Lilian Faithfull Care

Resthaven Nursing Home

Inspection report

Pitchcombe
Stroud
Gloucestershire
GL6 6LS

Tel: 01452812682
Website: www.resthavenpitchcombe.co.uk

Date of inspection visit:
05 July 2018
06 July 2018

Date of publication:
27 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 5 and 6 July 2018 and was unannounced. This was the service's first inspection under the current registered provider, Lilian Faithfull Homes. We rated the service as 'Good' overall.

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

Resthaven can accommodate 42 people in one adapted building. It predominantly cares for older people. At the time of the inspection 33 people lived there and required support with their physical needs whilst some also lived with dementia. People lived on two floors, each floor having single occupancy bedrooms with washing facilities, lounge and dining areas, communal bathrooms and toilets. Outside there was an enclosed garden as well as an open front garden with ample car parking. Attached to the home was a small chapel which people and visitors could use.

The service is required to have a registered manager and one was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had identified areas that required improvement when they took over the home in March 2017and had since made significant improvements to the service.

There were many positive comments from people and relatives about how caring and kind the staff were and we observed many kind and caring interactions from the staff. The provider had forwarded specific examples of where staffs' patience and kindness had improved people's quality of life and wellbeing.

Personal care was delivered in private but staff sometimes forgot to respect people's private spaces, for example, we observed staff entering people's bedrooms without first knocking on the door and being invited in. Although the provider subsequently told us staff were trained to do this we have recommended that the training around this be reviewed so that practice can alter.

People's preferences and their likes were explored with them and met. People's diverse preferences were included in people's care plans for staff information and to help staff meet these.

People had opportunities to take part in social activities which they enjoyed. On one of the days of this inspection the weather was unusually hot and this had an impact on what we observed in relation to activities on that day. People were sleepy and this had an impact on their ability to be engaged. On the second day of the inspection we observed people to be more involved and enjoying themselves. The

registered manager told us this was far more representative of the activities at Resthaven. We were given examples of how support with meaningful activities had improved people's self-worth, their confidence and quality of life. On-going improvements were being made to further support people's overall wellbeing.

People were supported to take their medicines and medicines were stored securely; records were well maintained. During the warm weather staff had found it difficult to meet the medicine manufactures' recommendations in relation to the temperatures medicines should be stored at. Action was being taken in response to this and the provider told us they planned to take further action to address this.

The provider continued to keep staffing levels and the deployment of staff under review. There were enough staff to keep people safe. Where needed agency staff were used to support this and successful staff recruitment had seen this usage reduced. Robust recruitment procedures were followed and helped to protect people from those who may not be suitable to care for them.

Systems and processes were in place to keep people safe and to ensure their health needs were met. Risks to people were identified and managed resulting in these being reduced or removed altogether. People told us they felt safe and well cared for and relatives told us they considered their relative to be well cared for. People had access to health care professionals to support their health needs. Some adaptions to the building and its grounds had been made to meet people's needs.

A complaints process was in place and records showed that complaints were fully investigated and where necessary action had been taken to address these. Managers aimed to resolve complaints to the satisfaction of the complainant but in some cases, this had not been possible, despite great lengths having been taken to try and achieve this. There was evidence to show that the provider's complaints procedures were adhered to and complaints were managed in a transparent manner. Where appropriate people were offered and explanation and an apology given. The registered manager used all complaints and other feedback as points for learning.

People's relatives were made welcome and they were consulted with, where appropriate, about people's health and care. People were afforded the right to have visitors in private if this was their wish.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People's independent decisions were respected by the staff. The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were adhered to in order to protect those who were unable to consent to live at Resthaven and received the care and treatment they required. Where people were unable to make independent decisions and where it had been necessary to make decisions on their behalf, these had been made in the person's best interests.

People's end of life wishes were explored with them. People were supported to remain comfortable at the end of their life. Those who mattered to people and who were important to them could stay with them at this time. Staff provided support to relatives and friends as and when they wanted this.

There were processes in place to monitor the quality of care provided to people and monitor the home's overall performance. Where required actions were identified and completed which led to continuous improvement being made. The home's continuous improvement plan showed what actions had already been completed and what further action was planned. For example, actions completed included the recruitment of further staff to support activities for people. On-going actions included those relating to people's care records; staff were getting used to the provider's new documents.

A change in the staff culture and how staff were expected to work had led to people receiving safer and more personalised care overall. Managers were managing these changes well. They were continuing to make improvements to the home's senior staff structure, so that best practice could be fully promoted moving forward. These changes were also providing staff with the support and direction they needed. The provider had supported the registered manager to make these changes and they continued to provide additional support and guidance where needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff on duty to ensure people were kept safe. Staff were recruited safely in order to protect people from those who may not be suitable.

People were supported to take their medicines as prescribed and there were arrangements in place to keep medicines safe.

