HC-One Limited

Pennwood Lodge Nursing Home

Inspection report

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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

Overall summary

The inspection was unannounced. When we last inspected the service in January 2015 we found there were four breaches of legal requirements. These were in respect of safeguarding people from abuse, consent to care and treatment, respecting and involving people and assessing and monitoring the quality and safety of service provision. We have checked during this inspection that the required improvements have been made.

Pennwood Lodge Nursing Home provides residential and nursing care for up to 60 people living with dementia. At the time of our inspection there were 35 people in residence but one person was in hospital. The home has four 15 bedded units, each with their own communal lounges, dining rooms and bathrooms. One of the units was closed and due to be refurbished. Of the other three units, one is for people with personal care needs

Summary of findings

(residential care) and the other two are for people with dementia and nursing care needs. All bedrooms were for single occupancy and the majority of rooms had en-suite facilities.

There was no registered manager in post at the service however the interim home manager had already made application to CQC to be registered and was due to be interviewed in July 2015. A permanent home manager has already been appointed but is unable to take up the post until the autumn. They will then apply for registration with CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The manager and staff team were knowledgeable about safeguarding issues and knew what to do if there were concerns about a person's safety. Events that had happened were reported appropriately to the local authority and the Care Quality Commission. This was a significant improvement from our last inspection when events were not being reported appropriately.

A range of risk assessments were completed for each person and appropriate management plans were in place. In addition, specific risk assessments were completed that related to the person's care and support needs, for example, the risk of choking, or risks resulting from their behaviours.

The premises were well maintained and maintenance checks were completed on a weekly, monthly and quarterly basis. Regular servicing of all nursing equipment ensured they were maintained in good working order. Some parts of the home were shabby and there was concern expressed by relatives in respect of the delay in refurbishment works.

There have been significant changes in the staff team since the last inspection. A new 'interim' manager was in place and a number of new staff had already been recruited. There was an ongoing recruitment drive in place. Agency staff were sometimes used. When they were, it was usually someone familiar with the service. This ensured people were looked after by staff they knew. Staffing numbers each shift were based upon the collective needs of all the people in residence and adjusted as and when necessary.

People's medicines were managed safely. There were procedures in place when a person who lacked the capacity to make decisions declined their medicines. This involved decisions being taken with the involvement of families, healthcare professionals and staff to decide if it was in the person's best interests to conceal medicines in their food or drink.

All staff completed a programme of essential training to enable them to carry out their roles and responsibilities. New staff completed an induction training programme and there was a programme of refresher training for the rest of the staff. Care staff were supported to complete nationally recognised qualifications in health and social care.

People made their own daily living choices and decisions where possible. Where people lacked the capacity to make decisions, best interest decisions were recorded by those involved. Staff received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and knew how to apply this to their role. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

The specific dietary requirements of each person were assessed to ensure they were provided with sufficient food and drink. There were measures in place to reduce or eliminate the risk of malnutrition or dehydration. People were provided with a balanced diet and were able to choose what they had to eat. The way in which some staff supported people to eat their meals could be improved to make the meal time experience for the person better. Arrangements were made for people to see their GP and other healthcare professionals when they needed to.

There were good relationships between people and the staff who looked after them. Staff spoke respectfully about the people they looked after. Relatives told us the manager and the staff were kind and friendly and always made them feel welcome.

Care planning documentation was generally well written and provided an accurate account of the person's care and support needs. Staff were provided with information about how planned care was to be provided. Care plan reviews were undertaken on a monthly basis and formal reviews with people's family were completed at least yearly.

Summary of findings

People were able to participate in a variety of social activities. People and their relatives were encouraged to have a say about aspects of their daily life and regular relative's meetings were held. People living in the service their relatives or people who acted on their behalf were encouraged to express their views and opinions.

