Mrs Janet Cole

Brecklands Nursing Home

Inspection report

28 Burnham Avenue,
Bognor Regis,
PO21 2JU
Tel: 01243863218
Website: The provider did not have one at the time of inspection.

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Ratings

Overall rating for this service	Good
Is the service safe?	Requires improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 06 January 2016 and was unannounced.

Brecklands nursing home provides accommodation for up to 19 people who require nursing and personal care. At the time of our inspection there were 16 people living at the service.

The provider is registered as an individual and as such does not require a registered manager. A registered provider is a person who has registered with the Care Quality Commission to manage the service. The registered provider are also 'registered persons'.

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider was present during our visit and also had a clinical lead in post.

Systems were in place to identify risks and protect people from harm. However these were not consistently followed, leaving people at risk and with delayed treatment. We found that staff did not consistently follow a care plan and risk assessment in two incidences relating to pressure areas. The maintenance of the

Summary of findings

environment was in need of attention and there were areas which were cluttered and unsafe. We observed that fire doors were wedged open, which presented a risk to people living at the service and others in the event of a fire.

The service is purpose built and accommodation is provided over two floors in single occupancy rooms. A passenger lift provides access between the floors. There were handrails along corridors to help people move around the building safely. There are two communal lounges, a conservatory and a dining room. The service had a cat which people told us they enjoyed seeing and a bird which was kept on the first floor.

People were protected against the risk of abuse as the provider took appropriate steps to recruit suitable staff, and staff knew how to protect people from harm.

People were supported to access healthcare from a range of professionals inside and outside the service and received support with their nutritional needs. This assisted them to maintain their health.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed, stored, given to people as prescribed and disposed of safely.

There were sufficient numbers of staff on duty to keep people safe and to meet people's needs. Staff recruitment procedures ensured only those staff suitable to work in a care setting was employed.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Decisions were made in people's best interests where they could not make decisions for themselves.

Staff treated people with kindness, respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the service. This helped people maintain personal relationships with people that were important to them.

People knew how to make a complaint if they needed to. Complaints received were fully investigated and analysed so that the provider could learn from them.

People, who used the service, and their relatives, were given the opportunity to share their views about how the service was run through meetings and feedback surveys.

Quality assurance procedures identified where the service needed to make improvements and where issues had been identified the provider took action to continuously improve the service.

People were encouraged to maintain their interests and hobbies and staff supported their personal preferences. People's care records were kept up to date to reflect the care and support they received each day from staff.

People were protected from nutrition and hydration associated risks with balanced diets that also met their likes and dislikes.

Staff were supported by the provider, clinical lead who was a registered nurse and other registered nurses through regular team meetings and observation. Staff had regular supervision sessions and felt their training and induction supported them to meet the needs of people they cared for.

People and their relatives felt the staff had the skills and knowledge to support people well.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Systems were in place to identify risks and protect people from harm. However these were not consistently followed to reduce risk in some instances. The maintenance of the environment was in need of attention and there were areas which were cluttered and unsafe.

The service had policies and procedures on safeguarding people from possible abuse. Staff knew what to do if they suspected any abuse had occurred.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Requires improvement

Is the service effective?
The service was effective.

People's health needs were addressed. People received the support they required in relation to eating and drinking.

Staff had completed sufficient induction and relevant training to meet the needs of people at the service.

The service had Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) policies and procedures and staff were provided with training. The legislation was being followed to ensure people's consent was lawfully obtained and their rights protected.

Good

Is the service caring?
The service was caring.

People were treated with kindness and compassion.

People were treated with kindness and dignity by staff who took time to speak and listen to people. Staff acknowledged people's privacy.

Good

Is the service responsive?
The service was responsive.

Concerns and complaints were well managed.

People were encouraged to express their views and had been supported to participate in activities that they enjoyed.

People's care plans identified the support they needed and it was provided.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

The provider sought the views of people, relatives, staff and professionals regarding the quality of the service and to check if improvements needed to be made.

There was an open culture at the service and staff told us they would not hesitate to raise any concerns.

There were a number of systems for checking and auditing the safety and quality of the service.

Brecklands Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 06 January 2016 and was unannounced.

The inspection team comprised one inspector and a specialist advisor. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported this inspection was a registered nurse.

Before the inspection, the provider 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 any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law. We used all this information to decide which areas to focus on during the inspection.

We spoke with five people who used the service and two of their relatives. We spoke with one visiting healthcare professional who was a community nurse.

