Folkestone Nursing Home Ltd

Folkestone Nursing Home

Inspection report

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Date of inspection visit:
06 November 2017
07 November 2017

Date of publication:
13 December 2017

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

Folkestone Nursing Home 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.

Folkestone Nursing Home accommodates 45 people in one adapted building. At the time of our inspection 39 people were living at the home. Folkestone Nursing home accommodates people over three units. One unit specialises in providing care to people with dementia, the second unit specialises in nursing care and the third unit is a mixture of nursing care and dementia care.

At the previous inspection in June 2016, we found three breaches of legal requirements. This was because although improvements had been made, there continued to be an issue with medicines not being managed in safe way, staff did not always receive up to date training and quality assurance and monitoring systems were not always effective. This unannounced inspection took place on 6 and 7 November 2017 and we found significant improvements had been made.

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

People's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans were in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed. Medicines were stored and administered safely.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is legislation protecting people who are unable to make decisions for themselves or whom the state has decided need to be deprived of their liberty in their own best interests. We saw people were able to choose what they ate and drank.

People and their relatives told us that they were well treated and the staff were caring. We found that care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager was approachable and open. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and relative meetings.

The home was in need of redecoration and repair. The physical environment of the home was not decorated in a way to assist people living with dementia. We have made a recommendation about the environment being more dementia friendly.

People's experience at mealtimes was not always pleasant. We have made a recommendation about people's dining experience.

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. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and mitigate risks.

Medicines were stored and administered safely.

Staff were recruited appropriately and suitable numbers were on duty to meet people's needs.

Is the service effective?

Good

The service was effective. Staff undertook regular training and had one to one supervision meetings.

The provider met the requirements of the Mental Capacity Act (2005) and DoLS to help ensure people's rights were protected.

People were supported to eat and drink sufficient amounts and eat nutritious meals that met their individual dietary needs.

People's health and support needs were assessed and appropriately reflected in care records. People were supported to maintain good health and to access health care services and professionals when they needed them.

People's cultural and religious needs were respected. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The home was in need of redecoration and repair. The physical environment of the home was not decorated in a way to assist people living with dementia.

Is the service caring?

Good

The service was caring. People and their relatives told us that

they were well treated and the staff were caring. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans to meet their needs were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities.

People knew how to make a complaint if they were unhappy about the home and felt confident their concerns would be dealt with appropriately.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place and a clear management structure. Staff told us they found the registered manager to be approachable.

The service had various quality assurance and monitoring systems in place. These included seeking the views of people that used the service.

Folkestone 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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. A notification is information about important events which the service is required to send us by law. The inspection was informed by feedback from professionals which included the local borough contracts and commissioning team that had placements at the home, the local borough safeguarding team, a dietician, optician, the clinical commissioning group and the GP surgery that provides services to the home. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 6 and 7 November 2017 and was unannounced. The inspection team consisted of two inspectors a pharmacist inspector, a nursing dementia specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 14 people who lived in the service and six relatives during the inspection. We spoke with the registered manager, the clinical lead, two nurses, two senior care workers, three care workers, the chef, one kitchen assistant, the activity co-ordinator, one domestic worker, and the administrator. We also spoke with a pharmacist who visited the home. We looked

at 12 care files, staff duty rosters, seven staff files which included recruitment and supervision records, a range of audits, minutes for various meetings, medicines records, accidents and incidents, training information, safeguarding information, a health and safety folder, and policies and procedures for the service.

Good

Our findings

During our previous inspection in June 2016, we found that medicines were not always managed in a safe way. During this inspection we checked to determine whether the required improvements had been made. We found the service was now meeting the regulation.

There were processes in place for the storage, recording and administration of medicines including controlled drugs as outlined in the providers own medicines policy. Medicines were stored securely including controlled drugs and appropriate room and fridge temperature monitoring was carried out to ensure that medicines remained suitable for use.

Review of people's medicine administration records (MARs) showed that they were given their medicines as prescribed, and stock could be reconciled with the administration records.

Where people were having their medicines administered covertly, there were appropriate mental capacity act assessments, documenting the reason for doing this, and that this was in their best interests. We saw records of pain assessments that were carried out for people on 'as required' pain relieving medicines, and staff told us how they assessed people's pain by asking those able to verbalise, as well as observing any changes in behaviours. Records showed that as required pain relieving medicines were regularly offered. Therefore we were assured that people's level of pain and response to the medicines was being monitored.