Since the last inspection there had been a change in the management and leadership of the service and this has benefitted the people who live there, their families and the staff team. Positive comments were made about the improvements by relatives and the staff team. The systems in place to monitor the quality and safety of service provision were being used effectively and had ensured that the required improvements had been made. Some minor improvements were highlighted during this inspection and have been detailed in the main body of the report. Because of the significant improvements that have been made since the last inspection, we have every confidence that these will be addressed by the provider and the manager.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People received care from staff who were trained in safeguarding and recognised abuse. Staff knew what to do to safeguard people from harm.

Staffing levels were calculated based on the collective needs of people in residence. There were enough staff to keep people safe, although at times people could be left unsupervised whilst staff were completing other tasks. Risks to people's health and welfare were generally well managed.

The recruitment of new staff followed robust procedures and ensured only suitable staff were employed.

Is the service effective?

Good

The service was effective.

People were looked after by staff who received training and had the necessary knowledge and skills. The staff were well supported.

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. Staff sought consent from people before helping them.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards. The appropriate applications to deprive a person of their liberty had been submitted to the local authority and were waiting to be processed.

People were provided with sufficient food and drink to meet their individual requirements. Where people were at risk of poor nutrition or dehydration, there were measures in place to monitor and manage the risk.

People were supported to see their GP and other healthcare professionals as and when they needed to do so.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness. People were at ease with the staff and had good relationships with them.

People were looked after in the way they wanted. Staff took account of their personal choices and preferences. People were supported to make decisions about how they were looked after, if they were able to express their views.

Is the service responsive?

Good

The service was responsive

People received the care they needed because their care plans were reviewed and kept up to date. Some minor improvements were required with the way one specific document was completed

Summary of findings

There was a varied programme of activities appropriate for people living with dementia.

People, or those acting on their behalf, told us they were encouraged to make comments about the care provided. Relative meetings were held regularly. People and their relatives were listened to.

Is the service well-led?

Good

The service was well led.

People, relatives and staff felt that the manager provided good leadership for the staff team because they were visible, approachable and provided opportunities to listen to the views of all.

There was a programme of audits in place to check on the quality and safety of the service. There were systems in place to learn from any accidents, incidents or complaints and actions were taken to reduce or eliminate the risk of reoccurrences.

Pennwood Lodge 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

The last inspection was on 5 and 6 January 2015. The service was given an overall rating of Inadequate. Since this inspection there has been a change in the leadership and management of the service. The provider chose to close one of the units thereby reducing the maximum number of people who could be accommodated to 45. The reason for this was to enable the service to stabilise and improve and also allow refurbishment work to proceed. Following our inspection in January, we asked the provider to tell us how they would improve and they submitted their action plans and said they would achieve this by the end of May 2015.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in respect of people living with dementia.

Prior to the inspection we looked at information we had about the service. This information included the previous inspection report and statutory notifications that the provider had sent to the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We analysed the outcomes of safeguarding concerns raised with the local authority since our last inspection in January 2015. We had not requested that the Provider Information Return (PIR) be submitted prior to this inspection.

Since the last inspection we have been meeting regularly with the Gloucestershire County Council commissioning team, social workers and the safeguarding team, and nurses from the continuing health care team. Their views have been incorporated in to the body of the report.

During the inspection we spoke with 13 people and 4 visitors. We also spoke with 14 staff, including the registered manager, the assistant operations director, nurses, care staff and other ancillary staff.

Not every person was able to express their views verbally therefore we spent some time observing how people were being looked after. 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 tell us about their life in the home.

We looked at six people's care records, training records for the whole home, staff duty rotas and other records relating to the management of the home.

Good

Is the service safe?

Our findings

People told us, "I feel very safe and well looked after", "The staff look out for us and make sure we don't do anything stupid" and, "I am not worried about anything. The staff are very good to me". One relative said, "I have greater confidence in the staff now and do not worry so much when I am not visiting". Information to advise relatives and other visitors to the home about what to do if they had concerns about 'elder abuse' or the safety of people was displayed in the main reception area.

Not all people were able to tell us whether they felt safe, therefore we spent time observing their interactions with the care staff. People were at ease with the staff and were spoken with in a kind and friendly manner. However there were many occasions throughout the inspection where we saw groups of people left unsupervised in the lounge areas for significant periods of time. This was brought to the attention of the staff who said they would not have left people unattended if there were concerns and they would keep the time to a minimum.

