held 12 May 2015 that people had been thanked for their contribution, patience and understanding in relation to the completion of new are plans which were 'now up and running' and that people were notified the 'usual monthly review would still occur and all residents or their advocate would be required to sign one document to prove that this review had taken place and they were happy with outcomes'.

Activities in the service were provided on every day of the week and were organised in line with people's personal preferences. Several people wished to continue with their faith and we saw that they were supported to do this. Activities were provided in the morning and in the afternoon every day of the week. The registered manager told us, that everybody was given a choice around activities and we saw a varied range of activities on offer for example singing, exercises, arts and crafts and films. There was also a dedicated hairdressing room which a visiting hairdresser used once a week. There were clothing parties and fayres and arranged for entertainers to visit on a regular basis. People told us they enjoyed the annual summer fete which was held in grounds and watching the birds on the bird feeders from the conservatory.

The activities co-ordinator's recorded the activities that people attended and gained their feedback, to assist with planning future activities that were relevant and popular. People told us they liked the social aspect of activities and in particular when they took place in the large entrance to the service which was also used by people as a place to meet and chat. One person told us "I like to sit there, read the paper and watch the world go by. If you want to know what is going on, that is the place to be". Staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff spent one to one time in people's rooms. One to one activities included painting people's nails, massage and reading to them.

People were able to give their views on the service at residents and relative meetings and their views acted upon. The registered manager told us the coordinated activities were being reviewed in an effort to offer more people more stimulation and we saw from the minutes of residents meetings that people had been asked for their ideas for

Good

Is the service responsive?

new activities. Those not wishing to attend were asked if they would like to raise any issues. One relative who had not attended the meeting but had contacted the service via e-mail had asked if a quarterly newsletter could be introduced. Everyone attending the meeting had agreed this was a good idea and people were asked to volunteer to help co-ordinate this. The minutes recorded that people had been engaged in planting up tubs of flowers which were growing on the patio and that there were plans for raised beds to be built in the garden for people who enjoyed gardening to use to grow flowers or vegetables. They detailed that it had been suggested a reading session could be reintroduced and that everyone present had agreed this was a good idea. One person had requested a musical evening and another a tea dance and discussions had taken place as to when the best time would be to arrange these activities. It provided details of an outing that people had been on and enjoyed and stated this would be repeated the following year.

Other information of interest to people was passed on at the residents and relatives meeting and discussed. For example the registered manager was considering buying a mini bus so that outings could be more spontaneous rather than always having to hire a mini bus in advance. A new passenger lift had been installed and people were reminded to use the conservatory. Dates for the entertainers were shared and ideas were welcomed from people to vary the menu.

There were systems in place for people to raise complaints. The providers complaints policy and procedure was available to people and contained in the service user guide and the residents hand book. People and their relatives told us they knew who they could speak to if they had any concerns and would feel confident they would be listened to. The complaints log showed that previous complaints had been investigated and the resolved to the person's satisfaction.

Good

Is the service well-led?

Our findings

At the last inspection in January 2015. We identified the service was not consistently well led. The provider was not meeting the requirements of the law because they had breached the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 in respect of the Regulation 17 good governance. This was because quality assurance audits had not effectively identified areas that needed to improve. For example shortfalls in care planning and risk assessments had not been identified and shortfalls in the management of medicines had not been picked up through medicines audits. In addition it was not evident how the results of the audits completed had been used to make improvements to the service. At this inspection we found this breach had been addressed.

Following our last inspection the provider sent us an action plan detailing the improvements they planned to make to ensure the service was fully meeting the requirements of the law. At this inspection we found the provider had followed their action plan and all the breaches identified at the last inspection had been addressed. It was evident some of the improvements had been made immediately after the last inspection whilst others, such as the development of new care plans, had been implemented over several months. All the improvements made had been completed and sustained since May 2015.

Systems of quality monitoring that were in place to identify, assess and manage risks to the health, safety and welfare of people were robust, as was other audit activity around areas such as health and safety, infection control, care plans, accidents and incidents. For example care plans were audited on a monthly basis. The audit monitored the completion of care records, evaluated the care delivered and monitored the completion of all supporting documentation such as food and fluid charts, daily bed rail checks, mattress checks, observation records, and people's daily plans. The feedback from the audit was delivered at staff meetings and at handover if appropriate allowing for continuous review of service user records and care delivered. Staff meeting minutes confirmed that the completion of care plans had been discussed at team meetings and staff had been encouraged to ask for help or for a briefing if they were not sure what needed to be done.

We saw staff had been reminded of the importance of completing detailed daily records of the care delivered to people. Accidents and incident records had been audited and analysed to identify any emerging themes or trends.

Every three months questionnaires were given to people to gain their views on the home. Any issues raised had been addressed. Staff meetings were held and the meeting minutes reflected information and updates had been passed onto staff as required.

It was clear from conversations with the registered manager they were aware of the full extent of the Care Act regulations and their responsibilities within the Act which came into force in April 2015. The registered manager explained they had obtained the CQC's publication 'Guidance for providers on how to meet the regulations' and had passed information about the changes to their staff team. For example staff had been informed about the duty of candour regulation that had come into force in April 2015 and the new responsibilities that came with that. They were reminded of the need to work in an open and transparent way and to keep people's families informed any accidents and incidents involving or affecting their relative. We noted that some of the staff that usually worked nights had attended staff meetings and we were told that copies of the minutes were made available to staff that had not attended the meeting to read.

Staff told us they thought the home was well managed and the registered manager was a visible presence in the home. We were told they were approachable and would always have time to talk to staff. One staff member said, "I can always go to them (the registered manager) if I need anything". People also recognised the manager as being in charge of the home and had confidence the manager would listen to their concerns. The registered manager knew people well. For example they knew the name of people and their relatives and could describe to us their care needs, likes and dislikes. A new manager had been employed to assist the registered manager in managing the service on a day to day basis. The registered manager told us this would give them more time to focus on their responsibilities as the nominated individual and have better oversight of the overall performance of the service.

All staff spoken to confirmed that they enjoyed coming to work, that senior staff and management were supportive. They were aware of the concerns that had been noted at

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Is the service well-led?

our last inspection and reported to us a lot of changes had been made since then. They all told us there was a positive and open culture and were happy with their working arrangements.