There was evidence that people receiving medicines that needed regular blood monitoring and dose changes such as people with diabetes and those taking anticoagulants were being monitored. However we did not see any medication risk assessments in care plans or MARs for people taking high risk medicines. Senior staff told us and we saw records that written guidance for high risk medicines was available to staff about the risks to people. Staff we spoke with knew how to mitigate the risks. After the inspection the registered manager sent us copies of completed medicine risk assessments for people.

People and their relatives told us they felt the service was safe. One person told us, "I feel safe. They [staff] are nice to me. Another person said, "I do feel safe here." A third person told us, "Yes I feel safe here. The staff are very busy but kind." One relative said, "We are satisfied [relative] safe here." One health and social care professional told us, "I believe the service is safe from what I have observed during my visits."

The service had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Each floor had the safeguarding policy

including local safeguarding procedures available to staff. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the registered manager. One senior staff member told us, "I would investigate first who is involved in the abuse. I would notify my manager. If nothing was happening I would tell CQC and the safeguarding team." One staff member said, "Need to report it to the manager or the nurse in charge. If nothing done you can whistle blow to take it further."

The registered manager told us and we saw records that showed there had been two safeguarding incidents since the last inspection. The registered manager was able to describe the actions they had taken when the incident had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as falls, mobility, skin integrity, challenging behaviour, communication, mental capacity, malnutrition, continence, and manual handling. Each assessment detailed the risk to people and the action needed to mitigate those risks. For example, assessments for people at risk of falls detailed the level of support required and the equipment to be used to ensure risks were minimised. We also saw records showed a number of people had been assessed as being at high risk of developing sore skin. We found there were safe systems in place that showed people had been regularly repositioned to alleviate pressure on their skin and this had been clearly documented. Staff had followed the guidance outlined in the risk assessments for people. Staff we spoke with demonstrated that they were aware of risks to people and that the guidance had been followed. Risk assessments were reviewed at least every three months or sooner if people's needs changed. Records confirmed this. One staff member told us, "If residents deteriorating would go to the nurse and inform them like if they were losing weight. They would get nutrition person in."

Staff we spoke with knew who was at high risk of choking. Printed information was available that gave staff information about the risks to that person. For example, one person's care file contained recommendations from the speech and language therapy team (SLT). The care file also included guidance and recommendations for the person's food and drink intake and what to do if the person was choking. Nursing staff we spoke with knew how to refer to SLT team. People would be referred to SLT team if they were having eating, drinking and swallowing difficulties. Records showed the SLT team notes and input were clear and staff took action on recommendations promptly. Feedback from SLT before the inspection was positive about the level of support the home provided to people. The dietician for the home told us, "The nursing staff know the problems with their residents and are eager to request my input when required. They use the Malnutrition Universal Screening Tool (MUST) correctly and I have audited them." One staff member said, "We have some residents who have difficulties swallowing. We are aware of this."

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded. For example, one person had three falls over a four week period. The home responded to this by informing the GP, the person's medicines were reviewed and they were also referred to the falls clinic for assessment. Records showed that after the actions were taken the person's mobility had improved.

The premises and equipment were managed in a way intended to keep people safe. Regular checks were carried out on hoists, emergency lights, bedrails, alarm systems, windows, water quality and temperature, and fire equipment. Records showed that fire safety checks and drills were done regularly .The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues.

One staff member said, "We have enough equipment and the right [staff] to keep people safe."

The staffing rota indicated sufficient staff however on the first day of the inspection we observed the lounge areas on the first and second floors had no staff available to people for periods of time. We asked the registered manager about this and were told they were unable to cover one shift for that day. On the second day of the inspection we observed the home was fully staffed and staff were available to people in the lounge areas.

People and relatives we spoke with gave varied responses when asked if they thought there were enough staff on duty. One person told us, "There seem to be enough staff here." Another person said, "They could do with a few more staff but they come when you call." A third person told us, "I don't think there are enough staff here. When I first came there were more." A relative said, "I think the staff are sometimes sparse, especially at weekends, but those that are here are excellent."

Staff also gave varied responses about staffing levels. One staff member said, "Certain floors need to be increased as we have individuals who are different." Another staff member told us, "Day by day can be different. If other floors not busy you can ask for help." A third staff member said, "Yes we are ok. Normally we call bank staff first and if we can't get will call agency."