We looked at six people's care and support plans. We reviewed other records relating to the support people received and how the service was managed. This included some of the provider's checks of the quality and safety of people's care and support, staff training, recruitment records and staffing rotas.

We spoke with the management team, including the provider, administrator, clinical lead, a nurse, two care staff and the cook.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

The service was last inspected on 25 November 2014 when no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People who had been assessed as at risk of pressure damage had been assessed using the Waterlow scale, which is designed for this purpose. People who were identified as at risk of pressure damage had care plans in place to guide staff in supporting good skin integrity such as regular repositioning, skin monitoring and regular mattress checks. However, we found in two incidences that staff did not consistently follow this care plan and risk assessment to keep people safe and provide proper treatment. One person's care plan identified they needed to be repositioned every two hours to prevent skin breakdown. However the repositioning chart in their documentation record did not demonstrate that this level of repositioning support had been consistently provided. The person was suffering from early stages of skin breakdown although had not yet developed a pressure sore. We informed the provider at the time of our visit, who took immediate action, by reinforcing to the staff the need for completing records accurately, this was written in the staff communication book for handover and the provider said they would raise this at their next staff meeting. The provider asked the nurse to check on the skin area affected. The staff told us the person was being repositioned.

The records for another person, who we observed as having a superficial pressure sore, did not indicate a nurse had been informed or what action was being taken to treat the pressure sore. The person's care plan and risk assessment identified the person as being at risk of pressure sores and for a wound care plan to be actioned if a pressure sore occurred. There was no body map to indicate when the wound appeared and no photo log to monitor if it the wound was healing. There was an entry in the persons daily records 'much improved' but the records did not indicate if the entry was related to what we observed. We informed the provider and nurse at the time of our visit who took immediate action to ensure the person was comfortable. Before our visit ended a body map was completed, a photo log had been started and a wound care plan actioned as per the wound care policy in place. However failure to do so prior to this being pointed out placed the person at risk of not having their skin integrity needs met.

Risks in relation to skin breakdown had not been consistently managed or appropriate action taken to minimise risk. **This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.**

We had a look around the service including some of the bedrooms, communal areas and bathrooms. We observed that the environment such as corridors and bathrooms were not always maintained and there were areas which were cluttered which could be a tripping hazard for people. For example bathrooms had items of furniture being stored in them and no longer used mattresses. The staff team had received fire awareness training within the last 12 months. A fire safety check was conducted each week and fire alarms were tested on a regular basis. A personal emergency evacuation plan (often referred to as a PEEP) was in place for each of the people living at the service to indicate the support people would need to evacuate in the event of a fire. However during the course of our visit we observed that many bedroom doors and communal doors had been wedged open. Retaining fire doors in an open position means they cannot close automatically, which places people at risk in the event of fire.

The provider had not consistently ensured the premises were safe to use for their intended purpose. **This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

We looked at how other risks associated with people's care and found they were appropriately managed. For example, a person who had diabetes had a care plan and risk assessment. This contained information on how to monitor and manage their health condition. Staff monitored their blood sugar to identify if it was too high, or too low. The care plan gave detailed instruction of how to deal with any identified problem and contact details to refer to a diabetes nurse. This meant someone who was not familiar with this person would have clear guidance to follow on how to safely manage any unsafe blood sugar levels and respond accordingly. This person's blood sugar levels were being monitored regularly and their condition was stable. Staff we spoke to told us they would know how to support the person in an emergency situation.

A process was in place for recording, monitoring and analysing incidents. A monthly analysis of incidents (such as falls) was undertaken by the clinical lead and had been

Is the service safe?

completed up to the end of November 2015. A post-falls checklist was in place to monitor the severity and impact the fall had on the person. This helped the staff to identify any trends and take action to minimise risk.

People told us they felt there was enough staff and they were safely cared for. One person said, "Yes, I am safe here" and another said, "I feel I am safe here." One relative we spoke with told us, "There are always enough staff around. They have a buzzer in their room to call staff."

People we spoke with confirmed they had buzzers available to call for assistance. One person told us, "In the night I usually press the buzzer and they are prompt." A visiting healthcare professional told us, “I’ve always been well engaged. They have called me when they have concerns at appropriate times. Really good with end of life care, pressure areas and catheter care. I regard them as a safe pair of hands.”