Risks to people had been assessed and action was taken to manage these and keep people safe. This included risks associated with infection.

Is the service effective?

Good

The service was effective.

People were looked after by staff who had received training and support to meet people's needs.

People were supported to make independent decisions. Where people lacked mental capacity the staff adhered to the principles of the Mental Capacity Act in order to ensure people's care and treatment was provided in their best interests.

People had access to health care professionals and were supported to attend health appointments. People had a choice in what they ate and support to improve their nutritional wellbeing.

Some adaptions had been made to the building and the gardens to help people live in and enjoy the home more easily.

Is the service caring?

Good

The service was caring.

People's received care which was caring and compassionate and which improved their wellbeing. People's preferences and wishes were explored and met.

People's care was delivered in private, although staff did not always knock on people's bedroom doors and wait for an invite to enter.

Information about people's care was kept confidential and care records were kept secure.

Family and friends were welcomed and people could spend time with people who mattered to them when they wished to.

Is the service responsive?

Good

The service was responsive.

People were supported to be involved in social activities.

People's care was planned with them and relatives (where appropriate) were included in this. Care plans included people's wishes and preferences. Improvements were continually being made to the content of these.

There were arrangements in place for people, relatives and other visitors to be able to raise a complaint. These were taken seriously, investigated and resolved where possible.

People at the end of their life were supported to remain comfortable and their end of life preferences were met. Relatives were also supported at this time.

Is the service well-led?

Good

The service was well-led.

People had benefited from the improved leadership in the home; provided by the registered manager and provider.

The provider's quality monitoring processes were effective in identifying areas which needed to be acted on. There were arrangements in place for continued improvement to the service.

People, relatives and staff could contribute feedback which was listened to and acted on.

Resthaven 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.

This inspection took place on 5 and 6 July 2018 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case used to caring for someone with health needs and who has knowledge of older people and their needs.

Prior to the inspection we gathered information to help plan the inspection. We reviewed notifications sent to us by the provider. These are information about significant events which the provider must legally make us aware of. The provider had submitted a Provider Information Return (PIR) prior to this inspection. This is information we require providers to send to us, at least once annually, to give some key information about the service, what the service does well and improvements they plan to make. We took this information into consideration when making our judgements about the service. The local authority had visited the home prior to our inspection but had not yet completed a review of the services provided. They confirmed they had no current concerns about the home.

During the inspection we spoke with 10 people who lived at Resthaven and two relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with the registered manager, the provider's Director of Care, training manager, care quality manager and the maintenance and estates manager. We spoke with one of the provider's physiotherapists, three nurses, three team leaders, two care staff and two housekeepers.

We reviewed a selection of people's medicine administration records and all current controlled medicine records. We reviewed records pertaining to complaints received and responded to. We reviewed three

people's care records and three staff recruitment files. We reviewed all current maintenance records, which included safety and servicing records. We reviewed a selection of audits which included the home's current compliance improvement plan and a report completed by an external consultant auditor. We attended a compliance improvement plan review meeting.

We requested and received information about staff training, staffing numbers, the home's Statement of Purpose and complaints investigations.

Good

Is the service safe?

Our findings

People were kept safe and their care needs met. People said, "I think there are enough staff here, I don't have to wait long if I use my buzzer to call for care." and "Yes, I feel safe here as there are staff around." Arrangements were in place to keep people safe during busy periods when staff were unable to supervise people in the communal rooms. Staff explained how they kept, for example, one person safe during these times. This person had experienced several falls and was at risk of falling again. Staff reduced the risk of harm to this person by supporting them to rest on their bed. This person's bed was designed to lower almost to the floor and it had a padded mat alongside it. An alarmed sensor mat was also used to alert staff to the person's movements. When the alarm sounded staff could respond to this and provide necessary support.

At various times during the inspection we observed senior managers, who did not normally work in the home, to be seated in the downstairs lounge. This provided staff
presence in this room when care staff were busy elsewhere or taking a break. Both the registered manager and operational lead told us they were available to do this when they were on duty. A receptionist was also able to help with this when needed. Further recruitment was taking place to both fill naturally occurring vacancies and to recruit non-care staff to support people's wellbeing when they were using the communal rooms.

The registered manager told us and our observations confirmed, there were enough staff on duty to ensure people were kept safe. The registered manager told us staff were very good at helping out when needed and that some staff had been happy to do twilight shifts. Twilight shifts were hours worked by staff which fell between the home's normal shift patterns. For example, starting an hour before the rest of the day staff (at 7am), or remaining for a couple of hours after the day staff had finished (8pm to 10pm) to help the night staff either attend to people's early morning needs or their bedtime needs. The registered manager explained these shifts could not be covered seven days a week, but also, if the home was not full or dependency needs were not high, this was not needed.