The registered manager told us staffing levels would be increased depending on the number of people on the unit. Also additional staff were added to the rota when staff had to escort people to appointments. Records confirmed this. The registered manager told us they were going to recruit for a second full time clinical lead person which would help staff on the units.

The provider had robust staff recruitment procedures in place. Records confirmed that checks were carried out on prospective staff before they commenced working at the service. These included employment references, criminal record checks, proof of identification and a record of the staff's previous employment. This meant the provider had taken steps to ensure suitable staff were employed.

The provider had a system in place to check nursing staff were registered with the Nursing and Midwifery Council (NMC) and their registration remained up to date. The NMC is the regulator for nursing and midwifery professions in the UK who ensure nurses and midwives keep their skills and knowledge up to date and that they maintain professional standards. This meant a safe recruitment procedure was in place.

The home environment was clean and the home was free of malodour. The home managed the control and prevention of infection well. Records showed staff had recently completed training on infection control. Staff had access to policies on infection control which covered such topics as managing an outbreak of infection, protective personal equipment (PPE), swine flu and meticillin-resistant staphylococcus aureus (MRSA). Records showed infection control had been regularly discussed in team meetings. The registered manager told us about and showed us records of a monthly infection control audit that covered PPE, hand hygiene, clinical waste management, and the disposal of sharps. Observations during the inspection showed staff wearing PPE for tasks such as preparing food, personal care, serving food and cleaning. One staff member told us, "You have to remove gloves and wear [new gloves] when doing a different task." One relative said, "Always spotlessly clean whenever we come."

Good

Our findings

During our previous inspection in June 2016, we found that staff did not always receive up to date training. During this inspection we checked to determine whether the required improvements had been made. We found the service was now meeting the regulation.

Staff we spoke with told us they received regular up to date training to support them to do their job. Records confirmed this. One staff member told us, "We always get training here. Someone comes in. We've had quite a few." Another staff member said, "We get training here in relation to the people here like manual handling and dementia." Records showed the training included infection control, safeguarding adults, dignity and privacy, health and safety, dementia, first aid, moving and handling, food safety and nutrition, challenging behaviour, equality and diversity, fire safety, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

New staff had been provided with induction training so they knew what was expected of them and to have the necessary skills to carry out their role. Records confirmed this. One staff member told us, "[Registered manager] gave me the induction. Showed me what to do." The registered manager told us they had recently introduced the Care Certificate for all new staff and records confirmed this. The Care Certificate is a set of standards that social care and health workers use in their daily working life.

People who used the service and their relatives told us they were supported by staff who had the skills to meet their needs. One person said, "They [staff] are helpful." One relative told us, "The staff are very helpful and kind towards [relative]." Another relative said, "My [relative] has received good care here."

Before admission to the service a pre-admission assessment was undertaken to assess whether the service could meet the person's needs. An assessment of needs was undertaken at a pace to suit the person. The assessment looked at the person's medical history, medicines, mobility, communication, and mental capacity. One nurse told us, "The manager will assess the patient and then tell me. We get a history of the patient. Manager will hand over information so you are aware. You always do an assessment when they arrive." Another staff member said, "The manager does an assessment and lets us know."

Staff received regular supervision. Records confirmed this. Topics covered included teamwork, training, practice issues and arising concerns. A staff member told us, "I do get it. I had one last week with [registered manager]. We talk about everything. How I can improve and if I need more training." Another staff member told us, "[Registered manager] will sit and ask me questions." Staff also received an annual appraisal where

their work performance was formally assessed.

People's cultural and religious needs were respected when planning and delivering care. Records showed people had access to spiritual activities. One staff member told us, "On a Sunday we have someone from [place of worship] that comes around. We have [culturally specific person] who will tell us when they want to pray." Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We don't discriminate. We welcome everyone." Another staff member told us, "We have to respect their gender. We would do a personalised approach." Training records showed staff had completed equality and diversity training. One staff member told us, "We did equality training. Management talk about equality."

Records showed people were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences and likes/dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly. If there were significant changes they would advise the GP and referrals were made to a dietician. The dietician for the home told us, "The chef is very good and has attended a number of training sessions I have provided. They [staff] are aware of what needs to be done to help the residents when problems with nutrition [issues] arise."