Information files regarding safeguarding procedures were located in all units. The files contained the provider's safeguarding policy and procedure, copies of Gloucestershire County Councils policies, guidance, protocols, and forms that were to be completed by the staff when safeguarding concerns were alleged, witnessed or suspected. Safeguarding tracker forms were used to record progress, discussions and updates for each safeguarding incident. In the last four months four safeguarding notifications and alerts had been reported. These events were appropriately reported and the documentation and tracking had been completed properly.

All new staff completed safeguarding training during their induction and 12 week probationary period. This training was repeated on an annual basis. At the time of our inspection 89% of the staff team had completed the computer-based safeguarding training programme. Staff demonstrated an awareness of how to report abuse and what constituted abuse. Staff were required to report any safeguarding concerns to the manager or nurse in charge but were aware they could report directly to the Gloucestershire County Council safeguarding team, the Care Quality Commission and the police. There was rolling programme for key staff to attend level two safeguarding training with Gloucestershire County Council.

At the last inspection we had checked that safe recruitment procedures were followed. All appropriate pre-employment checks had been completed and each staff file contained evidence of all the required checks and information. These measures ensured that unsuitable staff were not employed.

Risk assessments were completed for each person in respect of moving and handling, the likelihood of developing pressure ulcers, falls, continence and nutrition. Where risks were identified the care plans stated how the risk was managed and what actions the care staff had to take. Moving and handling plans detailed the type of hoist and sling and the number of staff required. Person specific risk assessments and plans were developed for other risks. Examples included the risk of choking, or the risks relating to a person's behaviour. Monthly reviews of the plans were completed in order to ensure that the measures in place reduced or eliminated any risk.

The service had a plan in place in the event of an emergency. The plan contained all the contact details for other agencies that may need to be contacted in the case of an emergency (for example loss of utility services and severe winter weather affecting staff availability). A copy was kept in the information file in each of the units along with a personal emergency evacuation plan for each person. In the main entrance foyer, emergency information was stored for the fire service to refer to.

People were cared for in a safe building although there were some areas of the service that were shabby and a number of the bathrooms were 'out of use'. A refurbishment programme had been due to start since our last inspection but we this had been delayed. The long standing maintenance person has recently left and temporary maintenance cover was in place to ensure the premises and facilities were maintained in good working order. Records were maintained of checks of the fire safety systems, specialist beds and hoisting equipment and call bell system. There was a programme of daily, weekly and monthly checks to be completed and these included the hot and cold water temperature checks. Staff recorded any maintenance issues in a log book kept by the manager's office and tasks were generally attended to, within a couple of days. Kitchen staff completed daily temperature checks of the fridges and freezers and had cleaning schedules with daily, weekly and monthly tasks to complete.

Since the last inspection there have been significant changes in the staff team. The provider had assigned an

Good

Is the service safe?

experienced manager who had a proven track record of "turning round" services that were failing. The manager had been in post since February 2015 and a new deputy had been appointed. Since the last inspection there had been some new staff recruited but there were still a significant number of vacant posts. Interviews had recently been held and job offers had been made. There were staff vacancies for nurses, care staff and a maintenance person. There was still one member of staff dedicated to activities and we were advised that when the number of people in the home was greater, additional activities staff would be recruited. The full time activity coordinator was supported by a volunteer three afternoons per week.

Agency staff were being used to cover those shifts that permanent staff could not fill. Where possible the same workers were requested in order to ensure that people were looked after by staff they were familiar with. Staff said the same agency staff tended to be used in order to maintain continuity. One said, "A lot of the times it is the same ones". The agency nurse working in one of the units on the day of the inspection confirmed this. Nurses and care staff generally worked all their shifts in one of the units. The staff team on each unit was led by a unit leader.

Staffing numbers were based upon the collective care and support needs for every person in the home. The person in charge of each of the units stated the staffing numbers for both day and night times and care staff confirmed these arrangements. They said, "Fine for the people we have; pretty much balanced", "We always have enough staff" and, "Staffing levels are good".