During our inspection we saw there were sufficient numbers of staff to support people and call bells were answered in a timely manner. We frequently saw staff in communal areas offering support to people. Staff we spoke with told us they felt there were enough staff to provide care and support to people. We asked the provider how they ensured there was enough staff to meet people's needs safely. The provider told us staffing levels were determined by the number of people at the service, their needs and their dependency level. The provider used this information to determine the numbers of staff that were needed to care for people on each shift.

The staff rota reflected what we saw; there was a nurse and three staff on in the morning, with a fourth staff member shadowing as part of their induction. The rota reflected two staff during the night, one of which was a nurse.

The provider told us they were committed to improving the numbers of permanent staff within the service and recruitment was on-going at the time of our inspection. The provider told us if they were short on shift due to sickness, training or annual leave permanent staff always volunteered to cover the shortfall. There was a clinical lead that was a registered nurse and provided additional support to monitor and oversee the nursing care provided to people. The role provides clinical supervision of checking on the nursing needs of individuals and procedures in the service, including medication administration, contact with GPs and clinical support for the staff. The provider and administrator were extra to staffing numbers and were available to provide support if required. Both the provider and administrator had completed the necessary training to support people safely. The provider employed a chef who served meals to people and there was a housekeeper so staff could concentrate on supporting people.

People were cared for by staff that had been robustly recruited to ensure they were suitable for the role. The provider had satisfactory systems in place to ensure suitably skilled and qualified people were employed at the service. All pre-employment checks, including nursing PIN registrations were in date and valid, that references were obtained and Disclosure and Barring Service (DBS) checks were obtained before staff commenced working in the service. Staff we spoke with confirmed that they did not commence work before their DBS check arrived. The DBS helps employers ensure that people they recruit are suitable to work with vulnerable people who use care and support services.

Staff understood how to recognise the different types of abuse that could occur and who to report this to. They told us, "I would report to the manager if I had concerns." Another member of staff said, "I would report to the person in charge. There is information in our office about who to contact in the local safeguarding team and a number we can call to ’whistle blow’". This meant if staff had concerns that the provider was not taking appropriate action to keep people safe, they could make an anonymous referral to the local safeguarding team or the Commission. The provider told us, "I encourage whistle blowing; I would expect concerns to be reported."

A qualified nurse provided us with an overview of how medicines were managed safely within the service. The medication was held in a locked trolley secured to a wall. There was a dedicated clinical room that was kept locked. Systems were in place for checking and recording the receipt and disposal of medicines. A list of staff authorised to administer medicines and their signatures was in place. We looked through all the medication administration records (MAR).They included a picture of each person, any known allergies and any special administration instructions. The MAR forms were appropriately completed. Short term plans were in place for people prescribed a

Requires improvement

Is the service safe?

time-limited course of medication, such as antibiotics. Specific guidance was in place for people who took medicine only when they needed it (often referred to as PRN medicine).

Medicines requiring cold storage were kept in a dedicated medication fridge. The fridge temperatures were monitored and recorded daily. They were within the correct temperature range. Topical medicines (creams) were stored safely. People told us that medicines were given out in a timely way. The person said they received their medicines on time and family members confirmed their relatives received their medicines at a time when they needed them. The nurse told us the medicines took a while because some people needed time to ensure they swallowed their tablets. The nurse said that some medicines were given by the nurse on night duty to ensure that the people who needed them before food received them before breakfast. The nurse advised us that people who were prescribed the same medicines at breakfast and lunch were given their breakfast medicines early so that there was an appropriate gap between doses.

Equipment such as hoists, standing aids and wheelchairs was clean and in good working order. Systems were established for checking the safety of the water, emergency lighting and equipment. Service level agreements were established for moving equipment, heating, lighting, electrical and gas checks. The records for the checking and servicing of equipment, including portable electrical appliances were up-to-date.

Good

Is the service effective?

Our findings

During our visit we saw staff had the skills they needed to effectively meet people's needs. Staff told us they had received training in areas the provider considered essential to meet people's health and safety needs. For example, training included infection control, manual handling, safeguarding, equality and diversity, emergency first aid, food hygiene and fire awareness. Staff told us, "The training is really good and it's on-going." Staff told us that as part of moving people training, they had to use a hoist to give them an understanding of how a person may feel when being moved. Another staff member told us, "I had all the mandatory training and I had to be assessed as competent to administer medication before I could start, it's really great training."

We spoke with two new staff and they told us they were on a comprehensive induction programme and are currently working alongside more experienced staff before working independently.