The provider continued to keep staffing levels and the deployment of staff under review. They were actively looking at ways of having a member of staff to start at 7am each day. Agency staff were used when needed to support safe staffing numbers but the usage of this had reduced following successful staff recruitment. The provider was also reviewing staff breaks to ensure they were planned around people's needs.

Staff recruitment records showed that the provider's recruitment procedures had been followed. Checks on staff, before they worked with people in the home, included, a clearance by the Disclosure and Barring Service (DBS). A DBS review looked at all police related charges, spent charges, convictions and cautions as well as checking against a list of individuals who have been barred from working with vulnerable adults. Employment histories were explored and references sought. This helped to protect people from those who may not be suitable to care for them.

People were protected from potential risk. Risks had been assessed, which included those related to

people's health as well as environmental risks. The provider had assessed all windows and their openings on purchasing the home. The provider's maintenance and estates manager confirmed that the initial assessment had shown that all windows had restrictors on. When engaged the restrictors successfully restricted the openings to 100mm as recommended by the Health and Safety Executive (HSE). At the time of this inspection the weather was very warm and we found windows, above ground floor level, open beyond the recommended 100mm. We found the in-built window restrictor could be easily overridden. We reported our findings straight away to senior managers. By the end of the same day, all windows had been reassessed, taking into account the ease by which the restrictors could be overridden. High risk openings, meaning above ground floor level and wide enough for a person to fall from, had been fitted with a restrictor which could not be overridden by the end of the day. Windows assessed as medium risk were fitted with the same type of restrictor by the following week. This risk had therefore been fully removed. The registered manager told us the importance of following health and safety guidance would be reiterated to all staff.

There were comprehensive records in place which showed that other environmental risks were reduced or removed. Risks associated with fire and legionella were assessed. There were systems and processes in place to ensure risks associated with these were reduced and removed where possible. Records showed that regular maintenance and servicing by outside contractors, along with the provider's maintenance team, helped to keep equipment and the building safe.

Infection control measures were in place and one member of the housekeeping staff explained how their team cleaned safely and in a way which reduced the potential spread of infection. To reduce risks of cross contamination care staff wore protective aprons and gloves when delivering personal care, wore tabards when serving people's food and used colour coded cleaning equipment. Laundry was segregated and soiled laundry managed separately. The kitchen had been fully re-fitted by the provider and inspected by the Food Standards Agency. It had been awarded a rating of '5'; the highest and best rating for food hygiene and safety.

Risks affecting people's health had been assessed and risks assessments and care plans were in place to give staff guidance on how to manage these. For example, people's risk of developing pressure ulcers was assessed and where required, on-going actions taken to prevent the development of these. We saw pressure reducing equipment in use; cushions and mattresses and staff repositioned people to relieve pressure from the skin. People's ability to move around safely was assessed from the point of admission and monthly thereafter. Action was taken to support people to do this safely. We saw people with walking aids and staff using hoists to manoeuvre people. Staff had received training and instruction on how to use moving equipment safely.

When people experienced a fall the risk of them experiencing a further fall was assessed and a risk assessment completed. Other records such a care plan and a falls action plan, in one person's case, recorded what actions were to be taken to avoid the person having further falls. In one person's case, during a period of several falls, staff and the person's GP had worked closely together to review all possible causes for their falls. For example, medicines had been reviewed and where it was possible for these to potentially add to the person's risk of falls, they had been stopped by the GP.

Potential falls from bed had also been identified and where required people had been provided with beds which lowered almost to the floor and a padded floor mat. This specialised equipment was used when bed rails were assessed as not being appropriate to use. For example, for people who lived with dementia or who were experiencing confusion and who may attempt to climb over a bed rail and fall from a height.

One of the provider's physiotherapists told us, they were supporting staff to look at further actions which

could help reduce the risk of 'potential' falls. This would involve the medical reviews, but also an earlier use of physiotherapy sessions to improve people's strength and balance. Accidents and incidents were recorded and monitored. The registered manager looked for trends and patterns in the information they gathered about these to help them check if the actions put in place, to reduce recurrences, were appropriate and effective.

During the inspection the weather was unusually hot and the conservatory on the first floor, which acted as the lounge and dining area for this floor, was too hot for people to use. People therefore remained in their bedrooms. We observed staff making sure people in their bedrooms were provided with enough cold drinks. Since this inspection the provider's estates and maintenance manager confirmed that the air conditioning, previously planned, had been successfully installed in the conservatory.

People's medicines were managed safely. Medicines were stored securely and all necessary records had been well maintained. This included people's medicine administration records (MARs) and all records pertaining to medicines which required additional security and different administration practice. Nurses informed us there had been issues with the supplying pharmacy, which had resulted in incomplete monthly supplies of people's medicines. Nurses said it had been necessary for them to "constantly chase" the pharmacy for people's medicines. During these difficulties one person had missed their medicines for two days. Staff had been in contact with the person's GP to check if the person was medically safe; it had been confirmed that the person had not suffered any ill-effects. The registered manager had attended numerous meetings with the pharmacist to try and resolve the issue. The registered manager had eventually decided to use another pharmacy to ensure the risk of people not having access to their medicines was fully reduced. Arrangements under the new pharmacy were due to start imminently.