The manager reviewed staffing numbers in response to changes in people's dependency or if staff identified challenges in providing the care required. At the time of the inspection there was one person in residence who was in need of 1:1 care and supervision in order to keep them safe. Care and nursing staff were supported by an administrator, a maintenance person, an activity organiser, catering and housekeeping staff.

People's medicines were managed safely. There were safe arrangements in place to obtain, administer and record people's medicines. A system of daily medicine checks was in place and included a random check on five people's medicines each day and a running stock balance of each person's medicines. This process helped to identify any problems quickly and ensured medicines were handled safely. There was an open culture of reporting medicine problems and we were told the usual concern that was picked up was where the medicine administration record (MAR) had not been signed after medicine administration.

Procedures for the administration of medicines to people who lacked capacity to make an informed decision were being followed. The service had a covert administration of medicines procedure dated April 2014 which detailed the procedure to follow. We looked at the MAR charts for those people where these arrangements were in place and found that best interest procedures had been followed. Their care plan and the MAR stated the person was to be given their medicines concealed in food or drink. The appropriate documentation had been completed and showed who had been involved in the decision making process, for example, health and social care professionals and family representatives.

Good

Is the service effective?

Our findings

People said, “The staff are very good and know what they are doing”, “The nurse insisted on calling the doctor when I was unwell and I am glad they did. I feel better now”, “The staff always ask if I am happy for them to help. I tell them to just get on with it” and, “I get enough to eat and drink”’

Relatives told us, “My mother is very well looked after. This is her home now and she is very settled”, “There have been a lot of changes since you (CQC) were last here. Everything is much better” and, “I realise there were problems here in the past but since my relative moved in, I can honestly say they are looked after extremely well”.

Staff said they received training and support that enabled them to do their jobs effectively. All new staff had an induction training programme to complete when they first started working at the home. One staff member who was relatively new to the home described their induction as “incredibly detailed”. As they were responsible for administering medicines, they had undergone a competency check with regard to this. They confirmed they had been assigned a mentor for their initial shifts and had ‘shadowed’ a more experienced member of staff. They said they had not been asked to do anything they did not feel confident in doing and there was always a member of staff available for support and guidance. New staff had to complete all essential training within 12 weeks.

For all staff there was a programme of essential training they had to complete. Staff said they had undertaken a mixture of training which involved computer based training and practical sessions. Records showed that 90% of staff had completed all courses. Ninety-one per cent of staff had completed modules one, two, three and four of the ‘open hearts and minds’ dementia care training. Fifty per cent had completed module five (consolidation, application and reflection of learning). One nurse described the dementia training that care staff received as “very good” adding, “They put it into practice and know the residents so well”. Other training included food safety, health & safety, infection control, safer people handling, equality and diversity and safeguarding adults. Staff confirmed they had received the relevant training to meet people’s needs and said they had the skills and knowledge to effectively support people. One member of the housekeeping team said they had received training in relation to working in the laundry, infection control and Control of Substances Hazardous to Health (COSHH).

The moving and handling trainer held practical training sessions with the nurses and care staff. This ensured all moving and handling tasks were properly completed. Staff confirmed they had received practical moving and handling training.

All care staff were expected to complete health and social care qualifications at least at level two (formerly called a national vocational qualification (NVQ)). One staff member told us they were looking forward to starting their level three diploma training.

The manager had completed all staff supervisions since they had been working at the service. This enabled them to get to know the staff and identify any concerns and training needs. The manager planned to delegate this task to the unit leads, nurses and senior care staff. The manager would continue to see all supervision notes and sign them off. The provider’s policy was that all staff would receive two formal and scheduled supervision meetings per year plus an annual appraisal. Staff members confirmed they attended supervision sessions.

Policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were in place. All staff completed ‘Understanding MCA and DoLS’ training and at the time of our inspection 87% of the staff team were in date with their training. The manager was aware there were staff who were either overdue or about to be overdue for the refresher training.

