The Royal Masonic Benevolent Institution

Lord Harris Court

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 10 May 2016.

Lord Harris Court is registered to provide care (with nursing) for up to 90 people. There were 74 people resident on the day of the visit, including three people in hospital. The building offers accommodation over three floors, in seven named units. There were eight vacancies and eight rooms not available because of refurbishment or repair. The first and second floors are accessed via a lift. The shared areas within the service are spacious and meet the needs and wishes of people who live in the home.

The service has not had a registered manager running the service since February 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was, currently, being managed by an interim manager, two support managers, and a deputy manager. A new manager had been appointed.

The management team recognised their responsibilities to keep people, visitors to the service and staff safe. Any risks were identified and managed to make sure that people and others were kept as safe as possible. Staff were provided with training in the safeguarding of vulnerable adults and health and safety. Staff were able to describe How they kept people safe from all forms of abuse and any physical harm.

People received safe care because there were enough staff, with the right skills and knowledge to care for people safely. The service's recruitment procedure ensured that as far as possible, all staff employed were suitable and safe to work with vulnerable people. People were given their medicines in the right amounts at the right times by properly trained staff. However, some records were not completed accurately and some guidelines for the use of medicines to be taken, as required, were not available.

The management team and staff protected people's human and civil rights. The staff team understood the relevance of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) and consent issues which related to the people in their care. The Mental Capacity Act 2005 legislation provides a legal framework that sets out how to act to support people who do not have capacity to make a specific decision. DoLS provides a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm. The staff team took the necessary action to make sure they upheld people's rights and the management team made the appropriate DoLS referrals to the Local Authority (Supervisory body).

Staff were properly trained and supported to enable them to meet people's health and well-being needs. People were supported to make sure they received health and well-being care from appropriate professionals. Staff were trained in a variety of areas of care, so that they could meet the complexity and diversity of changing needs presented by the people in their care.

The service had a strong culture of person centred care which recognised that people were individuals with their own needs and preferences. Staff built relationships with people so that they were able to provide more effective care. Staff encouraged people to make as many decisions and choices as they could to enable them to keep as much control of their daily lives, as was possible. People were treated with kindness, dignity and respect at all times.

People benefitted from a well-managed and improving service. The management team was described by staff as very supportive and approachable. Staff told us the management team that had been in the home for approximately four months had made improvements to the care provided. The service had a number of ways of listening to people and making sure they maintained and improved the quality of care provided. Improvements had been made as a result of quality checks and listening to the views of people, other professionals, people's relatives and the staff team.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was mainly but not always safe.

Some medicines records were not properly filled in which meant people's creams may not be given when they should be.

People who only had to have medicine at certain times may not be given these correctly.

All other medicines were givensafely, in the right amounts and at the right times.

Staff kept people safe and protected them from any type of harm or abuse.

There were enough staff to make sure people were cared for safely.

Staff were checked to make sure they were safe and suitable before they were allowed to work with people.

Is the service effective?

Good

The service was effective.

People were supported and cared for by staff who had been properly trained to meet their needs.

Staff helped people to stay healthy and happy, for as long as possible.

Staff encouraged and supported people to make as many decisions for themselves as they could and made sure they protected their rights.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and patience at all times. They made sure that people's privacy and dignity was respected.

People were helped to stay as independent as they were able for as long as possible.

The home had a friendly, homely atmosphere where people and staff felt at ease and laughed and joked with each other.

Is the service responsive?

Good

The service was responsive.

People's needs were responded to quickly by the care staff. They listened to people with regard to their daily choices and acted on their wishes.

People were recognised as individuals and were supported and cared for in the way that they preferred and that suited them best.

People had a variety of interesting activities they could choose to participate in. These were being improved as a response to people's opinions and views.

Is the service well-led?

Good

The service was well-led.

The management team were respected and praised for the improvements they had made in the service.

The provider, management team and staff regularly checked it was giving good care to people. A number of changes, to make things better and safer for people who live in the home, had been made.

The service had developed good working relationships with other professionals and worked co-operatively with them.

Lord Harris Court

Detailed findings

Background to this inspection

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

This inspection took place on the 10 May 2016. It was carried out by two inspectors, a pharmacy inspector and a specialist nursing advisor and was unannounced.

Before the inspection the manager completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the PIR and at all the information we had collected about the service. This included all information and reports received from health and social care professionals and others. We looked at the notifications the service had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we observed care and support in communal areas of the home and used a method called Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk to us. We spoke with the interim manager, two support managers, three catering staff, an activities provider, 12 care staff (including nurses), a person's relative and 21 people who use the service. We also received feedback from one health care professional. Additionally we received written and verbal comments from people's relatives and two other health professionals before and after the inspection visit.