During this inspection the nurses were taking all possible action they could to reduce the temperature of where medicines were stored. Manufacturers of medicines give guidance on what temperature medicines should be ideally stored at in order to maintain the medicines' optimum effectiveness. A heat reflecting blind had already been fitted at the window of the storage room and nurses were using ice blocks and fans to try to prevent the temperature in this room from increasing. A record was kept of the daily temperatures and despite this effort, on some days, the temperature had exceeded that which was recommended. It was subsequently confirmed by a member of staff that since the inspection, additional ventilation in the medicine room's door had been fitted. The provider informed the Inspector that they were planning to include air conditioning in this room as well.

There were arrangements in place to protect people from abuse and discrimination. Staff we spoke with understood their responsibilities in relation to reporting relevant concerns. Senior staff adhered to the provider's policy and procedures on safeguarding adults and worked with external agencies to help protect people from harm. Staff were aware of the provider's whistle blowing policy and understood how to whistle blow. The registered manager said, "For me it is that everyone feels safe here. I don't tolerate poor practice or poor performance. I encourage whistle blowing and staff have seen the benefits of this as they know I will act on what they report."

Good

Is the service effective?

Our findings

People were cared for by staff who had received training and support from the provider. The training record showed that most staff had received training in the following subjects, safeguarding adults, safe moving and handling, food hygiene, health and safety, fire safety and infection control. A system was in place to ensure all staff completed this training and then to ensure staff completed update training. We spoke with three nurses about the training provided to them. One nurse said, "Oh my goodness … so much training" and another confirmed they had been supported to re-validate their registration with the Nursing and Midwifery Council (NMC). A housekeeper told us they had completed all of the above training and was able to speak with us confidently about safe cleaning practices and their responsibilities regarding the control of substances hazardous to health (COSHH).

All staff who worked for the provider completed induction training. During this they completed modules of training from the Care Certificate (The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if staff are 'new to care' this should form part of a robust induction programme for them). Staff were also introduced to the provider's policies and procedures at this point as well as, the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). They also received an introduction to dementia care.

Although the training record did not record staff as receiving training on the MCA or DoLS the provider information return (PIR) stated that staff received this training and further support to understand the principles of the MCA. This was also confirmed during the inspection. Some staff, not all, had completed further dementia awareness training and training on equality and diversity. The PIR stated staff received tuition on specific health care subjects when required, for example, Parkinson's Disease, epilepsy and diabetes. Records showed that nurses also received update training on numerous clinical skills such as wound care and the taking of blood.

The training manager was aware that more training on dementia care was needed. 'Toolbox' training sessions had been provided by one of the provider's dementia link workers on how to support people's nutrition and communication when living with dementia and more sessions were planned. The registered manager was due to start the dementia leadership course in October 2018. It was hoped that the home would then be able to support more staff to become dementia link workers. Staff who completed these courses have an interest in dementia care and the skills to promote and support staff to deliver good dementia care. The training record showed that support sessions (supervision sessions) were carried out with staff on a regular basis which both the staff and registered manager confirmed as having taken place.

People's mental capacity was assessed where it was appropriate to do so. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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 met. The staff were following the principles of the Act. People were supported in the least restrictive way and supported to make independent decisions. People's decisions were respected by the staff and supported, even if others in the person's life disagreed with these or considered these to be unwise. Where it was suspected that a person lacked mental capacity to make an independent and specific decision, their mental capacity was assessed in relation to whatever the decision was that had to be made.

We reviewed several completed mental capacity assessments, which were decision specific and related to people's care and treatment. For example, nutritional care and personal care. One person's capacity assessment recorded the fact that the person could initially understand what staff were saying to them, about their nutritional care, but they could not retain the information being given to them or weigh up risks in relation to this. Appropriate records showed that in the person's best interests it had been decided that staff would support them at mealtimes so they could maintain their nutritional wellbeing. The same applied to the administration of the person's medicines. The least restrictive practice was used to support the person in taking these independently.

DoLS applications had been submitted to the supervisory body (the county council) where people had been unable to consent to live at Resthaven or consent to the level of supervision they required to keep safe. These applications had yet to be processed by the supervisory body. DoLS for one person had been authorised by the supervisory body and there were no conditions attached to this. Where best interests decisions had been made on behalf of people, in relation to where they should live for example, where appropriate, an independent mental capacity advocate (IMCA) had been involved to support the person's best interests. Arrangements were being made for one person to have access to independent support and representation as they had no-one to help them make necessary decisions.