The legal rights of people who lacked the mental capacity to make decisions about their accommodation, care and treatment was protected. The MCA and DoLS protect the rights of adults using services by ensuring that if there were restrictions on their freedom and liberty, these were assessed by professionals who were trained to assess whether the restriction was needed. The manager had received formal MCA and DoLS training and knew the correct procedures to ensure people’s rights were protected. Since the last inspection in January 2015, training sessions for all staff had been delivered by a representative from Gloucestershire County Council.

Good

Is the service effective?

Capacity assessments were completed as part of the overall care needs assessment process. Where appropriate a standard deprivation of liberty application had been submitted to the local authority.

Staff were asked how they gained consent from people who were living with dementia, when they needed support with personal care. Staff said they would ensure people agreed to being helped before they started to support people. They said, "You use persuasion, not physical, you try to guide them. If they say no I will ask for advice, or get someone else to try", "If someone wants a lie in that's fine, you're not going to pull someone out of bed if they don't want to" and, "Always be very calm; people are still in bed if they want to". Staff said they would tell the person in charge if someone was declining personal care and would record it in the care records.

People's nutritional needs were assessed during the assessment and care planning process. Where risks of choking were identified, specific instructions were detailed in the person's care plan and staff were instructed on the level of support the person needed. People's likes, dislikes and any food allergies were recorded and dietary preference sheets were completed and given to the kitchen staff. There was a four week menu plan. People were provided with a well-balanced diet including meat and vegetarian options. The catering staff prepared meals of different consistencies to meet people's specific needs.

People were supported to eat and drink sufficient amounts to meet their needs and their body weights were recorded on a monthly basis (more often if needed). Food and fluid charts were used to record how much people ate and drank where risks of malnutrition or dehydration were identified.

We asked care staff how they ensured people had enough to eat and drink. They said they regularly offered people food and drink, used fluid (monitoring) charts and recorded body weights monthly or weekly for those at risk of poor dietary and fluid intake. Care staff were aware of those people who had swallowing problems and were able to describe the interventions used to reduce the risk of the person choking. They stated, "You make sure they are fully awake, in a proper upright position at meal times, have swallowed food completely, the fluids are thickened and they have pureed meals". One staff member said they felt people had enough to eat and drink saying, "The meals are good and there is plenty of opportunity for snacks and drinks throughout the day."

We carried out observations in two of the dining rooms at lunch time. In one of the dining rooms quiet background music was playing. People were asked if they wanted to wear a clothes protector and where this was declined their wishes were respected. These people were assisted to clean up after the meal. People were offered a verbal choice at the time the meals were served although the cook had told us a library of menu pictures was being prepared. People were served their meals in a variety of different receptacles, large and small plates and bowls. The majority of food was served on white crockery and where coloured crockery was used we found that people could identify their food better. Those people who needed a soft textured diet or their meals to be pureed, were provided with an already prepared meal. The cook told us that they already knew the person's preference. On the day of the inspection the meals served were barbequed chicken or liver. We heard one person comment that the chicken was "really lovely" however it did not look like barbequed chicken and others said it was "sticky" and "too sweet". The appearance of the food and the 'title of the meal' may have confused some people.

Where people needed to be assisted to eat their meals this was not always done in the best way. Not all care staff sat down with the person they were supporting. We saw one member of staff standing over the person they were supporting and another member of staff announce they would "go on their break and help afterwards when they came back". Other care staff were supporting people with their meal but there was no interaction with the person. However, there were examples of good practice. One person who had been reluctant to sit down and eat their meal was asked, "Can you try this custard please and tell us if it is alright, we need your opinion". This person then sat down, ate the whole bowl of custard with two spoons, told the care staff what it was like, and then proceeded to eat the main meal. One person had a fortified drink brought to them and this was described as their "special drink". Another person whose meal was served on a small plate, was offered more food and then ate all of that. The carer explained that the person would not eat all their meal if served the larger portion.

Good

Is the service effective?