Staff used their skills effectively to assist people at the service. For example, staff used their manual handling skills to assist people to move safely. Staff used the correct equipment for each person, and people's privacy and dignity were protected.

The provider told us they had recently started enrolling staff on the Care Certificate Course. This is a nationally recognised qualification. This Certificate covers 15 standards of health and social care and are work based awards, that are achieved through assessment and training. Prior to this the service followed the Skills for Care 'Common Induction Standards.'

Staff were provided with additional training that focussed on delivering person centred care, wound care, Parkinson's disease, catheter care, dysphagia identification and management (this is a medical term for swallowing difficulties), and confidentiality. Staff felt it provided them with more insight into caring for people with these needs.

Staff confirmed they received regular supervision which allowed them to discuss their work, training and future plans with their line manager. Staff said they found the supervision sessions useful. Records of staff supervision and annual appraisals of their work were maintained and covered the care of people, training and updates on relevant legislation.

Staff had knowledge of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and what it meant for people. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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 provider had submitted a relevant application to the local authority and at the time of our inspection only one person was subject to a DoLS.

Staff understood issues around people's capacity to make certain decisions and why DoLS authorisations were in place for one person. One staff member told us, "We do involve people's families about best interests decisions and members of the community team." This would include social workers and relevant healthcare professionals providing support to people.

Staff told us they understood the principles of the MCA and DoLS. Staff gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. When asked about consent, one member of staff said, "We always talk to people, asking them questions about what they need and what." Another staff member told us, "If they say 'no' we might leave them and come back and ask again, or see if another member of staff can encourage the person."

Where people could not make all their decisions for themselves, we saw this documented in their care records. Records showed which decisions people were able to make on their own, and which decisions they needed support with as capacity could change.

People told us they received enough to eat and drink to support their health and well-being. They told us, "The food is very good", "We have choices at breakfast, lunch and in the evening" and, "there is a menu for every day and the girls comes around to ask you what you want." Another

Good

Is the service effective?

person told us, “Food is quite good, I chose pork today.” During our inspection we saw people having cereals, toast and cooked breakfasts and people receiving the nutrition they needed, according to their personal preferences, and their health needs. At lunchtime we saw one person did not like their first choice, and so staff tried to encourage them to eat the other choice. We saw another person did not want what was on the menu and requested soup, which they were able to have. During lunch people were offered apple sauce with their pork and other condiments. At breakfast and lunch we saw people were offered a choice of fruit juices, squash, water, teas or coffees. They had a good supply of hot and cold drinks during the day, as well as smoothies, yoghurts, biscuits and fruit and additional support for people who needed fortified foods that contained extra calories to help them maintain or gain weight. Most people ate their lunch in the dining rooms; however we saw others having food in their room which was their choice.

Staff told us it was important that there was good communication with relatives and healthcare professionals so they could have a greater understanding of people's needs and provide the right support. We spoke with a healthcare professional who told us they had developed positive relationships with staff, who they felt were responsive to the support and direction given to them.

The MUST (Malnutrition Universal Screening Tool) tool had been used where people had been identified as at potential risk of malnutrition. From the outcome of this tool, a care plan had been written which was reviewed monthly to look for changes in need and documented what actions staff should take to support good nutrition. Weight records were completed monthly to monitor any unplanned changes to people’s weight.In the kitchen there was a notice board with people’s preferences; which were reflected in the care plans staff used. For example, there were 6 people who preferred to have sherry half an hour before their lunch. The board indicated who needed their food cut and what equipment was needed such who as who had plate guards, plastic cups, straws and china cups. It stated who was diabetic and what the person’s preferences were for example one person preferred unsweetened apple juice served with a serviette.

Records showed us people's weights were checked regularly and appropriate referrals to heath care professionals such as dieticians were made when concerns were identified. People told us they had access to healthcare services when they needed them such as the doctor, dentist and optician and records we looked at confirmed this. They told us, "The doctor comes here every week.” "The dietician came to see me and she’s helping me get my appetite back.”

This demonstrated that staff took appropriate action and sought the advice of relevant healthcare professionals.

Good

Is the service caring?

Our findings

People told us, “I’m quite ill at the moment but they are really kind and caring when dealing with my problems”, "carers are very good, very kind”, "they are excellent. You can't fault them”. More comments included “I’m very comfortable, they’re good girls”, “They are very kind and patient, [staff name] is lovely.” Relatives told us, "Nothing is too much trouble” and, “I can come and visit whenever I want."