People's nutritional needs and risks were assessed and action taken to address these. People were supported to eat and drink and to make choices about their food. One person said, "The food is very good here, they usually ask me what I would like." We observed staff helping people to make their mealtime experience an enjoyable one. Dining tables were laid with table-cloths and flowers which looked welcoming. One person said, "I look forward to lunches and mealtimes as it breaks up the day and stops us staring at the four walls." Another person said, "I enjoy the food here, if I want something different I can get it." This person told us they could have fruit when they wanted it.

People's weight was monitored as was their appetite and any concerns about these were discussed with the person's GP. One person's appetite had reduced and they had slowly lost weight over a period of time. Action had been taken to support them which had included a fortified diet. This involved adding extra cream, butter and powdered milk to foods to increase the calorie content. Additional snacks and fortified drinks had also been offered as well as increased staff support at mealtimes. Records showed that over a period of three months the person had gained weight.

We observed one member of staff helping one person to eat and drink. This was done in a quiet and skilled way which maintained the person's dignity and took place at the person's own pace. Another person needed staff to remind them to eat and to try and help them remain focussed on their meal. This person frequently walked away from the dining table so they were also supported to eat in-between meals by staff

using 'grazing plates'. These were placed where the person could see them and contained finger foods. We observed this person returning to these plates and eating items from them as they walked past them. Pictures had been taken of the meals provided which were going to be made into pictorial menus for the dining tables. This was to support people to be able to make choices about what they wanted to eat.

People's health needs were assessed and they had access to appropriate health care professionals. People were supported to attend health appointments. A GP visited the home when people were poorly but the registered manager told us they wanted a more consistent and regular service from the practice. They were planning a meeting with the practice manager to discuss this. People's care records showed that various health care professionals had been involved in supporting people. These included community nurses, mental health practitioners, physiotherapists, occupational therapists, dental and optical services and a visiting chiropodist.

The registered manager had ensured people had been able to discuss their resuscitation wishes with their GP. They had also ensured that any GP 'do not resuscitate' (DNR) orders was recorded and known to the staff. We saw clear and accessible information about these in people's care records. Where people had not been able to independently discuss this decision with their GP, the GP had consulted their representative.

There had been adaptions made to the building to support people's needs, for example, communal bathrooms were fitted with equipment which helped staff bathe people safely. This included hoists, slip reducing flooring and easily accessible showers. Hand rails had been placed alongside toilets to aid safer use. A call bell system had been fitted in all bedrooms and communal rooms. One outside garden area had been enclosed with fencing so that people could use this independently and safely (some areas of the home's garden originally merged seamlessly with the natural countryside that surrounded the home). The provider was aware of the need for more communal space on the ground floor and plans were in place to extend the building after the summer season. Arrangements were underway to improve the signage in the home and plans were being made to introduce colour, both of which would help people orientate themselves.

Good

Is the service caring?

Our findings

People told us staff were caring and friendly. Comments included, "Carers [care staff] are very good here, everyone is friendly here and they are very good" and "I like the staff here, everyone is friendly and they make me feel safe. I don't feel I have any worries here" and "I can't fault it here, everyone is nice and I don't have to worry about anything" and "I feel very well looked after here, everyone's nice and I feel listened to."

Relatives said, "I cannot speak highly enough of Resthaven. The care and support received has been second to none, all of the staff have been able to build a good relationship with my Mum and have always been very respectful" and "I feel the service is caring, it seems unrushed and carers take their time" and "I feel Mum is well looked after here, staff are caring and relaxed which helps Mum feel safe and calm." Prior to the inspection we had received feedback from a relative telling us how caring staff had been towards their relative.

We observed many caring interactions from staff when they supported people. These included getting down to the person's level so they could be seen, holding people's hands to provide comfort and reassurance and giving people time to express themselves and responding in a kind and supportive way. We observed one member of staff's approach not to be so attentive but this was the only case. The provider subsequently explained that an accumulation of several factors on this day had an impact on this member of staff's performance. This observation was not representative of the caring approach usually shown to people at Resthaven. The above feedback from people and relatives, other observations made by us and information gathered during and following our visit to the home, told us staff were caring and compassionate.

The registered manager carried out observations of staffs' interactions as well as their approach towards people, to ensure there was a caring and compassionate culture. They also monitored how staff interacted with each other to ensure staff respected and valued each other. A lot of work had been done on changing and improving the staff culture in respect of how staff treated each other and worked together as one team. Staff meetings and staff support sessions had focused on effective communication, positive relationships and team working. The registered manager had made her expectations clear in relation to staff values and behaviours.
The registered manager told us there had been improvements in the staff culture and she was confident these would continue moving forward.

