Ward House Limited

Ward House Nursing Home

Inspection report

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14 July 2016

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 and 14 July 2016 and was unannounced. Ward House provides accommodation and personal care for up to 23 adults, including people with dementia and physical disabilities, who require nursing care. There were 23 people living at the home when we visited.

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

People and external health professionals were positive about the service people received. Medicines were managed safely and people received these as prescribed. People were positive about meals and the support they received to ensure they had a nutritious diet.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care involving people were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

People felt safe and staff knew how to identify, prevent and report abuse. Legislation designed to protect people's legal rights was followed correctly. Staff offered people choices and respected their decisions. People were supported and encouraged to be as independent as possible and their dignity was promoted.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care. Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

The registered manager and provider were aware of key strengths and areas for development of the service. Quality assurance systems were in place using formal audits and through regular contact by the provider and registered manager with people, relatives and staff.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse.

Medicines and risks to people were managed effectively. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. People received the personal and nursing care they required and were supported to access other healthcare services when needed.

People received a varied and nutritious diet and they were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

Improvements to the environment were continuing with the communal areas completed.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to build friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with planning how their care needs would be met.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the care they required.

People were offered a range of activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

Is the service well-led?

Good

The service was well-led.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

The service had an open and transparent culture. A suitable quality assurance process was in place, including formal audits and informal monitoring of the service.

Ward House 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 7 and 14 July 2016 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has experience of caring for an older person.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. The registered 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 spoke with nine people living at the home and five visitors. We spoke with the registered manager, one nurse, five care staff and ancillary staff including the activities staff, the chef and housekeeping staff. We looked at care plans and associated records for five people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas.

The home was last inspected in June 2014, when we did not identify any concerns.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "I like it here". A visitor told us when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relative was safe at Ward House.

The provider had appropriate policies in place to protect people from abuse. Staff said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member told us, "I've had safeguarding training and I know what to do. I would make sure the person was safe and report my concerns to [the manager]". All staff were confident the registered manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. There were notices around Ward House about the importance of staff awareness to signs of abuse and the process for reporting safeguarding matters. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They followed local safeguarding processes and had responded appropriately to allegations or concerns of abuse.

Where individual risks to people were identified action was taken to reduce the risk. These included, for example, the risks to people of falls, choking, nutrition and skin damage. Moving and handling assessments clearly set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance. People who were at risk of skin damage used special cushions and pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were set appropriately, and people were assisted to change position to reduce the risk of pressure injury. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable diets to reduce the risk. Risk assessments, with specific actions to reduce the risk where possible, were relevant to the individual person and had been regularly reviewed. The registered manager had ensured staff were aware when new procedures were required to reduce and manage risks to people. For example, staff were aware of a new risk associated with fluid thickening powder; risk assessments had been completed and action taken to ensure this was managed safely.

Environmental risks were assessed and managed appropriately. Records showed essential checks had been completed on the environment such as fire detection, gas, electricity and equipment such as hoists were regularly serviced and safe for use. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Records showed fire detection and fighting equipment was regularly checked. Staff were also aware of how to respond to other emergencies. Nurses had access to an 'RGN emergency folder'. This contained relevant information and procedures for managing a variety of potential emergency situations such as severe weather, loss of power to the home or a missing person.

There were appropriate arrangements in place for obtaining, recording, administering and disposing of

prescribed medicines. There were also effective processes for the ordering of stock and checking stock into the home to ensure the medicines provided for people were correct. We checked stocks of some medicines and found these were accurate. We spoke with one registered nurse about their knowledge of medicines and found this was up to date and comprehensive. They told us they had received training in medicines management and administration and had yearly competency assessments. We observed nursing staff administering medicines to people in a patient manner, and informing people what the medicine was for. They did not hurry the medicines rounds and we found the Medicines Administration Records (MAR) were up to date and complete.

There was a procedure in place for the covert administration of medicines. Covert medicines administration is when essential medicines are hidden in small amounts of food or drink and given to people. The procedure at ward House protected people's legal rights and ensured that all relevant people including GP's, dispensing pharmacists and relatives were involved in the decision to administer medicines covertly. The provider used 'as and when necessary' (prn) protocols for pain relieving medicines, and a recognised pain assessment tool was in use for when people were not able to state they were in pain. Additional individual indicators of pain were also included in care plans. For other 'as required medicines' guidelines were not always in place. The registered manager arranged to have these completed soon after the inspection. There were suitable systems to ensure other prescribed medicines such as nutritional supplements and topical creams were provided to people.