We looked at twelve people's records and records that were used by staff to monitor people's care. In addition we looked at a sample other records related to the running of the service. These included ten medicines administration record charts, six recruitment files, staff training records, duty rosters, menus and records used to measure quality and safety.

Requires Improvement

Is the service safe?

Our findings

People's medicines were generally given and stored safely. However, Information relating to medicines was not always recorded accurately, which could increase the risk of administration errors. For example, one person had allergies to several medicines listed in their care plan, but was recorded as having 'no known drug allergies' on their medicine administration record (MAR) chart. A MAR is a document showing the medicines a person has been prescribed, and recording when they have been administered. The manager sent us evidence to show that this issue had been addressed the day after the inspection.

Additionally, several people had medicines prescribed to be used 'as required'. Information about why, when and how these medicines should be administered to the individual person was not available with the regular MAR chart. Although protocols were in place to support staff to know when to administer these medicines, these were not always complete or accurate. For example, four protocols did not identify whether people were able to verbally ask for their medicine when they needed it. Another protocol, which had the wrong dosing frequency recorded, had been photocopied and used for several people. We could not be sure that the processes in place ensured that people received the most appropriate combination of medicines. Management staff at Lord Harris Court had recognised this was an issue, and had started taking steps to address it.

People who had been prescribed creams or ointments also had topical medicines administration records in place. However, these provided limited information to the staff applying the creams, and had not been signed by staff to indicate they had been applied. For example, staff had signed one person's chart on 13 of the past 24 days, and another on only four of the past 24 days. The shift leader confirmed we were looking at the correct charts, and one person told us that creams were applied but "not every day". This meant there was a risk that people did not receive their topical medicines as prescribed. One person's medicine administration record detailed that the person self-administers cream. Their care plan, reviewed 24 April 2016, detailed for staff to, "apply Diprobase cream daily". From this, it was unclear whether the person required support to apply the cream, or if as a prescribed cream it had been applied daily. A person's relative also stated, "We were concerned about dad's medicine today as he has to have his medicine at 11am, but was not given it until 11.20am. The timing is crucial to prevent falls". The management team told us they had prioritised areas to work on such as serious medicine administration errors. They had identified other errors for improvement and were in the process of developing systems to address these.

A detailed, "Management of medicines and clinical procedures" document was in place to ensure that handling and administration of medicines was in line with regulations and national standards. However, this was a corporate document, which did not always reflect local processes. For example, the recent introduction of missed dose checks at handover to identify medicines-related problems was not described within the policy, whilst a procedure for providing homely remedies was detailed within the corporate document, but was not available at Lord Harris Court. This meant there were not always clear and transparent processes in place for staff to follow.

Medicines were stored securely and handled appropriately at Lord Harris Court. Systems were in place for

the safe receipt, administration and disposal of medicines. People's medicines were stored in locked medicines cabinets within their own rooms, and access to medicines was restricted appropriately. Items were stored in a fridge where necessary, and fridge temperatures were recorded daily and found to be within the required temperature range.

Staff gave people their medicines as prescribed by the doctor. Staff were able to describe to us good practice in medicines administration technique, and we observed staff giving medicines to people safely. Appropriate arrangements were in place for the recording of medicines administration. We reviewed ten MAR charts and found them to be completed appropriately.

We saw that people were offered pain relief, which was available and administered when needed. One person told us that their medicines were well managed, and they had access to them when they needed them. We saw records and results for medicines requiring monitoring for example certain anticoagulants.

The service had reported 19 medicine errors over a 12 month period, prior to the inspection. They had taken action to reduce errors, going forward. There were systems in place to minimise the risk of medicines errors. Medicines were administered by trained staff who wore red tabards to prevent interruptions during medicine rounds. In response to a reported medicines incident, staff checked all the MAR charts at the end of each shift to make sure people had been given their medicines correctly. Staff told us this had reduced the number of missed doses of medicines. Some people administered their medicines to themselves. Staff used a risk assessment to check this was safe, which they regularly reviewed.

Staff we spoke to had a clear understanding of what to do in the event of a medicine error and of the process for reporting incidents involving medicines. Staff described a positive reporting culture and we saw documentation detailing how incidents, and near misses, had occurred and the action taken. These were logged and reviewed to minimise the risk of repeat incidents. Staff told us about the recent introduction of monthly medicines audits. These had been completed for the previous two months and included action plans to address the issues identified. We saw how learning from audits had changed practice; for example, creams supplied directly to residents by district nurses were now labelled with information to support the correct use of these products.

Staff told us they received training and supervision to support them to effectively manage and administer medicines. This included checks of their competency, through observations by senior staff.

We recommend that the service review some parts of their medicine administration procedures in line with nationally recognised good practice guidelines.

People told us they felt safe. Comments included, "oh I feel safe" and "yes I feel safe, staff are very kind".

