Avante Care and Support Limited

Northbourne Court

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

At our inspection on 8 April 2015 we found several breaches of legal requirements. The systems for the management of medicines were not safe and did not protect people using the service. People were not supported by a sufficient number of staff to ensure that their needs were met. In addition people's capacity to give consent had not been assessed in line with the Mental Capacity Act 2005 (MCA). We asked the provider to make improvements in these areas. We also recommended that specialist advice was obtained to deal with fluctuation of water temperatures and potential issues associated with water born infections. Following that inspection the provider sent us an action plan telling us of how and when they were going to make these improvements. They kept CQC informed of the changes that had been made.

At this inspection we found that significant improvements had been amde in all of these areas. We found that systems for the management of medicines were safe, the provider was acting in accordance with the MCA and action had been taken to support people with sufficient numbers of staff. However, we had concerns about the high level of falls at the home and have made some recommendations within the report about this issue.

Summary of findings

Northbourne Court is a large care home located in the London Borough of Bexley. The home is registered to provide accommodation and support for up to 120 people and specialises in caring for people living with dementia. At the time of our inspection 112 people were using the service.

There was a manager in place who was in the process of applying for registration. 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.

People using the service said they felt safe and that staff treated them well. There were enough staff on duty and deployed throughout the home to meet people's care and support needs. Safeguarding adult's procedures were robust and staff understood how to safeguard people they supported. There was a whistle-blowing procedure available and staff said they would use it if they needed to. Appropriate recruitment checks took place before staff started work.

We found that people and their relatives, where appropriate, had been involved in planning for their care needs. Care plans and risk assessments provided clear information and guidance for staff on how to support people using the service with their needs. There was a range of appropriate activities available for people to enjoy. People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

The provider took into account the views of people using the service and their relatives and staff through surveys. The results were analysed and action was taken to make improvements at the home. Staff said they enjoyed working at the home and received appropriate training and good support from the manager. The manager and other managerial staff at the home conducted regular checks to make sure people where receiving appropriate care and support.

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

There was an element of the service that was not always safe. Although the home had assessments and actions in place, people had experienced a number of falls with resulting injuries that were higher than would normally be expected in a home of its size and complexity.

People told us they felt safe and well cared for. There were arrangements to deal with emergencies and staff were aware of signs of abuse and what action they should take. There was a whistle-blowing procedure available and staff said they would use it if they needed to.

Medicines were managed safely and records showed that people were receiving their medicines as prescribed by health care professionals.

There were enough staff deployed within the service and appropriate staff recruitment procedures were in place.

Is the service effective?

Good

The service was effective.

Staff had completed an induction when they started work and were supported with supervision and training relevant to the needs of the people using the service.

The manager and staff demonstrated a clear understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and acted according to this legislation.

People told us they enjoyed the food and that there was a good choice available.

People were protected against the risks of inadequate nutrition and dehydration. There were appropriate arrangements in place to ensure that people were receiving the food and fluids as recorded in their care plans.

People had access to a GP and other health care professionals when they needed it.

Is the service caring?

Good

The service was caring.

Staff were caring and spoke with people in a respectful and dignified manner. People's privacy and dignity was respected.

Staff knew people well and were aware of changes in their moods or routines.

People and their relatives were involved in making decisions about their day to day care.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care files included detailed information and guidance for staff about how their needs should be met.

There were activities and entertainment for people to participate in and staff encouraged participation consistent with individual's needs and abilities.

People knew about the home's complaint's procedure and said they were confident their complaints would be investigated and action taken if necessary.

Is the service well-led?

Good

The service was well-led.

The provider and manager were working to improve the lives of people and were adopting best practice techniques in trying to reduce areas of concern.

The provider took into account the views of people using the service, relatives, health care professionals and staff.

The manager recognised the importance of regularly monitoring the quality of the service provided to people using the service and senior staff were extensively involved in day to day care and supervision of staff.

There were meetings with staff and management where issues were raised in an attempt to resolve problems, aid communication and to ensure quality was maintained within the service.

Staff said they enjoyed working at the home and they received good support from senior staff and the manager.