People living at the home had a variety of individual health care needs as well as their dementia. They were registered with one of two local GP practices. The GP's and district nurses visited at the request of nurses or senior carers when this was identified as needed. We had not contacted any healthcare professionals prior to this inspection. However we were told in January 2015 that staff communicated well with them, were helpful, followed any treatment instructions and "their patients were well looked after". Arrangements were in place for people to receive support from psychiatrists, visiting opticians, dentists, podiatrists and occupational therapists. This liaison with other health care professionals ensured people were well looked after.

The premises were well designed for people living with dementia. Each of the units was designed to support people who were restless and wandered. There were tactile points placed along some of the walking routes, but there was an absence of visual aids to help orientate people and to enable them to find toilets, the communal rooms or their own bedroom. Some parts of the home were tired and shabby whilst other parts had been redecorated. The programme of refurbishment that had been due to commence in April 2015 was "on hold" and this was a cause of concern to a number of the relatives we spoke with. A number of the bathrooms were out of action because the assisted baths were irreparable or the showers were broken. These were to have been addressed as part of the refurbishment works.

Good

Is the service caring?

Our findings

People told us, “Everyone is very kind to me”, “I think I must know them very well because they are all very good to me”, “They care” and, “I cannot think of anything they could do better”. Relatives made the following comments: “The staff seem much happier now which makes the whole environment better”, “There has been a huge improvement in my father’s health since he came to live here” and, “I am satisfied that my mother is being well looked after and is safe. She has a good life now and is surrounded by people who care about her”. One relative said the care staff were “very tactile and cuddly” and they had never heard raised voices or seen anyone being unkind. They said, “The fact that he is happy here means that we are happy”. From our conversations and observations it was evident that staff had built up trusting relationships with the people they were looking after. This was apparent in the relaxed and confident manner people interacted with the care staff. Staff spoke to people with respect for the person and with dignity.

Staff received training on equality and diversity. They gave us specific examples of how people liked to be looked after and what individuals liked to do. For example one person liked to spend their day reading, doing puzzles and tending to their plants. Staff were taught to knock on people’s doors and either waited to be invited in, or to pause for a few moments before entering. People’s bedroom doors and doors into bathrooms and toilets were closed when people were receiving care. People were called by the name of their choice and this was recorded in their care plan.

During our visit we observed a senior carer being supportive to a person living with dementia when they became distressed. The member of staff gave them a hug, which they appreciated, and spent some time with them, which alleviated their distress. We also observed people being supported to participate in the sing-along session that was held in the afternoon outside in the sunshine. One person who was confined to a wheelchair but able to stand, was supported by a member of staff on each side and was able to sway in time to the music, an activity they clearly enjoyed.

Good

Is the service responsive?

Our findings

People were supported with their daily living tasks as when they wanted or were ready to be supported. They said, "We get all the help we need", "The staff do everything for us. I am quite lazy now" and, "I wouldn't manage living in my own home now". Relatives told us "The staff are very hard working and caring", "My wife does not want for anything" and, "I am only a relative but the staff look out for me as well. The girls are very attentive".

Staff knew a lot about the people they were looking after. They were able to tell us about the sort of things that different people liked to do, for example, what time they liked to get up and retire to bed at night. A number of the care staff lived locally and knew people before they lived at Pennwood Lodge. This meant they had a common history and shared life experiences. During the last inspection and this inspection we heard care staff using events from the past to engage and reminisce with people, for example royal family events and a local summer fete.

Care records we looked at included an assessment of care and support needs completed on admission or after a full review because of significant changes. The assessments covered all aspects of the person's daily life and specifics about how their dementia presented and their nursing care needs. Plans were devised for each person and provided details about personal care needs, mobility, support needed with eating and drinking, wound care management and night time requirements. The care plans were generally well written and provided information about how planned care was to be provided.

Care plans were, on the whole, reviewed on a monthly basis. New care plans were introduced as and when people's needs had changed. Formal reviews with people's families were completed on at least an annual basis, more often if needed. For those people who had been resident at the service for a number of years a re-assessment of their care and support needs had been completed and new care planning documentation had been prepared.