People were protected from any form of abuse by staff who fully understood their responsibilities and knew how to safeguard people in their care. They were able to provide a robust response in relation to their understanding of safeguarding. They had received safeguarding training and where fully aware of the provider's whistleblowing policy. One member of staff told us, "I wouldn't tolerate any type of poor care. I am confident the managers would listen and take immediate action." Another said, "Any issues, especially those regarding people's safety are picked up straight away." A number of safeguarding concerns had been reported and all were investigated and dealt with effectively. There was clear evidence that the service was working closely with the local authority to reduce the number of safeguarding incidents.

People, staff and visitors were kept as safe as possible, whilst in the home. Staff followed health and safety

policies and procedures which were included in the induction process. There were up-to-date generic risk assessments which included manual handling, slips, trips and falls and infection control. Maintenance checks to ensure the service was safe were conducted at the required intervals. These included equipment such as lifts and hoists (15/03/16) and a full fire risk assessment (03/05/16). The service had comprehensive emergency plans in place. These were kept in a 'disaster' box in the staff office. Contents included torches, full evacuation plans, first aid equipment and emergency contact names and numbers.

The service was awarded five star (very good) environmental food safety standards in July 2015. The home was clean and well presented with no offensive odours. Staff used protective clothing to provide people with personal care and when handling food. They changed their gloves and aprons when entering different areas of the building. Red bags were used to separate soiled linen from general laundry. One of the support managers took responsibility for infection control. She told us a company, engaged by the provider, was contacted to dispose of clinical waste and 'sharps'. They collected waste once a week and sharps boxes when required. The interim manager told us the laundry was about to be refurbished. A meeting was due to be held on 6 June 2016 to discuss the project. All new equipment supplied would meet infection control requirements.

People's individual care plans included risk assessments in the relevant areas of care. These were individualised and included personal evacuation plans and risk of falls. People's care plans were cross-referenced with falls assessments and detailed their strengths and abilities to maintain their independence. For example an individual's falls risk assessment was fully completed and a management plan was in place. The individual had no recent falls on record which suggested the risk assessment had significantly reduced the risk of falling. The service had sought the help of the local, care home in reach team (a team of external professionals with expertise in the care of older people) to assist them to deal with falls risks to increase people's safety. Staff were provided with falls training and 'falls champions' were identified. Whilst the number of falls over the last month remained similar to the preceding two months, the severity of injury caused by falls had significantly decreased. An example of actions taken included using pro-active personal care so that an individual was helped with their personal care at set intervals. This had reduced the number of falls experienced. The service used recognised assessment tools for looking at areas such as nutrition and skin health. For example a high pressure ulcer risk assessment score resulted in the provision of an air mattress.

The service learned from accidents, near misses and incidents. Accident and incident reports recorded the incident, the investigation and described what action was taken and any further action or learning needed. For example one falls investigation included equipment and bed assessments. A review of the individual's mobility assessment, time of fall and staff on duty. Actions taken included the introduction of a resident falls flow chart to advise staff what to do in event of an actual or 'near miss' fall, the provision of a new bed, hourly checks put in place for one week and then reviewed and a GP referral. Body maps recorded any unexplained bruising or injuries.

The weekend prior to our visit, the outside temperatures in the South of England had risen to above 22 degree Celsius. We spoke with a person who had sunburn. They said, "I did not realise I was being burnt. I was assessed by the nurse who applied a cold compress and told me to use calamine lotion". The person added, "I haven't got any sunscreen as you don't think to bring that stuff in with you. I was told to put a cardigan and hat on, but I had to laugh, a boiling hot day and they asked me to put a cardi on". However, the service had an extreme hot weather procedure which was reviewed in April 2016. This included detailed instructions such as, care staff are to advise people who choose to sit in the full sun to wear hats and long sleeve clothing. It stated that staff must help people with their sunscreen and advise them it is available to buy in the home's shop, if they don't have any. It also noted that the service provided well maintained

awnings for people to sit under, how often staff were to offer fluids and how they should keep people's rooms cool. One of the support managers undertook to ensure staff were reminded of the procedure.

People were looked after by staff who were recruited safely via robust recruitment procedures. These procedures included requesting and validating references, and checks on people's identity. Disclosure and Barring Service checks to confirm that prospective employees did not have a criminal conviction that prevented them from working with vulnerable adults, were made. Application forms were completed and included a full past employment history. An explanation for any 'gaps' in employment history was generally noted on the application form or in interview documentation. The selection process consisted of three parts. Interaction with people, knowledge and understanding of effective personal care (written questions) and a formal question and answer interview. Records of response from candidates were kept of each part of the process.