Northbourne Court

Detailed findings

Background to this inspection

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

This unannounced inspection was carried out on the 12, 13 and 14 January 2016. The inspection team consisted of two inspectors, a specialist advisor and an expert by experience on the first and second day and one inspector on the third day. Before the inspection, we looked at the information we held about the service including notifications they had sent to us. A notification is information about important events that the service is required to send to us by law. We also received feedback from health care professionals that we used to help inform our inspection planning.

We spent time observing the care and support being provided to people, spoke with 12 people who used the service and five relatives. We also spoke with nine members of staff, the provider, the manager, care managers and health care professionals visiting the home. We looked at 16 people's care records, staff recruitment and training files. We also looked at records relating to the management of the service including audits, incident logs, feed-back questionnaires, staff rotas and minutes from meetings. In addition, we looked at all areas of the building including bedrooms, communal areas, offices and outside grounds.

Requires improvement

Is the service safe?

Our findings

At our last inspection we found that sometimes there were insufficient members of staff available to support the needs of people. At this inspection we found that improvements had been made in this area and the records we considered and observations we made supported that there was an appropriate level of staff available.

People told us that they felt safe and the home was a safe place to be. They felt confident that there was always sufficient staff around to support them. They said that there was always a senior member of staff on hand and that permanent staff knew them well and their issues. One person who uses the service said, "I feel perfectly safe and happy here." Another said, "When I ring my bell someone comes straightaway." We did however identify a high number of falls at the service.

A relative who had been visiting the home for two years said, "I think there are enough staff, they are always about." We spoke to nine members of staff and there was a mixed view about staffing levels. One staff member said she thought there was sufficient staff and another said, "We need more support in the mornings as many people need the support of two carers." Another told us that weekends were more problematic due to the number of agency staff used to cover shifts. One staff member said, "There are not enough permanent staff at present." However, the manager told us that since our inspection in April 2015, more staff had been recruited, there was now less reliance on agency staff and there was a program of further recruitment to be carried out. The records we reviewed and observations we made during the course of the inspection confirmed that there were enough staff on duty to meet people's needs.

We found that falls assessments were in place for people at risk of falls and for those who had experienced a fall. We tracked one person's care plan who had had a recent fall at the home. We found that a full risk assessment had taken place before the fall and a monitoring system to help prevent further falls was in place. Systems of regular 30 minutes observation checks were in place during the day and 15 minutes at night. Alarm mats and other devices were in use to help inform staff when a person was trying to get up out of the chair or bed and were vulnerable to falls.

We saw that care plans had been appropriately updated following incidents of falls and on one occasion we noted an instruction for staff to use a chair alarm mat at all times as that was when falls had occurred. A referral had also been made to the falls clinic to ensure appropriate support was in place to minimise or prevent the risk of falls. The care plan instructed staff to make regular 30 minutes checks to help prevent falling and to check that the chair alarm mat was switched on at all times.

We looked at two care plans where recent incidents of falls were documented and these had resulted in a review of the care plans. These incidents were still under investigation, one had led to an emergency hospital attendance and following assessment the service user had been discharged back to the home. These examples showed that the service was acting properly in relation to the safety of people and were referring people appropriately to specialist care.

However, we remained concerned about the number of falls at the service. The provider told us that they were concerned about the high level of falls and had analysed the circumstances of the falls and had reached a number of conclusions for the higher than average rate. They accepted that some people may have needs that would be better met in a more specialised setting as they had deteriorated since admission. We saw documentation that the manager had refused admissions to the home where it was felt that people's needs may be better met elsewhere. The manger had also informed commissioners when people required the support of a specialist service.

We noted that the manager was an advocate of the use of high contrast colour schemes in the areas where it had been assessed that residents were at high risk of falls and that the redecoration had led to a reduction in the number of incidents. Unfortunately, and after a few weeks, the area had been redecorated in neutral colours following comments by visitors.

A health care professional told us that the GP practice were aware of the number of falls occurring in the home and this had been discussed at the practice meetings. They said, "We are informed of all falls and the home are trying to manage them more robustly. Appropriate referrals are always made to the GP practice."

A senior member of staff told us that they had attended a meeting at the GP practice to discuss the level of falls within the home and this meeting had included a

Requires improvement

Is the service safe?

representative from commissioners of services. She said, "The home is doing further work to identify what they can do to prevent falls occurring." However, we were unable to monitor this at the time of the inspection.