One person recently had a fall and sustained a bony fracture and been discharged back to the service to recuperate. There was no clear plan in place to direct care staff following discharge from hospital with regard to moving and handling, mobility and observation. The person had dementia and was prone to attempt to get out of bed and mobilise. Minimal information had been provided by the hospital but the nurse knew the person should not cross their legs, weight bear and should avoid unnecessary movement. However, this information had not been recorded in their care plan. The person was seen by their GP and an occupational therapy assessment had been requested. Before this person could be seen they had dislocated their new hip and had returned to hospital for further care and treatment.

Improvements were needed with the completion of the do not resuscitate (DNR) or do not attempt cardio-pulmonary resuscitation (DNACPR) forms. Some had not been completed with the date they were signed and one had been signed by a member of staff in the section that was to be completed by the healthcare professional responsible for the person's care (generally the person's GP). The manager agreed to address this with the GP's straight away to ensure the correct documentation was in place.

People were able to participate in a variety of social activities. A newsletter was produced on a monthly basis and people were told about the activities that month, any birthdays to be celebrated and whether any of the staff had received a Kindness in Care award.

The hairdresser was visiting the home at the same time as the inspection and was seen as a "very important part" of the week for a lot of the ladies. One person said, "I wouldn't feel right if I didn't have my hair washed and set each week". Their relative said, "Mum would have to be really poorly to miss having her hair done". There was opportunity for people to go on outings outside of the home. The home had a minibus and the activity coordinator said that outings had been undertaken to local shops, garden centre and the seaside.

There was a varied programme of activities for people to participate in and an experienced activities coordinator led the programme. They told us the programme was very much based on what people said they wanted to do or had previously enjoyed. In the activities room a volunteer was supporting people who were painting, whilst one person was having a cup of coffee and a chat with a staff member and the activities coordinator was making preparations for the national care homes open day the following day. At this open day there was to be display of people's art work and there were many fine pieces of work. There was a programme of planned activities each week however these

Good

Is the service responsive?

varied on a daily basis according to people's needs or demeanour. The coordinator kept notes showing which people were involved in which activities on what days and an evaluation of the activity.

In the entrance hall there was a range of photographs displayed of previous activities that had taken place and details about forthcoming activities that were taking place. There was a 'knit and natter' session, an art club, a sing a long session with an outside entertainer, and a gardening club arranged. There was a two hour period each day when the activities organiser spent time on one of the units and interacted with individuals on a one to one basis.

One person enjoyed looking at the fish in the home's fish tank. This had originally been situated in the main entrance hall. Staff had arranged for the fish tank to be moved to a lounge on the first floor, where the person lived, in order for them to access it more easily. This action was undertaken following feedback from the person's relatives and is an example of the services 'You said, We did" approach.

Each staff member coming on shift received a handover report from the outgoing day or night staff. One person was supported by agency staff on a 1:1 basis and when they needed a break, a verbal handover report was given to the staff member taking over so they were made aware of any issues prevalent at that time. These measures ensured staff received up to date information to enable them to provide the care required by each person and were aware of any changes.

People were asked to share their views or make comments about things that upset them whilst being provided with personal care. Staff said they knew if people were unhappy with something because of changes in behaviours. However on the whole their relatives spoke up for them. Relative meetings were held on a monthly basis. The meetings were either held in the afternoon or the early evening, to ensure that as many families as possible were able to attend. The notes of the last three meetings showed that staff changes, the refurbishment and the January 2015 CQC inspection report had been discussed. The last meeting had been held on 3 June 2015 and the next was scheduled for 7 July 2015. The assistant operations director will be attending this meeting as a number of relatives were concerned about the delay in the refurbishment plan.

Relatives said they felt confident in raising concerns and were now "more sure they would be listened to and issues be addressed". They said the manager was approachable, the open door policy they had always been told about was now a fact and their views and opinions were actively sought out.

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Our findings

People and their relatives had been provided with accurate information about the last inspection. Two separate relatives told us they had been given a copy of the summary report from the January 2015 inspection. On the information stand in the main reception area there was a full copy of the whole report displayed. This evidences that the registered provider and manager were being open and honest with the families of people living in the home.