People were provided with safe care by adequate numbers of staff who were effectively deployed and organised. Staff told us that there was always enough staff on duty to keep people safe and to carry out their duties without feeling they had to rush people. In the case of shortages, staff worked additional hours or agency staff who were familiar to the service were used (whenever possible). One staff member told us that the agency staff used were, "Very good although they don't know the people as well as we do." Others said staff were, "One big team, whatever you do in the home and whether you're a permanent staff member or not." Some relatives felt that some agency staff may not have the knowledge or skill that permanent staff had. The service continued to recruit to permanent posts as quickly but as safely as possible.

Safe staffing levels were calculated by using a 'dependency' tool. The dependency assessments were completed a minimum of monthly and reviewed for each of the units separately and the overall staffing levels of the service. Staff worked in two shifts from 7.45am until 2.45pm and 2.15pm until 9.15 pm. A minimum of eight night staff worked from 9pm until 8am. There was a registered nurse on duty in the nursing wing throughout the day and night. Staff sometimes worked both shifts but had breaks within the shift. Handover periods were 'built in' to the shifts throughout the day. The service had recently introduced a staff 'floater'. This staff member was available to answer call bells over all the units and/or fill in for staff who called in sick at short notice. The staff told us this was a very successful post and a, "Brilliant idea." They said it meant that they were confident they had enough staff on duty at all times and had alleviated any concerns about leaving people too long when they rang their bells. The service had recently recruited two registered nurses who, staff and managers said, were extremely knowledgeable and supportive towards the staff team. Members of the management team were able to increase the staffing for any out of the ordinary events such as illness or other crises, as necessary.

Good

Is the service effective?

Our findings

People described staff as, "really lovely", "they support me to the dining room and with personal care". One person said, "all of the staff are nice". Another said, "there are a lot of agency staff, but I take it as it comes, I get on well with them all" and "no complaints about the staff, they are ok".

People were supported to stay as healthy as possible. People's healthcare needs were clearly described in their care plans and they were able to access health care services and received ongoing support from external professionals. For example, we saw changes in medicines had been made following advice from a specialist nurse. Health care records showed visits by and to other professionals, medication needs and records of healthcare appointments/outcomes. Examples included referrals to the occupational therapy and tissue viability nurses (TVNs). People's care plans reflected multidisciplinary involvement in their care. For example one person had the dietetic nurse and the TVN when they were required and had an annual vision review.

People's nursing care needs were met by qualified nurses and knowledgeable care staff. There were observational pain assessment tools within people's care plans. These were used in the care of people who may not be able to verbally communicate that they were experiencing pain. Pain assessment charts scored pain intensity from zero to five and detailed the site of the pain. One pain management care plan documented that, "I need PRN (regular)." and there was other information such as staff to observe facial expressions and body language. However, whether a pain assessment tool had been used, in this instance, was not clear. Staff we spoke with did not always know about the assessment tools used and included in people's files. However, they were able to fully describe how they identified if a person was in pain from knowing the person and facial expressions. They gave examples of people raising eyebrows, grimacing, grabbing staff and pointing to pain sites.

A person's wound management care plan showed a history of reoccurring blisters and they were being treated for a grade 4 heel sore. Blisters were reported healed following the use of antibiotics. There had been appropriate consultations with a TVN and the wound was healing. Photographs and body charts of wounds were in place. However the wound dressing care plan reflected that dressings were due for change every three days this was not always reflected in records. One entry showed that there had been a seven day gap between re-dressings. However, the wound was healing well which suggested a recording rather than care omission.

Mattress settings were not always set correctly according to people's weight. Staff corrected the settings when these were pointed out and the management team undertook to ensure all mattress settings were checked.

A person's catheter management care plan noted that re-catheterisation was reviewed following a GP review. Clear short-term care plans for the use of antibiotics for skin infections were in place and there were recent GP reviews of medication in April 2016. The illegibility of a small number of daily notes meant important information could easily be missed or misinterpreted with regards to this person's care needs

interventions. However, staff were knowledgeable about people's needs and received detailed handovers.

We joined staff at their handover meeting (exchange of information from morning staff to the afternoon staff). All of the staff were involved to ensure clear lines of communication about people's needs and of important changes that needed to be passed on. The handover was delivered in such a way, that if you were a stranger to the home you would have been able to recall people's needs and meet those needs as required. Staff members told us the handover was, "Absolutely brilliant. We share all our information and talk about residents and the plan for the day." Another staff member told us each staff member was delegated people they were responsible for. This meant they had to ensure people ate and drank enough and that their care plan was followed. However, a relative told us they felt the main issue for the service was their lack of cohesive communication. They gave examples of staff not being able to tell them what was happening to their family member and staff not completing care, as required. They did feel there may be a difference between permanent staff who knew their family member well and agency staff who did not. This view was not expressed by staff, other professionals or people themselves.