We recommend the provider continue with their assessments and analysis of falls incidents and apply advice and guidance from a reputable source. In addition, we recommend the home should make adaptations to the environment, including decorations, which follow accepted best practice in areas where people are at risk of falls.

All of the 16 care plans we reviewed included a range of risk assessments. For example the assessments documented the risk of falls, skin integrity and movement and the handling procedures that were to be followed. We also saw guidance had been provided to staff about what support was required when mobilising and what walking aids were to be used. We found that there were monitoring systems in place such as Waterlow assessments for skin integrity and body maps were in use. Waterlow gives an estimated risk for the development of a pressure sore. A MUST tool was used to assess weight and BMI and we found these were recorded on a monthly basis and more frequently as required. MUST is a Malnutrition Universal Screening Tool and is a five step screening tool used to identify adults who are malnourished or at risk of being undernourishment. We saw that one person was on a weekly weight monitoring program and we saw appropriate referrals had been made to the GP for specialist assistance. The person's care plan had been updated to reflect this referral and input from the GP so that carers were aware of the additional support that was required.

A staff member told us, "If we have any concerns about weight loss these are referred to the GP and thereafter on going monitoring details are made available to the GP either by fax or during their regular visits to the home." A health care professional said, "If someone's condition deteriorates they are good at asking for help." Other healthcare professionals told us that they felt that people get good safe care at the home.

At our last inspection, 8 April 2015 we found that people were not always protected against the risks of unsafe management of medicines. We asked the provider to make improvements about how medicines were managed.

At this inspection we found that medicines were administered and stored safely. We spoke to a team leader about how medicines were managed and observed a medication round. They told us that only trained staff administer medicines to people using the service. We saw an example of the medicines competency assessment which was applied to all staff before they could undertake the administration of medicines. Competency assessments were undertaken annually which ensured that medicines were managed safely. We looked at the medicines folders for the home. The folders were clearly set out and easy to follow. They included individual medication administration records (MAR) for people using the service, their photographs, details of their GP, information about their health conditions and any allergies. The majority of medicines were administered to people using a monitored dosage system (blister packs) supplied by a local pharmacy.

Cream applications were applied by the carers and these were recorded by them on a separate MARs chart kept in the medicines folder. Guidance for staff on when to offer 'as required' (PRN) medicines was recorded in the care plans and a separate PRN medication form was in use. The care plans set out the PRN medication to be administered and detailed the amount and frequency and why this might be required. For example, a medicine for when a person had pain. We saw that a care plan described the behaviour a person may display if they were in pain as they did not have the ability to verbally communicate this to staff.

Medicines were stored securely in locked trolleys secured to the wall in a locked cupboard and controlled drugs were stored in a cabinet in the locked medicines cupboard. Room and fridge temperatures were monitored correctly to ensure medications were stored safely. There were safe systems for storing, administering and monitoring of controlled drugs and arrangements were in place for their use that were approved by health care professionals. We saw a controlled drugs record book. This had been signed by two members of staff each time a controlled medicine had been administered to people using the service. Staff we spoke to were knowledgeable about how to administer medicines safely.

Drug reconciliation sheets were also maintained in the MARs folder and were completed for each medicine administered that was not contained in a blister pack. We

Requires improvement

Is the service safe?

looked at the MAR's for seven people using the service. We checked the balances of medicines stored in the medication cabinet against the MAR and found these records were up to date and accurate.

We saw that the home had a safe system for the disposal of medicines. Medicines were returned to the pharmacy in a sealed blister pack and liquids were also returned to the pharmacy in a labelled bottle.

The arrangements for the administering of covert medicines were reviewed. We tracked one person's care plans and found they contained mental health capacity assessments and detailed instructions on the administration of covert medicines. A multidisciplinary approach had been taken in reviewing the need for covert administration in accordance with the provider's policy document. A health care professional told us, "There is a robust process in place for covert medicines. A care manager said, "The GP practice participates in best interest meeting to agree the best approach on an individual basis." The records we looked at confirmed this.