People's privacy was usually upheld. One relative said, ''When I visit my Mum staff always make sure there is quiet area for me to spend time with her, it is nice to have this privacy." There were times when we observed staff walking into people's bedrooms, irrespective of if the door was a-jar or closed, before first knocking and waiting to be invited in. This happened on one occasion when we were talking with a person, in their bedroom. People's bedrooms are their own personal spaces when they live in a care home and need to always be respected as such. The provider subsequently confirmed that staff were trained to first knock on people's bedroom doors.

We recommend that the service, seek further advice from a suitable source, about the training provided to

staff in relation to this, to ensure it can be effectively put into practice.

Personal care was always delivered behind closed doors and staff discussed people's care, either with the person quietly or with each other, in private. Care records were kept secure and only people's legal representatives and relevant professionals could access to these. People's correspondence such as their post was kept confidential and delivered to them or their legal or preferred representative.

People were supported to maintain links with people who mattered to them. People were able to have a phone line in their bedroom and the homes Statement of Purpose stated that WIFI was available. People's relatives and friends were able to visit at times which suited the person living at Resthaven. One person said, "When my friends visit they are always made to feel welcome and I enjoy spending time with them." We observed family and friends visiting at various times of the day and being welcomed. We observed visitors looking relaxed and in one case enjoying the garden and surrounding countryside. People could go out with family and friends when they chose to.

Staff had received training on equality and diversity as well as dignity and respect. The content of people's care plans contained personal information gathered from people, or where appropriate, their relatives, on their personal and preferences. For example, information was available for staff on people's likes and dislikes with regard to their care and support and other diverse preferences. People had clearly been asked about how they wanted their care and support provided to them and their responses had been included in the care planning. Staff knew people well and their needs were able to be supported in a personalised way.

Information was subsequently forwarded to us which gave us examples of where the formation of meaningful relationships with staff and the delivery of personalised care, had benefited people. On admission to the home one person, who lived with dementia, had been resistive to personal care, was socially isolated and showing signs of depression. Interactions with this person were limited to just a few staff so relationships could be built up. The person was included in social activities on their terms. Over a period of time their resistive behaviour subsided and there were other outward signs which showed the person's wellbeing had improved. This had been a consequence of the staff's' patient and caring approach.

Time had also been taken to explore the things that mattered to people so that staff could get to know people as individuals. One person said, "I'm not sure I could always choose what time I get up, but I feel very lucky with the care I do get." Another person's preferences were met and they felt happy with how their support was provided. They said, "I like spending time in my room. I feel perfectly free to do as I want. If I wanted anything I would feel very happy to just ask." One relative told us how staff had built up a "good relationship" with their relative and how staff "knew them well."

The provider also forwarded a further example, of how meaningful relationships, built up between the person and staff, had improved the person's quality of life as well as their self-worth and confidence. By caring about the individual person and taking time to talk with them, staff found out what their likes and preferences were. Staff spent time with the person enjoying some of these with them and providing friendship. Through these meaningful interactions staff also learnt about the person's religious faith and had been able to support this. For example, staff introduced the person to the church services held in the Chapel attached to the home.

Good

Is the service responsive?

Our findings

People told us staff met their needs. Care plans provided staff with guidance on what people's needs were and how these were to be met. The registered manager and care quality manager told us the maintenance of care plans and other care records had improved. The provider required all care plans and care assessments to be reviewed and updated monthly; before, if people's needs altered. Staff were getting used to a change in the provider's care records so, arrangements were in place to ensure staff were completing the right records. The registered manager told us the monitoring of care records was an on-going part of their quality monitoring
process. Whenever we spoke with staff about people's care needs and their risks, they could tell us what these were and how they should be met.

On the first day of the inspection several events showed that staff needed to be able to respond to many different needs and situations, which they did well. On this day this included the death of one person earlier in the day. Staff needed to be available to support the relatives during their wait for the GP to certify the person's death. A long delay in the GP being able to do this was upsetting for both the relatives and the staff. Once the GP had visited arrangements were made to remove the person's body. The relative said, "I cannot fault the care here, though the care after a loved one has passed away lacks any dignity." The registered manager told us they would follow this up with the GP practice as the wait had been too long. They wanted to avoid this from happening again. Later in the day one new person's admission needed to be completed and they also required support to settle in. Another person required the support of staff to attend a health appointment which they were provided with.

Technology was used to help staff respond to people's needs in a timely way. For example, people who were at risk of falls from bed or who were prone to walking unaided and becoming disorientated or unsafe, had alarmed pressure mats alongside their beds or chairs. These alerted staff to movement so they could attend to the person and provide the support they needed.