We observed staff, being kind and supportive to people and we saw people's privacy and dignity was respected. For example, we saw a member of staff preserve a person's dignity, the person had quite a cold and their nose was running; staff gently guided the person to the nearest toilet and was able to support the person become more comfortable. The staff member then supported the person back to their chair and gave them a supply of tissue. The staff member asked if the person was warm enough and could they get them a blanket. The person didn’t want a blanket and thanked the staff member for their time. Staff knocked and waited before they went into people's rooms. We asked people if they felt staff treated them respectfully and they told us, "They are very respectful." We saw one person become anxious about being left on their own. A member of staff stayed with them and this reduced their anxiety. The member of staff gave the person a hug and this was welcomed by the person.

People and relatives told us they felt involved in making decisions and planned their own or their family member’s care. One relative told us, "Staff always tell me about how [person] is and discuss her needs with me." Staff we spoke to told us how important it was that they involved people in making decisions about how they wanted to receive their care. One staff member told us, "People have the right to say no and we have to respect that decision, it's all about their own choices." Another told us, “People who use the service always come first”.

It was evident in people’s care files that people and their relative’s involvement in pre-admission assessment, subsequent decisions and during reviews was encouraged and in place. For one person they had a particular diagnosis that meant they were only able to communicate their needs through facial expression. The person’s relatives and staff had written the person’s communication plan together and the relatives sought consent from their relative to use the plan. This was reviewed monthly. We observed staff communicate with this person using clear verbal communication. They used short sentences and waited for the person’s response which took time. Staff did not hurry the person and positioned themselves at eye level facing the person.

We asked people whether they were given choices about how they received their care. One person told us, "I think I do have a choice”, another told us, and “Here you can do what you want. I have breakfast, read the paper, go for a walk, listen to the radio”. People told us they could go to bed and get up when they wanted; this was reflected in care plans reference to what time people preferred. We observed a person go to the dining room after 9am for breakfast, they were sitting on their own, when we asked if the person was ok, and they told us they liked their breakfast in peace and quiet.

Staff promoted people's independence by encouraging them, where possible, to do things for themselves. This included eating and drinking, and encouraging people to move as much as they could without the use of hoists or aids. We observed a person who had a wheelchair and zimmer frame. We were told the person can become tired quite quickly and the wheelchair could be used on those occasions. During our visit we observed staff encourage the person to use their zimmer frame throughout the day.

Staff told us they enjoyed working at the service, because of the interaction they had with people who lived there. We asked one staff member what they thought was the best part of their job and they told us they loved working with the people and being able to spend time talking and engaging with them. We observed staff through the day working in a non-hurried way, sitting with people chatting and giving each person time they needed. One person told us they received specialist support from palliative care professionals and we saw some people at the service had been consulted about their wishes at the end of their life. We reviewed care records which documented their preferences. One person told us they had discussed with the provider that they wished to end their life at the service.

People had access to advocacy services if they required them. An advocate is a designated person who works as an independent advisor in another's best interest. Advocacy services support people in making decisions, for example, about their finances which could help people maintain their independence.

Good

Is the service responsive?

Our findings

People told us they felt listened to. We found the service gathered feedback from people, their relatives, professionals and staff to identify improvements, such as changing menus and improving access to events and activities. A visiting health care professional described staff as, "responsive and caring".

Records we saw contained detailed information about people's health, personal and social care needs. Each person had a social history outlining their lifetime events, achievements and experiences. This provided a basis for engaging with people who were unable to give this information. The information we saw reflected how people would like to receive their care, treatment and support including individual preferences, interests and aspirations. Staff had the correct information to ensure individual needs were responded to. For example, it was documented for one person that they preferred to sit in the conservatory rather than the lounge; we saw that this person did sit in the conservatory through the day. Another person had indicated in their care plan they preferred to go to bed between 6.30pm and 7pm. We spoke to the person and they told us this was correct. They told us they liked to get up quite early so preferred early nights. For another person they preferred to have one bath during the week and showers on the other days. Records indicated that this was happening. A person had indicated they preferred breakfast in their chair each morning in their bedroom. We checked in the morning and this person was in their room eating their breakfast with the radio on.