We found that the provider had an effective recruitment and selection process in place and the staff files we saw included an application form that listed experience, skills and qualifications. Each of the files reviewed included two references, information on work clearance checks and photo identification. All staff had a Disclosure and Barring Service (DBS) check prior to employment. Their references and qualifications were checked. These checks were completed before staff started the post into which they were appointed.

We reviewed a copy of the job description and job specification for carers. It was noted that on making an application for the post each applicant was matched to the job specification during the short listing process. An interview took place and the interview panel consisted of two people who were part of the management structure of the home.

The service had safeguarding and whistleblowing policies in place and staff members we spoke to said that they were confident they could escalate any safeguarding concerns. Staff said they had received training on safeguarding and were aware of whistleblowing procedures. One staff member said, "The manager will always listen to us and will act immediately." Another said, "There's a really open policy at this home and nothing is hidden."

There were procedures in place in the event of an emergency. Staff knew what to do in the event of a fire and told us that regular fire drills were carried out, which was confirmed by records we reviewed. Records also showed that staff had received fire safety training and that regular checks were made on emergency equipment to ensure alarms and other prevention measures were working. It was noted that the Fire Service had completed a routine inspection at the service in June 2015 and found that it was compliant in relation to issues of fire safety and that personal emergency evacuation plans were well designed.

Good

Is the service effective?

Our findings

At our last inspection, 8 April 2015 we found that the provider did not always assess people on their capacity to make decisions. At this inspection we noted improvements in this area and that managers and staff demonstrated a clear understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

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).

During the inspection we checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People told us that staff asked for their consent before they provided care and we observed this to be the case throughout the inspection. For example staff checked that people consented to the support they offered in helping them mobilise or with personal care. In some circumstances it was noted that best interest decisions had been taken in consultation with relatives and relevant professionals. For example, we saw consultation related to people's night check agreements and the use of alarm mats to prevent falls. In another a capacity assessments had been completed relating to the use of bed rails at night time. We also saw annual reviews that recorded discussions with people, their social worker, relatives (where appropriate) and staff about issues affecting the person's care.

Care plans contained a capacity assessment for each aspect of daily living, which described whether people had the capacity to consent, and identified ways to ensure they were involved in their care. For example it was noted in one record, "Due to the progression of dementia, carers will need to prompt to undertake self-care and assistance with eating and drinking." In another it said, "Sometimes (the person) will have capacity on (the issue) and staff are reminded to always ask first and not presume lack of capacity."

At the time of our inspection we noted that 43 DoLS application had been authorised and 19 were in the process of consideration by the local authority. We saw that the applications had been made in a timely fashion and had been kept under review. The conditions of the authorisation were being followed and in line with legal requirements.

Although care managers monitored all DoLS applications and authorisations to ensure that appropriate procedures were followed, sometimes the documents available to care staff did not always clearly state whether a DoLs application had been made or whether one was in place. DoLs documents were available in a separate folder kept in the care unit's office and sometimes inaccessible to care staff. In three records where DoLs authorisation had been granted, we could not find reference to the assessment and authorisation within the care plans. This was raised with a care manager during our inspection. By the end of the inspection it was noted that records had been updated and we saw a clear reference at the front of care plans.

People using the service said staff knew them and their needs and how best to provide support to them. One person said, "The staff are good and some are really chatty." Another said, "The staff are superb at seeing how I am. They look after me." A student health care professional who was on a placement at the home said, "There are really good bonds between staff and residents. They also seem so cheery and happy and that helps with the atmosphere on the unit."

Staff were knowledgeable about the people they cared for and demonstrated that they were aware of their health and support needs. One member of staff said, "I am encouraged to really get to know the residents on my wing. I know them all and their needs, likes and dislikes." Another said, "I love the residents' stories and all the individual personalities. It's a large home but we have meetings at the start of every shift where we are told how things are going for the people in our care and that's really useful and helps in getting to know them all."

Good

Is the service effective?

We found that people were supported to have a healthy and nutritious diet. People's nutritional needs were assessed and people were encouraged to have a balanced diet. All 16 care plans we reviewed had assessments of individual nutritional needs. People's weight was monitored monthly or more frequently if required and people's dietary needs were well known. We observed people's needs were met when diabetic meals and soft diets were required. Staff were also aware of people's likes and dislikes and were observed to accommodate these over meal times. For example one person requested warm milk with their breakfast and another asked to have their breakfast in bed.