The majority of the people and their relatives told us they liked the food. The chef was aware of the people who were on specialised diets and explained the meal preferences for these people. This was reflected in the care plans we looked at. The chef told us that people could ask for alternatives to the food choices for that day. There was a rolling four week food menu in place which included at least two hot meal options, one of which was a vegetarian option and desserts. On the first day of the inspection the main meal on offer was lamb shank and vegetables and a rice dish. Staff told us and records confirmed people were asked their food option each morning. The food for people who were at risk of choking was presented well and blended separately allowing people to experience and taste the different flavours. One person told us, "I find the food excellent. Exceptionally good in quality and quantity." Another person said, "I love the food. I did once send back a piece of pie because I didn't like it and they changed it." A third person told us, "I like the food. It's very good. There's a choice. There's plenty to drink." A relative said, "[Relative] says the food is good and she eats it well."

As part of our inspection, we carried out an observation over the lunch time period. On the first day of the inspection we observed the dining room on the ground floor. From our observations this was not always a pleasant experience for people. One person had not been given their cutlery and started to eat their food with their hands. The staff member saw this and quickly gave the person some cutlery. Also people were not offered drinks until the end of the meal. However on the second floor the dining experience was more pleasant for people. We saw staff sitting and supporting people to eat in a relaxed and unhurried manner. We overheard one staff member say, when supporting a person to eat, "We will take as much time as needed." On the second day of the inspection we observed two dining areas for lunch and people had access to cutlery and drinks were available.
We recommend that the service seek advice and guidance about supporting people with dementia to have a pleasant dining experience.

People in the home were supported to see health professionals when required. A GP carried out a visit on a weekly basis and staff identified people who needed to be reviewed. Records were kept in people's care files to show when healthcare professionals had visited the person. This included GPs, district nurses, podiatrists, dentists, chiropodists, opticians, speech and language therapists and dieticians. One person said, "[GP]

comes on Tuesdays. You can see him when you want." Another person said, "The staff arrange a doctor when I want and the chiropodist also comes." We contacted the GP surgery before the inspection for feedback. They said, "The manager and nursing staff know patients and their relatives well. They listen, identify concerns and issues and find ways to resolve them either by bringing it to the attention of the GP, referring to a certain service or resolving the issue in-house when possible."

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process he would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection.

Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members asked their consent before helping them. This consent was recorded in people's care files. One person told us, "They [staff] ask before they do anything." Another person said, "They [staff] do ask when they do stuff." A third person told us," They [staff] talk to me before they do something." This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Observations around the home showed that parts of the building were in need of redecoration and repair. For example, skirting boards had scuff marks, handrails had chipped paint and doors needed repainting. One relative said, "It needs to be done up." Another relative told us, "The place could do with a lick of paint but the care is good." We spoke to the registered manager about this and they told us this had been discussed with the provider and was being looked at.

The physical environment of the home was not decorated in a way to assist people living with dementia. The home had spacious lounge areas and hallways on each floor. However these areas lacked colour and contrast which would be helpful for someone living with dementia. Pictures were on display in the communal areas however they lacked colour to engage people. Noticeboards had small photographs and writing which was not dementia friendly. The lounge areas on the first and second floor were sparse, lacked colour, and were impersonal. One staff member told us, "They could put up more pictures up as it's a dementia home. Need more colours." Another staff member said, "Needs decorating according to [people's] needs." One relative said, "The place is run down and dreary."

We recommend that the service seeks advice and guidance from a reputable source about providing a

dementia friendly environment to have a positive impact on people's wellbeing.

Good

Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "They [staff] treat me with respect." One relative told us, "I can't fault [relative's] care. The staff are respectful and loving." A health and social care professional told us, "During my visits I have found the care given to the residents to be of a good standard. I have noticed they engage with different individuals according to their needs, tailoring their care towards the resident rather than having the same approach with every resident." Another health and social care professional said, "The service is caring and supportive to the residents and families."

Relatives we spoke with told us they were kept informed about their family member and were involved in the planning of their care. One relative told us, "I think my [relative] knows about her care plan. I know she has one. If anything happens they phone."

Staff knew the people they were caring for and supporting. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member told us, "Caring for people with dementia is a lot more than just feeding and washing them." Another staff member said, "You do get attached to people and become fond of them. When you see them deteriorate it really affects you." The same staff member told us, "Had a patient who died last week and that really affected [me]. I shed a bit of a tear." A third staff member said, "'I treat my residents as I would treat family. I always think about how I would want my mum to be treated." One person said, "They [staff] sometimes sit and chat with me."