People were supported to make as many decisions and choices as they could. People's consent or that of their power of attorney was noted in care plans. Care plans noted people's capacity in a section called, "maintaining control of my life." Staff understood how people's capacity to make choices could vary dependant on matters such as time of day, health and mood. For example, an individual's care plan included a mental capacity assessment which showed that the decisions were made for close monitoring, care and treatment, use of bed rails and support on accessing the community. Staff described how they helped people to make everyday decisions such as offering a choice of two things and using photographs, as appropriate.

People's rights were upheld by staff who understood consent, mental capacity and Deprivation of Liberty Safeguards (DoLS). Staff had received mental Capacity Act 2005 (MCA) training and were able to explain their understanding of the principles of mental capacity and when a DoLS referral may be necessary. The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service made appropriate DoLS referrals, 12 applications had been made and four had been authorised by the local authority (the supervisory body), with no restrictions. The other eight applications had been submitted and the service was awaiting an outcome.
DoLS authorisations were renewed every 12 months, as required by the Act.

People were provided with and supported to eat adequate amounts of nutritious food of their choice and to drink enough fluids to keep them healthy. People had an eating and drinking care plan and their weight was monitored. A relative of a person stated, "dad has put on weight since coming here to stay". The catering manager said, "I speak with residents about their food regularly. For example, one person has her own menu that includes eight other choices to that of the main menu. This is because they find it difficult to eat. So I have tried to help by giving them more choice."

When people had been identified as being at high risk of malnutrition or dehydration, food and fluid charts were in place. Recordings on food and fluid charts were up to date and staff were able to tell us what

thickeners were used for an individual. Nutrition care plans reflected people's current needs. For example someone with a soft diet and thickener had an accurate care plan, which was being reviewed monthly. It showed all the necessary consultations with the Speech and Language Therapy Team (who monitor people's ability to swallow safely).

People were given a choice of food and given time to make their decisions. They were helped to eat in a pleasant and relaxed atmosphere although some people said it was, "too noisy". For those requiring intensive support staff sat next to people and provided appropriate and sensitive encouragement for them to enjoy their meal in their own time. However, one person was hurried with their meal, as the member of staff had not allowed sufficient time between spoonfuls. We discussed this with the manager who said they would take immediate action to address this concern.

People told us that there was always plenty to eat and food was freshly prepared. Comments about the meals were mixed and included, "excellent food." "Breakfast is the best in town, but lunch is … awful". "I've made a toad-in-the-hole a darn sight better than they have today" and "it varies the toad-in-the-hole was not bad today". A person said, "I don't like the water here" when referring to his class of wine. "They give us a glass of wine with our meal on a Sunday, but otherwise I provide my own." Another person said, "I don't share their view so I dissociate from his comment on the water". Two people spoke of the staffing arrangements within the kitchen. Stating, "They are a separate company, so we have no direct control. However, they have improved recently as there are more staff on the floor."

People were supported by staff who were trained to meet their needs. Training had been developed for staff to meet health and safety, mandatory and statutory training requirements as well as receiving training to support specific individual's needs, such as dementia care. The service used a computer programme to provide a training matrix which 'flagged up' when people need to renew their training. The service was recruiting to a newly created 'in house' trainer post. The purpose of the post was to improve the provision of training in general and particularly in areas specific to the needs of individuals.

Staff told us they had, "Fantastic opportunities to participate in training." another staff member said, "More and more training is being provided." Some staff said they had not received training that covered pressure care awareness or diabetes, but felt confident if they asked this training would be provided. Other staff told us they had received training in special areas of care such as pressure care and catheter care. Continence awareness was planned for the near future. Staff said they were often provided with person centred and experiential training which helped them to fully understand how people felt when (for example) they were sat in a wet pad for a long time. All staff, including those in ancillary roles were given the opportunity to participate in the whole training programme.

There was a comprehensive induction programme which met the requirements of the care certificate framework (which is a set of 15 standards that new health and social care workers need to complete during their induction period). One staff member told us they had received, "A really good induction." They told us this included a five day dementia care course and a 'shadowing' period. They said they were able to shadow experienced staff for as long as they and their supervisor felt was necessary. Staff told us and records showed that they received regular supervision and annual appraisals. Detailed supervision notes were kept in staff files for future reference.

Staff described colleagues as supportive and said they worked well as a team. Comments included, "The managers are really supportive" and "We get big support from management and colleagues." Staff told us that there were regular staff meetings and that they felt confident to raise issues for discussion.