We spoke to the home's chef who showed us a revolving menu with a choice of meals that was changed seasonally and explained how they regularly met with residents to establish likes, dislikes and inclusion of new items on the menu. The chef had a good understanding of how food should be fortified when required and showed us how they received information from staff about people's daily preferences at individual meal times.

We found that people were supported to maintain good health and had good access to health care support. The GP contacts were documented in all the records reviewed. People were supported to access care from a range of professionals for example, chiropody, district nurse, and dental and hospital appointments. A health care professional said that there were weekly GP visits and any concerns are communicated. They said, "There is good communication and liaison with the home. They follow advice and are getting better at taking a holistic approach to care." The visiting chiropodist said, "Staff are very friendly and attentive. They regularly raise issues with me and if I ever need assistance, they always help."

A mandatory three day induction was undertaken before staff started in post. The manager told us all staff were given a staff handbook as part of this induction. An 'on the job' induction was then provided and a buddy scheme was in place to support and supervise new staff. Staff had a six month probationary period and we saw records in connection with the probation review and steps the staff member had to complete in the forthcoming 12 months of service.

We found staff ability to undertake their roles and meet the needs of people were assessed as part of the recruitment process and were placed within a unit of the home best suited to their skills and experience. One staff member said, "I'm new but all the staff are on hand and I'm never left to deal with a complicated matter on my own."

Staff had access to training which meant that there were a range of suitably skilled staff on duty to meet people's needs. We saw that staff could access on-going training and their mandatory training was monitored by the manager and head office. Mandatory training areas included food hygiene, fire safety, medicines, manual handling, safeguarding adults, health and safety, infection control and dementia awareness. Staff told us they had good access to training and confirmed the that they undertook a comprehensive induction programme before starting in post. One staff member said, "We are supported to develop and I have done my NVQ 3 training here."

Staff confirmed that they received regular supervision sessions as required with their line manager and appraisals of their work performance. The records we saw confirmed this and we also saw that the home had a system in place to ensure that all staff received formal supervision three times a year one of which was the annual appraisal. We saw one record where a team leader had recorded an observation of competency of staff using a hoist. The competency checks provided staff with feedback on their performance and staff said that it gave them confidence in using the equipment. During the inspection we saw examples of senior staff mentoring junior staff. For example, a new member of staff asked for support and a team leader provided the necessary assistance.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person said, “The staff are very good. I’m happy with my care here.” Another said, “The girls’ are very nice. We are well looked after.” A health care professional visiting the home told us, “There is good compassion and kindness towards residents. I’ve even seen carers come in on their day off and offer comfort to residents who are at the last stages of life.”

Care was delivered by staff in a way that met people's needs, for example staff were observed assisting people in daily living activities. We saw staff acting in a kind and considered way when dealing with people using the service and actively listened and encouraged people to communicate their needs. They responded to people’s needs in a calm way when for example supporting them to the toilet, participate in activities and when responding to a request for drinks and snacks

Staff appeared to know all the residents well and they were observed to give people time. We observed staff respected people’s choice for privacy as some people preferred to spend time in their own room. Staff interacted with people in a considered way and it did not seem to be task driven but based on care and kindness. A health care professional that visited the home most days said, “Staff are kind and caring and tell us of any concerns. We get good feedback from relatives about the care provided in the home.”

We observed staff providing care over lunch when we observed carers providing support in a caring and calm way to those who required support. Staff gave people encouragement to eat lunch and were observed to assist people in a caring manner ensuring they went at their pace.

We observed that some people’s room doors were open during the day to support staff in observation and to prevent social isolation if people choose to stay in their room. Dignity and privacy was maintained whilst personal care was provided. We saw care staff would knock before entering people’s room and requested entry respecting people’s wishes for privacy.

People’s personal interests were acknowledged and supported. In one care plan we saw a remark, “Carers to remind (the person) about the home’s keyboard as they likes to play which makes them feel happy and really enjoy this activity.” A member of staff said, “We love to hear (the resident) sing. We encourage them whenever we can and they will sometimes sing along with the guest performer.”