The atmosphere of the home was friendly and calm. Staff communication with all residents was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not. Staff delivered care in a manner that was flexible and attentive to people's individual needs. One staff member said, "Just because they have dementia does not mean they stop liking the things they liked. I always try my best to engage with them and try and not make them feel bad because they forget things."

The home used different types of communication to interact with people. The registered manager told us they aimed to recruit staff that spoke at least one language of people with a culturally specific background. Staff we spoke to confirmed this was correct. For people whose first language was not English communication aids were available. For example, we saw in people's rooms and in care files simple phrase print outs of that person's language that staff could use to communicate. We also saw pictorial communication prompts to help with questions such as 'yes' and 'no', drinking and eating, and if they wanted to go to bed. One staff member told us, "We have residents with language barriers. There is a carer

that speaks that language. We find certain words [in that person's language] and share with the other carers."

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. One staff member told us, "Some [people] will ask to close their door for privacy." Another staff member said, "When giving personal care I will knock on their door and tell them what I am doing. I will ask to change their pad." A third member of staff told us, "We respect privacy. Make sure when doing personal care you ask if it is ok and to explain yourself. If they say no give them time and comeback." One relative told us, "[Relative's] dignity is respected, especially when it comes to changing her pads."

People's bedrooms were personalised with personal possessions and were decorated to their personal taste, for example with family photographs and soft toys. One staff member told us, "We encourage [people] to decorate their room. We can paint their room if they want."

Good

Our findings

People told us they enjoyed living at the home and the care they received was responsive to their needs. One person said, "They [staff] speak to me and listen, especially if I want something." A relative told us, "We have peace of mind that my [relative] is being kept clean. The staff look after me when I come in too. They do all they can."

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included guidance for behaviours, mobility, communication, nutrition, toileting, personal care, medicines, mental capacity, activities, sleeping, and skin integrity. Most care plans were written in a way that reflected people's individual preferences. For example, one care plan for a person with challenging behaviour stated "Staff to use diversion techniques that work with [person] whilst offering assistance. These include chatting about things he likes like film and television." The care files had a section called 'resident's life history' which included the person's likes and dislikes in regard to food, interests and routines. Records showed care plans had been reviewed regularly or as the person's needs changed. The plans had been updated to reflect these changes to ensure continuity of their care and support. Detailed care plans enabled staff to have a good understanding of each person's needs and how they wanted to receive their care.

However care plans were not always clear how to support people diagnosed with diabetes. They detailed what to do if a person had hyperglycaemia (hyperglycaemia is an abnormally high blood glucose (blood sugar) level), but did not detail what the signs would be for someone who had hyperglycaemia. Nevertheless, staff we spoke with could describe the signs and had completed training on diabetes. We spoke with the registered manager who told us they would update the care plans to include how to identify the signs of hyperglycaemia.

People had access to planned activities. The home employed an activities co-ordinator who worked Monday to Friday. The activities co-ordinator told us the care staff provided activities on the weekend. Each floor had on display the activities available each day which included bingo, games, dominos, massage, dancing, exercises, parties, and arts and crafts. Peoples' and relatives' views were mostly positive. Positive comments included, "I can do activities in the lounge when I'm up. I like them", "There's plenty to do here. I sometimes go to the activities", and "I like the colouring and doing crosswords and I enjoy going into the garden when I want if the weather's good." However some people said, "There's not much to do in here. There are not really things for me to do here" and "I don't go to the activities. I'm not interested in them."

During our inspection we saw group activities with people. On the first day of the inspection we saw people doing chair exercises and ten pin bowling in the ground floor lounge. On the second day we saw people playing a ball game. People were engaged and enjoying the activities. The activities co-ordinator told us she provided one to one activities for people in their room. Records confirmed this. However not all people who were confined to their room were aware of one to one activities available. One person said, "Nobody comes to my room to do things with me." The registered manager told us they had arranged further training for the activities co-ordinator for people with dementia.

There was a complaints process available and this was on display in the communal area so people using the service were aware of it. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. We looked at the complaints policy and we saw there was a clear procedure for staff to follow should a concern be raised.

Most people and relatives knew how to make a complaint and knew that their concerns would be taken seriously and dealt with quickly. There were systems to record the details of complaints, the investigations completed, actions taken as a result and the response to complainant. Records showed there had been three formal complaints for 2017. We found the complaints were investigated appropriately and the service aimed to provide resolutions in a timely manner. One person said, "I do complain if I'm not happy, and they listen." Another person told us, "I would talk to the staff if I were worried."