The service provided (wherever possible) people with any necessary equipment or building adaptations to ensure people's comfort and to keep them as mobile as possible. One person said, "I moved rooms, because the girls were having trouble with the hoist. I now have a nice big double room with a ceiling hoist and en-suite shower." A persons relative stated, "They bent over backwards to put a new shower in so that dad could stand." The relative showed us the communal bathroom that had been installed with a new shower and grab rails to enable people to stand, while still having the original shower for people to use who preferred to sit on a shower chair. For one person a hoist was used for transfers and the care plan reflected that a large sling, a super deluxe sling or a quick fit full body sling was to be used on an oxford advance or similar hoist. This was not a detailed instruction for care staff. However, care staff had a good knowledge of the person's manual handling procedures.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. Comments included, "Staff are kind". "The staff are very good here; they are always respectful towards me." "Wonderful, very, very good. They leave you to yourself. The place is very comfortable and table service excellent, can't have it better." "There's no doubt about it they (staff) are very helpful and kind; well I've found they are very good with me." One staff member told us, "The staff team have a big heart, they are all very caring." Another staff member said. "Staff are caring and respectful. We do it (the work) because we care."

People were treated with kindness and compassion. We observed staff interacting with people in a kind, caring and compassionate way during medicines administration rounds and throughout the visit. Staff spoken to and observed demonstrated kind and compassionate behaviour towards the people they were looking after, knew the residents by names and spoke with respectful language with the people when they were giving care.

Staff addressed people appropriately in a warm and friendly manner and encouraged them to make decisions. For example, staff approached a person who we knew could only hear from one ear. (We had been made aware that you had to speak slowly and directly towards the person's hearing ear.) The member of staff spoke with the person in a kind and reassuring manner whilst making sure the person was able to hear what was being said. They asked the person what they would like to drink and to confirm what they had chosen for lunch. Staff were attentive towards people, such as acknowledging people when they passed by. There was a real sense of community spirit as people and staff laughed and joked with one another in a polite and caring way. Staff told us, "We are like a big family here."

Staff made sure that they maintained people's privacy and dignity. They gave examples such as knocking on doors and provided same gender care if people wanted it. People's preferences with regard to support with personal care were recorded on their care plans. People's bedrooms were personalised with items of their choice.

People were asked for their permission before staff undertook care or other activities. Staff had developed strong relationships with people. They were knowledgeable about people's individual needs and personalities and were fully aware of people's likes and dislikes. Staff had received training that included dignity and respect. They were able to provide a good account of people's needs in a very respectful and caring manner that we could see was natural for them.

People were supported to maintain as much of their independence as they were able to, for as long as possible. The management team told us that they were committed to person-centred care and actively sought out ways to support people to maintain their independence, "Both in the home and in the wider community." Care plans described how staff should encourage people to control their daily lives. Examples included, people choosing when to go to bed and get up and choosing what to wear. Staff described how they encouraged people to complete as much of their personal care routines as they were able to. Staff described person-centred care clearly. One staff member stated, "It's about recognising that people have

different wishes and treating everyone as an individual."

People were fully respected and the management and staff team encouraged people to have a voice about decisions made in the home. Staff told us they were very respectful of people's choices and wishes. They gave an example of ensuring people were helped with their personal care by staff who they had a good relationship with. A person who uses the service chaired a residents' committee. People told us that they valued having a residents committee and used this to provide feedback about their feelings of the services provided. The chairperson said, "After a meeting, which takes place monthly, we have a meeting with the deputy manager and talk about any problems raised."

People told us that they felt they were kept up to date about the management of the home and of any changes. Comments included, "Yes they make sure we are informed, we were told there is a new manager starting in the middle of May and that his name is (name)." A person's relative said, "They get in touch with us straight away if something has happened."

People's equality and diversity was respected. Care plans included, "values beliefs and feelings". This detailed information such as whether the person was able to practise spiritual beliefs. People spoke of the chapel within the home and of being supported to attend religious services of their choosing. One person told us that they, "needed new hymn books in the chapel" and that the "Association of friends' (a volunteer group who organise fundraising for the home) went and bought new ones."

The provider told us that they planned to implement end of life care training for staff in 2016. There were advanced care plans in people's files, according to people's choice and as appropriate. These enabled the person to express some views, preferences and wishes about future care.

End of life care plans were developed, when necessary, taking into account people's preferences. For one person we noted that their relative was actively involved in making decisions about their changing needs and resultant end of life care planning. The daily care being given was caring and compassionate and as described in the care plan. A staff member had been allocated to the individual to meet their daily needs. The person was being kept as comfortable and pain free as possible. Methods being used included two hourly positional changes and using a teaspoon to give fluid and soft food. We observed a sensitive and caring discussion as the GP and staff explored all areas of care to ensure the person was comfortable and the family were supported. Do not attempt cardio-pulmonary resuscitation forms (DNACPR) were completed and signed by the GP or consultant, where appropriate.

Good

Is the service responsive?