A staff member said, “Life histories of residents are in their care plans and we use them to support people in one to one situations. We can see them to see what we need to do when we are in a one to one situation.”

People and their relatives told us they had been consulted about their care and support needs. One relative said, “They involved me in the care plan and keep me up to date if my relative’s condition changes.” Another said, “I get regular updates from the staff and they are no bother when I call to see how things are going.”

Good

Is the service responsive?

Our findings

One person said, “I like to help out with functions at the home and they let me do that. I especially like the entertainment and everyone participating in their own way.” Another said, “I join in on things going on but am left alone when I want some peace and quiet.” A relative said, “There is a good program of activities and I see my relative regularly and am encouraged to participate as well.”

A visiting health care professional told us, “There always seem to be something going on when I visit which is good and I see lots of staff encourage participation.” We spoke to a member of staff who was one of the activities coordinators who showed us records of activities for the week that included exercising, singing, mini-bus trips and a show that was provided on the second day of our inspection by a Pearly King and Queen.

During the inspection we saw people sitting reading newspapers or watching television. Some people were playing a board game together and a member of staff was supporting some to participate. Some people were observed socialising together and others sitting with visitors in an area where there was a café which was used as a central meeting place.

The provider had a complaints policy and people told us they were provided with a guide when they moved into the home. We saw that the pack included important information such as the complaint’s procedure, policies and important contact numbers. Relatives were encouraged to consider it and people said that if they did not understand any of the content, staff would help them.

People who used the service told us they knew how to complain. One person said, “I know how to complain and am sure that the manager takes what we say seriously.” The manager maintained a log of complaints that included a copy of the complaint’s procedure and forms for recording and responding to any complaints received. There had been one complaint about the service since our last inspection and it was noted that the issue had been acted upon and the complainant had been involved in the process and kept updated of progress.

Before people began living in the home there was a pre-assessment and an admissions process which assessed their individual needs and suitability. Each person that used the service had a care plan in place, risk assessments and documented personal goals. Each person's care plan described activities of daily living and the range of support they required. For example, it showed communication methods to be used and support with personal care and mobility needs. One plan asked staff to ensure they prompt and supervise personal care. Another set out likes and dislikes for example that they liked porridge for breakfast and tea that wasn’t too hot. One care plan asked staff to encourage one person to engage in activities as the person had difficulty in expressing this verbally.

We reviewed 16 care plans. Each plan set out the care needs for each service user. It included historical information and personalised information about the person and their family. It stated clearly if they had any allergies and for example one record highlighted in bold ‘vegetarian requirements’. An ‘At a Glance’ summary provided carers with a summary of people’s history, likes and dislikes and recorded key information. All of the care plans and risk assessments we looked at had been reviewed on a monthly basis or more frequently if required. We saw daily notes that recorded the care and support delivered to people. This supported that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

Care plans included guidance for staff on medication administration. It was noted that one person was reluctant to take their medicines at times prescribed by healthcare professionals. In another plan we saw that a person had refused medication on a number of occasions. We noted that both of these issues had been referred to the GP and nurse practitioner. Following advice and assessment we saw that the home’s covert medicines policy had been instigated. In addition, both plans provided helpful guidance to staff on how to explain the benefits and why it was felt beneficial to take the medicine.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare. People's care plans and risk assessments were reviewed regularly and reflected any changing needs. It was noted, where appropriate, that relatives’ views were obtained. We found care plans were reviewed each month and staff signed to demonstrate care had been reviewed. The team leaders took responsibility for updating and changing people’s care plans. One team leader told us each review required the gathering of information they said, “We sit

Good

Is the service responsive?

down and review the care and we always try to involve the relatives and sometimes we have to do this over the phone." An annual review system was in place and we found relatives were engaged in these reviews. Views from one person's relatives were seen in the document and confirmed their agreement to the care plan.

People's records included a Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms where required. The DNAR is a legal order which tells a medical team not to perform Cardio-pulmonary Resuscitation on a patient. However this does not affect other medical treatments. These had been fully completed, involving people using the service, and their relatives, where appropriate, and signed by their GP.