There were a number of opportunities available for relatives to communicate with the manager and the staff team. Relatives were involved in care plan reviews with the nurses and care staff and there were regular relative meetings they could attend. Two separate relatives told us the management arrangements now in place were "far better". They said, "When we visit we are acknowledged by the manager. If she is in her office she will come out and say "hello" and "The manager is so much more visible. She is regularly out and about on the units, talking to people, the staff and us".

Staff said, "The home feels a better place to work", "The manager comes on to the units all the time", "The manager is committed to getting everything right again" and, "It is a shame that she cannot stay with us. We would all like that". The staffing structure within the home was unchanged and still consisted of a manager, a deputy, unit leads, nurses, senior care staff and care staff. Alongside the care team there were catering staff, housekeeping, maintenance and an administrator employed to meet people's daily living needs.

The manager held a short 'flash' meeting every morning with the heads of department and senior staff. In this meeting discussions were held about care issues, staff issues, tasks that needed to be completed and who the 'resident of the day' was. For the resident of the day this meant their care plans were reviewed and they were visited by catering and housekeeping staff.

General staff meetings were held regularly and records were kept of all meetings. Unit leads held meetings with their staff team as well. The manager attended regular home manager meetings with the assistant operations director or operations director. Due to the difficulties within the service for the last 10 months, the assistant operations director and operations director have been frequent visitors to the home and have met with the manager, the staff team, people who lived in the home and relatives. This evidences that the provider has taken seriously, the shortcomings that were found and have monitored that the required improvements have been made.

There was a programme of monthly, quarterly and six monthly audits in place. The manager was expected to complete and submit these to the assistant operations director. Monthly audits were completed of medicines, catering and 12 care files. Quarterly audits were completed in respect of infection control procedures and falls. A six monthly health and safety audit was completed, one by the home manager and then six months later by the providers health and safety advisor. This programme of audits ensured the quality and safety of the service was maintained. The audits identified where any shortfalls were and provided a tracking process to ensure remedial action was taken.

Records were kept of any accidents or incidents that occurred. Paper records and electronic records of all events were kept. The manager was expected to record what happened, what immediate actions had been taken and a final outcome. This process enabled an analysis of accidents and incidents to take place and to identify triggers or trends. This in turn meant that preventative actions could be taken.

The manager was aware when notifications of events had to be sent to CQC and these had been submitted in a timely manner. A notification is information about important events that have happened in the service and which the service is required by law to tell us about. Since the last inspection in January 2015, 11 notifications had been submitted in respect of expected deaths, one unexpected death and 21 safeguarding alerts. Whilst the number of safeguarding alerts was high, a number of these had been submitted in retrospect because the previous home manager had not done so. In the last three months, four safeguarding notifications had been reported appropriately and the relevant action taken by the staff team.

Results from a survey carried out by the provider called, "What Customers Say", were reported on in March 2015. The results were based upon feedback from relatives/ people living in the service and other stakeholders at the end of 2014. The service had been rated with an overall score of 78%. The service was rated on the following: staff and care, home comforts, having a say, quality of life and

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the home itself. The service had only scored 69% in having your say. The manager and assistant operations director said that the survey would be repeated and they were confident that the results would be improved.

A copy of the complaints procedure was displayed in the main reception area and stated all complaints would be investigated and responded to in writing. Information was also given to relatives so they would know what to do if they wanted to raise a concern or complaint. The home had received one formal complaint since the last inspection in January 2015. This was in respect of the lack of refurbishment in the service and the "depressing" environment that people and staff had to live and work in. The manager said that any issues arising from complaints would be used as an opportunity to learn from mistakes and make improvements.

Following our inspection in January 2015, the provider put together their action plan to ensure the required improvements were made. Their action plan was used to plan our inspection. The Gloucestershire County Council quality assurance team has also visited the service on 20 May 2015 to ensure that improvements were being made. They noted that "the home had made and sustained good progress since their previous visit" and, "implemented many changes since the CQC inspection". The majority of their improvement actions had been met with improvements in other areas were on-going.

This section is primarily information for the provider

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.