Our findings

People told us that call bells were answered quickly or reasonably quickly. The management team had responded to delays in answering call bells and adopted systems to ensure they were answered in less than six minutes. After the six minutes the call bell sound changes to the emergency call. A relative told us, " There has been a few issues with call bells, dad now wears a wristband to alert staff should he have a fall as the call bell system is quite antiquated." The person was also wearing a neck pendant and there was a call point within the en-suite bathroom that linked to the same system as the pendant. A person said she had a fall, "I was on my own, we had a bell to ring and I have a pendant, but it only works in the room. (The management team told us the pendant does alert staff.) I don't have a wrist alarm." "They come reasonably quickly when you call them, but I did have to wait once when I had a fall." Additional handsets for staff to carry, so that they are able to respond more quickly to call bells are being installed.

People's needs were assessed before they moved in to the service and people had detailed, individualised care plans which met their specific needs. Care plan summaries identified people's needs and wishes for care and support. For example, "I will need the assistance of one carer and a wheelchair to take me to the dining room" and "I like a mug of tea, I don't like small cups". Care plans were personalised and detailed daily routines specific to each person. They included eating and drinking and mobility and were cross-referenced to falls assessments that detailed the person's strengths and abilities to maintain their independence. People signed their care plan to confirm they were involved and agreed with the detail written.

Care plans were reviewed every month. Monthly reviews were recorded and noted any changes made such as, changes in people's health and well-being. Staff were flexible and would listen to people, relatives and other professionals and respond to people's immediate needs. The staff team met people's diverse and changing care needs with little or no delay. For example staff were able to identify the rapidly changing needs of a person who had been admitted to the service during the previous three months. They discussed the individual's changing health needs with their GP, who prescribed antibiotics, on the day of inspection.

People told us that external health care professionals were consulted and that appropriate referrals and reviews were made when their needs changed. The service had good working relationships with other professionals and shared required information (with people's consent) with others to ensure people had the best possible care. Staff followed protocols and worked jointly where referrals to other teams were required. For instance, staff told us how information about medicines was managed when people moved between services. We saw that medicines information, including changes to treatment, had been accurately exchanged following one person's recent hospital admission. We saw a team of external professionals assessing someone to provide relatives with specific, special armchair requirements so they could provide it in one week. Care plans included a section on recording the interventions of visiting health care practitioners and their recommendations were clearly recorded.

People were provided with a variety of activities that enhanced their lifestyle. Care plans detailed people's cultural, social and spiritual values, social interests and hobbies. On the day of our visit, a number of people

attended a tai chi class. The instructor told us that tai chi combines deep breathing and relaxation with slow and gentle movements and may help people to improve balance and general mobility. People said, "I really enjoy it" and "I come every week." In the afternoon, some people told us that they enjoyed "a bit of pampering" and were participating in a nail care session. One person told us, "I didn't like the first colour they put on my nails, so I selected another".

People told us that they enjoyed the recreational activities organised by two activity coordinators (staff) and said, "There are lots of things for us to do, for example, crafts and outings." "We take it in turns to go out on outings." "Tomorrow we're going shopping and this Friday we're going to the museum." "We went to a farm shop the other day and to the cafe and had tea and cake." In reference to the transport used by the home, people said, "They can only squeeze two wheelchairs on to the bus, which can be a bit of a problem." Another person said, "Oh the other day we went to the garden centre. They have opened some clothes shops there and I do enjoy shopping for clothes." One person said of activities, "I can do as much as I want, but don't have to join in if I don't want to".

The service had an established Association of Friends' (a voluntary group who fund raise for the home.) People spoke enthusiastically about the group. Comments included, "They pay for a lot of things like outings and run a shop within the home." "They take us to the chapel, I go a lot, and they are really nice." "They also do a coffee morning raffle and put the money towards funds for our trips out."

In their free time, some people chose to stay in their room to watch television, in order to have their own private space. Where people required support to go to, for example, the hairdresser who visited that day or to the communal areas, staff assisted them. They responded to people's needs and requests. In the communal lounges people appeared to enjoy each other's company as they chatted and/or relaxed quietly listening to music.

People were able to make complaints and comments about the service. The service listened to complaints and concerns and took action, if possible and appropriate. People and their relatives told us they made complaints, as necessary. People told us, "There have been certain suggestions we have made. For example, to have numbered tables and appoint staff to set tables, but this fell on the wayside." However others said, " We did complain about the standard of service, (in reference to the dining experience) it is a lot better now" and "I have no qualms or complaints; I feel I would be listened to." A relative told us they had made a number of complaints and expressed a number of concerns. They said that these were, generally, taken into account and action was taken, in response. Further relatives' comments included, "I have to say, all issues we have had have been documented and there have been solutions to most problems, on the whole they have bent over backwards to settle dad, as has his key worker [name]." "…I complained to (name of interim manager), she listens, I know she does because, she dealt with it promptly and all was done within a matter of a day".