During the inspection we spoke with healthcare professional who were visiting the home and they told us they had no concerns in relation to the care provided, the home responded well to input and that the staff and management called on external services appropriately. One said, "We get to know about things quickly at Northbourne and they are efficient at providing information when we need it. The staff are well informed and get good handovers from previous shifts." Another said, "There is good communication and liaison between the practice and the home so that things get done quickly."

Good

Is the service well-led?

Our findings

At our inspection 8 April 2015 we found breaches relating to the management of medicines, sufficient number of staff to meet people's needs and people being able to make decisions about their own care and treatment. We asked the provider to make improvements in these areas. Following that inspection the provider sent us an action plan telling us how they were going to make these improvements. They kept CQC informed of the changes that had been made. At this inspection we found significant improvements in all of these areas.

Audits were carried out to monitor the quality of the service and to identify how the service could be improved. For example we saw up to date records dealing with monitoring and auditing of areas of the service including health and safety, cleaning schedules, fire checks, moving and handling equipment, decoration and maintenance. These records had been completed by dedicated staff and one of them said, "I take maintenance issues seriously as I know they affect residents and can assist staff in providing care."

The manager showed us the organisation's quality monitoring system which allowed them to improve the quality of the service for people. This monitored areas such as medicines, training, care plans, falls, weight loss, infection control, incidents and accidents and complaints. In a recent medicine's and associated training audit we saw that gaps in some staff undertaking annual medicines competency assessments had been identified and a plan was put in place to undertake checks within seven days. A regional care director told us they had external access to this system and was present during the inspection to conduct a further audit related to medicines. When shortfalls were identified it was noted that action was taken.

The manager had taken steps to address the high number of falls experienced by some people at the home. It was noted that this included analysis of times of falls, locations, susceptibility of the person involved and had led to the extra staff training and technology to assist people in avoiding incidents. The steps the manager had taken in relation to falls were considered by the specialist advisor who formed part of the inspection team and it was noted that the home were adopting current best practice techniques in trying to avoid falls by people in their care.

The training for staff was suitable and there was an appropriate use of technological aids to alert staff to the risk of a person falling when they were out of sight, especially in their own room.

A relative told us, "It's a different place today. I hope that the manager continues with the improvements." Comments from people using the service included, "The manager has made improvements."

The home had a manager in post. They were appointed in February 2015 and had applied for registration with Care Quality Commission. The regional director was providing supervision and support to the manager on a regular basis whilst they were applying for registration. One staff member said, "The managers do a great job; they are always there to support you." Another staff member said, "The team leaders will always listen and give you practical help and advice. We see the manager regularly and can go and see him. The door is always open." A member of staff told us the manager had "made a real difference to the home."

Staff told us there was good communication with the provider and senior managers at head office and said there was an open culture where significant events were reported and learnt from. Staff were aware of the reporting systems for falls and safeguarding. One staff member said, "Openness and honesty about mistakes is encouraged from top to bottom so that we all learn and improve the lives of the residents." One care manager said, "We have good team work and an open culture with good reporting systems which we all follow." Another manager said, "Senior staff at head office and the home's manager monitor that all staff receive the correct level of supervision and training and action is taken when there are issues."

Staff told us they enjoyed working at the home and the support they received from the managers and other senior staff. It was noted that senior staff were always rostered to be on duty and there was an out of hours on call system in operation that ensured that management support and advice was always available.

People using the service and their relatives told us there were regular residents and relatives meetings. Minutes from the meetings showed that people using the service and relatives discussed a number of issues included food, cleaning, laundry and activity planning. One person said, "We say what we want and things that could make the

Good

Is the service well-led?

place better. Sometimes the manager speaks to me about how better to improve our lives." Another person said, "I enjoy our meetings where we open up about what we'd like. I have spoken to the chef and made suggestions and it's good to see them implemented." A relative told us, "There are relatives meetings; I get along when I can."

There were regular staff meetings. We looked at the minutes from a recent meeting and saw that many of the matters raised by staff had been acted upon such asemployment of different shift patterns to increase the number of staff available at busy times.

We noted that the manager took account of feedback from people and relatives by conducting surveys. People using the service were generally positive about the care they received and were happy with being able to live at the home as they wanted and chose to live. In a survey of staff the majority commented that they felt that their opinion counted, they could approach senior staff with matters of concern and that their views counted when they made suggestions for improvement.