At the time of our inspection the home did not have any people receiving end of life care. Staff in the home had recently received training in end of life care. The registered manager told us the home worked with palliative care teams and a local hospice when people were at end of life. We saw information was available from the local hospice for staff and people. The service had an end of life policy called "Care of the Dying" which was appropriate for people who used the service. One staff member said, "We will contact the GP if patient is deteriorating. GP does an assessment and family will be involved. We would notify the palliative team for advice." The GP for the home told us, "They [staff] are skilled at recognising end of life and contact the palliative care team without delay when required." The GP also told us, "Regular meetings are held at the nursing home where the manager, lead nurse, GP, practice manager and a liaison Care of the Elderly consultant discuss palliative patients and other concerns." We saw cards of thanks and appreciation from relatives in relation to the end of life care provided to people who had lived in the home. The cards showed how staff had supported people with kindness and empathy.

Good

Our findings

During our previous inspection in June 2016, we found that quality assurance and monitoring systems were not always effective. During this inspection we checked to determine whether the required improvements had been made. We found the service was now meeting the regulation.

The provider had a number of quality monitoring systems in place. These were used to continually review and improve the service. The registered manager told us they conducted a monthly infection control audit, nutritional needs audit, health and safety audit, unannounced night checks, and care plan audits. Records confirmed this.

The quality of the service was also monitored through the use of annual surveys for people and relatives of the people who used the service. The last survey completed was for April 2017. Surveys for people and relatives included questions about choice, respect, involvement in care planning, environment, staffing levels, food, activities and health professionals. We viewed completed surveys which contained positive results. One comment was, "The care and consideration is shown and is always good." The registered manager had completed an action plan of issues that were raised and records showed when they had been addressed. For example, one action had been for the home to use more external activity services. Records showed the registered manager had a discussion with the activities co-ordinator and this had been actioned. The registered manager gave an outcome of the actions at the relative's meeting on 18 August 2017.

People who used the service told us they thought the service was well managed and they spoke positively about the registered manager and the senior staff. One person said, "I am on good terms with the manager who is sympathetic. I could talk to him if I had a problem." Another person told us, "I recognise the manager." A third person said, "The manager asks me how I am every morning."

Staff told us the registered manager was approachable and had made improvements with his communication style since joining the service. Staff had felt he did not always listen to concerns however over time was much more welcoming and accessible. One staff member told us, "I feel he treats employees all the same. Our relationship is much better. I can talk to him about any problems. He has a good heart." Another staff member said, "He's approachable. He's more open than before." A third staff member told us, "If I don't understand something I will always bother him. He is quite friendly. We have good communication." Staff always felt supported by the clinical lead person. One staff member said, "[Clinical lead] is lovely. She helps and support. She explains everything. We all work as a team and support each

other."

The home had an open culture where staff could receive feedback and share ideas. For example, the provider had conducted an annual staff survey to get the views of staff. The last staff survey completed was April 2017. The registered manager had completed an action plan of issues that were raised and records showed when they had been addressed. For example, one action had been to respond to staff requests for more specialised training. Records showed the registered manager had a discussion with an external trainer and booked training courses specific to the needs of the people using the service.

The home also held regular staff meetings where staff could receive up to date information and share feedback and ideas. Topics included in staff meetings were training, care plans, equal opportunity, infection control, confidentiality, equipment, medicines, unannounced night checks, record keeping and quality assurance. One staff member told us, "We are given an opportunity to raise what needs to be improved. If things change we are told." Another staff member said, "We have one on the 16th November. We talk about handovers, our wages and medicines."

Residents and relatives meetings were held on a regular basis to provide and seek feedback on the service. Topics recorded for the meetings included complaints, fire procedure, personal care, staffing, activities, recruitment, food menu, accidents and incidents, end of life care and laundry. One relative told us, "They do [have meetings]." Relatives we spoke with were aware of the meetings. Information about the next meeting was on display in the communal areas.

The home provided quarterly reports to the local authority that had placements in the service. Records showed the reports looked at the action plan updates from the last monitoring visit, staffing, supervision, recruitment, training, policies and procedures, quality assurance, safeguarding, and home environment. The local authority confirmed they received the quarterly reports and regular contact and updates were maintained.