People told us they were involved in planning their care, including risk assessments, and were encouraged to be independent. The care plans and risk assessments were planned and reviewed monthly in relation to peoples complex needs to ensure the information was up to date and reflected current needs. For example skin integrity and mobility. When people's needs changed we saw that their care plans and risk assessments had been changed accordingly. For example, when a person was discharged from hospital using a catheter, their continence care plan and risk assessment had been reviewed and updated. The community healthcare professionals were referred to and it was documented when they had visited, to ensure the care the plan and risk assessment met the person's needs.

We saw a person become distressed and staff responded appropriately by reassuring them and asking if they would like to have a rest and then assisting them to their bedroom. The staff member remained in the bedroom supporting the person; they took their time and used their hand on the person's arm as reassurance. The person responded by holding the staff members hand.

We saw support was offered to people to be engaged in activities throughout the inspection. Staff engaged individually with people to ensure they were part of the process and were not left out. Most people were involved in some way, including one to one contact. In the afternoon we saw that staff on duty facilitated discussions from known interests highlighted in peoples care plans. People therefore received a personalised service that responded to their preferences and interests.

People were supported to follow their interests wherever possible and take part in social activities. People interested in gardening had enjoyed growing plants. They had expanded their social contacts in the community by taking part in local agricultural shows. The service is a member of 'Daily Sparkle' which allows staff everyday access to professionally written reminiscence and activity tools to improve the lives of people. The service had a weekly and monthly programme detailing the 'Daily Sparkle. Activities included articles, quizzes, old news stories, gossip, puzzles, singalongs and entertainment geared towards stimulating the mind and improving memory. We saw records indicating these were being used on a daily basis, in groups and 1:1. People told us they enjoyed participating in these activities.

We saw the complaints procedure was on display. We reviewed complaints that the service had received and investigated. We found all complaints had been investigated openly and the complaints records were comprehensive. These gave a full response to the complainant within the time scale specified. Responses to complaints had reached a satisfactory conclusion. People told us they knew how to make a complaint and were confident it would be dealt with in a courteous manner. One person said, "I would tell the manager" and a relative said, "I know how to make a complaint".

Good

Is the service well-led?

Our findings

Most people told us they were aware who the provider was and that they had good relationships with the provider and clinical lead. A relative we spoke to knew they could approach them with any concerns. A visiting healthcare professional told us, “[name of provider] is always approachable and amenable.” Staff told us, “The service users and ourselves are very well supported”. A new nurse employed told us, “I have only been in post three weeks, still learning the role, but the clinical lead is great, encouraging and supporting”.

The provider told us they encouraged an 'open door' policy and promoted a culture of openness and honesty amongst staff. This was achieved through team meetings and supported by the clinical lead, being available to speak to staff if they had concerns. Staff told us having various levels of management within the service made it easier to discuss issues or concerns they had. They told us communication with the provider, clinical lead and nurses was positive as issues and concerns were addressed quickly. The provider’s office was in the main foyer and during our inspection we frequently saw people visiting and speaking to them. Staff told us they felt there was a clear support structure in place for them and a 24 hour on call number for any issues outside office times if staff needed to speak to a senior member of staff.

Between April and November 2015, the provider had further developed ways to obtain the views and opinions of people about how the service should be run through questionnaires and resident meetings where relatives could attend. Feedback from resident questionnaires, completed in November 2015, was all positive with suggestions around menu changes. We checked the menus and these suggestions had been incorporated. Feedback from the meeting with people and relatives in September 2015 was all positive with suggestions of implementing audio books, which had since been actioned.

The provider told us they used regular staff supervision and appraisal meetings to obtain feedback from staff and to provide support where necessary. Staff told us they received supervisions regularly. One told us, "I get regular supervision and I can say how I feel.”

The provider monitored accidents and incidents in the service and looked to see how improvements could be made to reduce any reoccurrence. Where investigations had been carried out support from relevant healthcare professionals was requested. The clinical lead had analysed any incidents and put in place interventions. They then checked to ensure any actions required were carried out by the nurses. The provider was informed and carried out their own analysis and checked with the clinical lead that appropriate actions had been taken.

The provider completed other regular audits to monitor and improve the quality of the service they provided. We saw from recent audits that care plans had been identified as requiring more detailed information. The clinical lead was taking positive steps to improve this. They told us they were working with the local commissioning group and local authority to identify areas of best practice and welcomed feedback in order to improve and drive the service forward.

Overall the information provided in the PIR reflected what we found during our inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practicable to mitigate risks. The premises being used by the provider were not always safe to use for their intended purpose. Regulation 12(1)(2)(a)(b)(d)(h)