People had access to activities and the registered manager said, "Activities are as important as the care." The activity provision we observed across the inspection varied in quality and people's ability to be engaged. On the first day, in the morning, we observed some ladies having manicures and their nails painted. Those taking part in this appeared to be relaxed and enjoying it. In the afternoon people's ability to be engaged in activities varied as did the staffs' skills in providing meaningful activities at this particular time. The weather was unusually hot and people were observed to be sleepy. In response to this heat one manager went to a local hardware shop and purchased additional fans to help cool people down. On the second day the activities were of a beach themed afternoon in the garden and, although still very warm, was well attended by people whose engagement in the activities was fully supported. We heard a lot of laughter during this activity, which included hooking plastic ducks in a paddling pool. The registered manager told us this session was more typical of those held at Resthaven, where people were fully engaged and enjoying themselves.

The registered manager had also introduced an activity which had proved to be successful with people. This

activity involved people in the home taking a virtual cruise. They visited a different country each month and during the month some activities were linked to the country being visited. This had encouraged people to share memories and experiences of their travels, gain more knowledge of the country being visited and sometimes try the foods of the country being visited. This had involved the kitchen staff preparing themed meals. The registered manager told us staff were employed from seven different countries and the cruise had visited some of these. Staff had therefore participated and had talked about their countries and some had dressed in clothes from their country. External entertainers also visited the home and for example, when people were visiting Turkey, a belly dancer had visited the home.

We were subsequently provided with a record of activities which had taken place on other days. These included reminiscence, arts and crafts, music and singing sessions and activity coordinators supporting people on a one to one basis with an activity they particularly enjoyed. People's response and levels of engagement in the activities they took part in were noted by the staff. This helped staff to ensure people received activities which were predominantly meaningful to them and which they enjoyed.

There were arrangements in place for people, their representatives and other visitors to the home to be able to make a complaint. The provider's complaints process was on display for guidance. Some people told us they knew how to make a complaint and others were not so sure. One
person said, "If I wanted to make a complaint I wouldn't be too sure what I would do" and another person said, "If I was unhappy with anything I would soon let the authorities know about it." One relative said, "I have not had to make a complaint though if I needed to I know what to do. We have a copy of the complaints procedure to go through if we need to."

The registered manager told us they were keen to provide people with opportunities to raise concerns or discuss with them any areas of dissatisfaction they may have. To support this the registered manager spent time visiting people and talking with people informally each day. Set meetings had been organised for people and relatives to attend, but these had been poorly attended. The registered manager told us they met with most relatives on a regular basis anyway or relatives contacted them by phone or email. They told us people and relatives preferred to speak with them or provide feedback on an individual basis. One relative said "There is good
communication between myself and the manager. Mum knows who the manager is." One person who lived at Resthaven said, "I feel the manager is very approachable and the service is well managed. I am lucky to be here. I don't have any worries here."

We reviewed how complaints had been managed and responded to. Complaints were recorded, along with when they were initially received. Any investigation carried out and the final response provided to the complainant was also recorded. Records showed what action had been taken in response to the complaint. In one case this had included a staff disciplinary. In some cases, the director of care had been involved in completing a further investigation and responding to the complainant.

One complaint had necessitated a response from the provider's accounts department which had been provided to the complainant. Another complainant had shared their concerns with other external agencies including the Care Quality Commission. Concerns shared with us were being investigated by another external agency. There was evidence to show that the provider was complying with the additional due process. The registered manager and director of care told us they aimed to resolve complaints to the satisfaction of the complainant, but sometimes this had not been possible. There was evidence to show that in one complex case senior managers had gone to great lengths to try and resolve things for the complainant but they had remained dissatisfied.

Care staff frequently looked after people who were at the end of their life. The registered manager said, "The staff are brilliant when giving end of life care. They are able to think out of the box. It's a privilege to be with someone when they are leaving this world and to give them a peaceful death." They told us their vision for the home was to become a specialist in palliative and end of life care. Staff had received training in this area of care and nurses had the skills and knowledge to be able to meet people's health needs at this time. Staff also worked closely with other professionals at this time, for example, health professionals as well as religious leaders, to ensure the person was fully supported. People's end of life wishes and preferences were explored with them during their stay at Resthaven. These were recorded so that at the end of a person's life staff were clear about how a person wanted to be supported.

The chapel attached to the home was available for people to use and for their relatives to use when they needed time to reflect or following a loss. It had been used by one family for their relative's service of remembrance. The staff were happy to organise wakes at the home if this is what people and relatives wanted.

We spoke with one relative during the inspection who had just lost their relative. They and another relative had been able to remain with their relative throughout the day and night. They told us staff had been very caring and compassionate, both towards their relative and them. It had been the relatives' wish to remain with their relative until they were collected by the undertaker, which the staff supported them to do privately.

Good

Is the service well-led?

Our findings

People had benefited from the improved leadership being provided by the registered manager and provider. The provider had identified areas that required improvement when they took over the home and had made significant improvements to the service. The provider had identified some areas for on-going improvement, which were in the process of being addressed. These included the monitoring by the registered manager of completion by staff, of the provider's new care records. Actions already completed had included further support for the provision of activities, which included the recruitment of two new activity co-ordinators.