The service had recorded seven complaints and six compliments in the four months preceding the inspection visit. The complaints had been appropriately recorded and dealt with in accordance with the service's comprehensive complaints policy and procedure. The complaints log recorded, in detail, the complaint, the investigation and the outcome of the complaint. For example, we saw that one complaint had resulted in an investigation, an overall analysis, a meeting, an apology letter and actions taken. Complaints were analysed for trends and repetitions and actions were taken if any were identified. The service responded to any issues raised by the local authority and worked with them to achieve a successful conclusion.

Good

Is the service well-led?

Our findings

The service did not have a registered manager in post. The previous manager cancelled their registration February 2016. They left the service in December 2015. An interim management team had been in place since December 2015. The management team consisted of an interim manager, two support managers, and a deputy manager.

People, relatives, staff and other professionals told us the interim management team were responsive, approachable and efficient. One staff member said, "The home has a lovely open culture. The lovely managers are very supportive and have made a lot of improvements." "The care has really improved this year." Others commented, "I feel I and my opinion are valued. Even though I am not direct care staff I feel I have done some good work and my contributions to people's care is valued. Things have definitely improved recently (over the past few months)." "They give good support and open the door for promotion, qualifications and everything." "There is an open door policy and you can always get help, support or advice from a manager." Staff commented that it was a very good team, whose focus was on the needs of people and who support each other to give the best care. Carers showed an understanding of residents needs and were motivated and confident in their roles. They were able to talk freely with the nurse in charge, on the day of the visit.

The service had appointed a permanent manager who is taking up their post on 31 May 2016. People had been informed of the new managers start date. We were informed that the current manager and the two support managers would remain in the service for at least two to three months after the new managers start date. Most of the people we spoke with were anxious about what a new manager would bring to the home. Comments included, "We have been without a manager, but we have (name of interim manager) assisted by (name) and between them they have done an excellent job. But it is not like having a manager as you feel it is just temporary". Some people were concerned that the new manager would not be committed to keeping people involved in decision making in the home. They were specifically concerned that they may seek to 'disband' the residents' committee.

The quality of care people were offered was monitored and assessed to make sure that good standards were maintained and improved, if necessary. The management team and provider completed a variety of audits to check on all aspects of the service. One of the support managers who worked as a clinical advisor regularly worked alongside nursing and care staff. She told us she supported staff by doing care plan and medicines audits and helped staff to evidence the care they provided. She ensured that staff attitudes, values, skills and knowledge were as required by the management team and the provider. Additionally, she supported staff to improve their clinical practice and knowledge. The management team completed various audits and checks such as detailed falls audits, complaints analysis and care plan reviews. The provider completed a two weekly visit which resulted in discussions with the management team and the production of action plans, if necessary.

The manager and staff worked in partnership with external health and social care professionals to improve the care offered to people. Arrangements had been made for the 'care home in reach team' to visit the

home. This is a team of health care professionals who provide services that includes working with staff to enhance their skills and improve their confidence by building on existing good practice. The service had responded to concerns raised by the local authority's safeguarding and commissioning teams. Concerns centred around medicine errors, falls, training and care plans. After a visit on 16 March 2016 they were happy that, "good progress had been made."

The management team listened to and took into account the views and opinions of people, staff and others involved in the service. Residents and family meetings were held regularly and surveys were sent to people and their families. The last resident meeting was held on 20 April 2016. Minutes showed that people discussed a variety of issues such as staffing, laundry, fire drills and key/link workers. Additionally, the service had an active residents' committee who also surveyed people who lived in the home. The chairperson told us, "They (people who use the service), seem to be largely happy. We just did a survey about people's feelings and found that 89% were satisfied with everything." Actions taken as a result of listening to people and their families included improving the dining experience and people meeting with the catering company every three months to discuss the food. More live entertainers had been planned into the activities programme. Effective hot plates to keep people's food hot for a reasonable length of time and butter knives had been provided.

The service held staff meetings once a month (approximately). The last meeting was held on 17 April 2016. Other meetings such as medications safe practice group supervisions and management meetings were held, as required. These informed staff of any new /revised good practice and any other relevant issues. The management team responded to ideas and input from the staff team. For example they had instigated an 'employee of the month scheme' in recognition of the staff team's hard work and had provided staff 'floaters' to augment the staffing numbers.

Good care was supported by records, relating to people who lived in the service, which were mainly accurate and up-to-date. However, some records such as the application of creams and when required medicines needed reviewing and improving. The service was aware of some shortfalls in people's personal records. They were, currently, reviewing all care plans and introducing new recording systems. People's records, overall, gave staff enough information to enable them to meet people's needs safely and in the way they preferred. Records relating to other aspects of the running of the service were well-kept and up-to-date. Statutory notifications were sent to the Care Quality Commission when required and in the correct timescales.