The provider had effective quality monitoring arrangements in place which led to improvements being made to the service. There were processes in place to ensure the provider was fully informed of improvement actions being taken and of those completed. A quality care manager, appointed by the provider, in late 2017, had given consistent support to the registered manager since December 2017. This manager oversaw the creation of a continuous improvement plan (CIP). The CIP recorded all actions for improvement. For example, this had included the monitoring actions in relation to the care records and actions taken to support social activities. The CIP was formally reviewed monthly. Once the quality care manager evidenced that all actions had been completed, these were signed off and removed from the CIP. The CIP also recorded any actions identified through the provider's auditing programme. The CIP provided a structured plan for on-going continuous improvement of the service.

The registered manager and her staff completed the provider's yearly plan of audits. We reviewed a selection of audits. These included for example, an infection control audit completed in May 2018. This showed that all necessary areas for compliance and safe infection control had been met. Care plan and care record audits were completed and were effectively picking up areas which needed review or completion by the staff. A process was in place to communicate the findings of the audit back to the staff in order for them to know what action to take. The registered manager followed up actions to ensure staff were completing these. This ensured people's care plans and care records remained relevant and up to date. We also reviewed monthly and weekly medication audits, which showed that staff and managers monitored the safe management of medicines.

The provider had used the services of an external auditor. Their auditing acted as a second check of the home's compliance and provided a report for the provider on the home's overall progress so far. The last visit by this auditor had been May 2018 and they had made some recommendations. These had been added to the CIP. We attended a meeting where the quality care manager reviewed the CIP with the registered manager. This meeting went through the many actions which had been fully completed and gave an update on other action which were making good progress.

People and relatives told us they knew who the registered manager was and they felt able to approach them. The registered manager had been in post since April 2017. The care home must have a registered manager in post as a condition of its registration with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager worked alongside staff, had an open-door policy and met with people and relatives. This enabled them to receive feedback and communicate with different groups of people and staff. An open and transparent culture had been promoted. We read reflective reports, which the registered manager had written since being in post. This helped us to understand the journey they and the home had been on. Significant changes had been needed to keep people safe, ensure they received the care they needed and to enable the home to continue providing a service. These changes had not suited all staff and some had left. Poor practice had not been tolerated and some staff had been dismissed. The registered manager said, "Everyone (meaning staff) has to work together." The formation of a settled and strong senior staff team had been one of their main challenges and work was still in progress to get this right. When talking with the registered manager about the changes already achieved they said, "Understanding why things need to be done is important." Staff meetings and many individual sessions had been held with staff to help them understand what needed to be achieved and why.

We asked for further information to be forwarded to us on what had already been implemented with regard to staffing and how the provider planned to staff the home moving forward. They also provided an update on planned staff recruitment. The information received showed that the provider had supported and continued to support the home so that on-going improvement could be achieved.

Staffing numbers had been significantly increased both on day and night shifts in the last year. The provider had continued to support the use of agency staff when needed. Staff recruitment had taken place to both increase staffing numbers generally and to address the high staff turnover during a period of change. Further recruitment was planned to both fill naturally occurring vacancies and to improve services for people. For example, in the provision of activities and ensuring people's well-being was maintained when they were using the communal rooms.

A risk register, managed by the director of care, gave an oversight of the home's dependency levels. This was updated and reviewed each week. It helped senior managers make decisions about future admissions to the home. It prevented inappropriate admissions and people being admitted with needs the staff were not in a position to meet. It also monitored people's changing needs and identified if people may require a different type of care, for example, dementia care, which other homes owned by the provider maybe better placed to provide.

The registered manager was open to staff suggestions and ideas and those of the people and their relatives. For example, when discussing plans for the redecoration of the home, a staff member suggested incorporating and reflecting the local surrounding countryside. This had been agreed on and was to be implemented. Suggestions and ideas from staff about how further links with the community could be made had also been agreed on. Therefore, further links with local schools and a Brownie Pack were to be made.

The home was already very much part of the village and parish it was in and people benefitted from the links already made. For example, with churches, a local choral society and a nearby library. Residents of the village the home was in supported events at the home and one villager change the flowers in the home's Chapel each week. The registered manager told us they planned to have closer links with surrounding village agents so they were aware of what support the home could offer.

Feedback from people, relatives and others had been informally gathered in the last year but the provider planned to gather more formal feedback in 2018 through its satisfaction survey process. Information from

this would be collated, shared and acted on.

The registered manager was aware of their responsibilities under their registration with the CQC and met these. These responsibilities included ensuring necessary regulations and other legislation was met and to strive to improve the services provided. They also knew to ensure the rating awarded to the home by the CQC was prominently advertised and to forward appropriate notifications to the CQC.