People and visitors felt there were usually enough staff. By 11:00am care staff had completed their morning care routines and were seen to have time to spend with people. At lunch time one person was sat awkwardly in their chair. A non care staff member said "I can't help you to sit up but I will get someone to help". Moments later two care staff members came and assisted the person to reposition. This showed that whatever their role all staff considered the needs of people and staff were available to ensure these were promptly met. Staff responded promptly to call bells. During a busy time of the morning we saw call bells were answered promptly. The registered manager told us they were able to review call bell response times and used this information to identify times of the day where staff were busier and additional staff may be required.

Staffing levels took into account the people who were living at the home and the level of support they needed. The registered manager completed a monthly dependency assessment tool which identified the number of care staff hours required to ensure people's needs could be met. Absence and sickness were usually covered by permanent staff working additional hours which meant people were cared for by staff who knew them and understood their needs. On rare occasions agency nurses were required. We heard the registered manager booking one during the inspection. As the allocated agency nurse had not previously worked at the home there were arrangements for them to undertake a shadow shift to enable them to receive an induction to the home.

The provider had safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed before new staff started working with people.

Good

Is the service effective?

Our findings

Some people living at Ward House had a cognitive impairment and were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people in consultation with family members. Staff members explained that if the person did not have the capacity to make a decision about the care and support they were receiving then they would need to do what was in the person's 'best interests'. Care plans reminded staff of this. For example, in one we read, 'If tasks are completed without consent ensure these are in [name person's] best interests'. Care plans contained information about the decisions people could make for themselves. One person's care plan advised staff to observe for nonverbal consent such as opening their mouth for food or drinks. Where people were able to give consent care plans reminded staff to obtain the consent of the person before providing care or using restrictions such as bedrails. Care plans also contained information as to who had the legal right to make other decisions on behalf of the person. When in place, copies of the legal documents confirming this were held.

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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff understood the Mental Capacity Act (2005) and their responsibilities within this. One care staff member told us "It's about residents being able to make choices or not. If they can make the choice, and know what they are choosing then it's their choice. If they can't you do what is best for them". They added "Care plans have information about this." They then gave an example of choice, explaining how they would show items of clothing to help the person make a choice.

People told us they received the personal care they required in a way that met their preferences. Care staff told us how they offered choices and sought consent before providing care. One said "We ask them. If they said no, we don't do it but try later. We would document and review or try a different staff member." Care plans reflected this stating for example, 'If [name person] declines personal care staff should revisit at various points to see if they would prefer personal care at another time'.
People can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We found the provider was following the necessary requirements and DoLS applications had been made with the relevant local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met.

People received the personal and nursing care they required. One person said "The staff are fantastic, very good, I get all the help I need." A visitor told us they were happy with the way their relative's personal care needs were met. The relative also confirmed that health professionals were contacted when required. Staff recorded the personal care they provided to people including if people had declined offered care such as a

shower or bath. These records showed people were supported to meet their personal and other care needs. The registered manager stated they reviewed records of care monthly to monitor that people were receiving the care they required.
People's general health was monitored and they were referred to doctors and other healthcare professionals when required. Nursing and care staff described how they supported people which reflected the information in people's care plans and risk assessments. Care staff told us they had been provided with information about a new person's diagnosed condition prior to the person being admitted. They said this helped them to understand the person's needs and how they should be met. People were seen regularly by doctors, opticians and chiropodists as required. Ward House had equipment suited to the needs of people living there, including specialist equipment for people who required this due to their body shape or size. We spoke with three visiting healthcare professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

One person had been admitted to Ward House with significant skin care needs and wounds. Records viewed showed these were being appropriately managed and that they had improved in the relatively short time they had been at the home. The person described how staff managed their wounds and said they were pleased as they were healing well. The person also told us staff ensured they kept their legs raised to aid healing. We saw other people were supported to return to bed in the afternoon to change their position which would protect any vulnerable areas of skin from damage. Nursing staff undertook a daily check of all pressure relieving mattresses to ensure they were at the correct setting for the person. They told us they had received wound management training from a specialist tissue viability nurse who they felt able to contact for guidance when necessary.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "I always get a choice of meals". They added that the food was very good. A visitor said, "I am always given a dinner and the food is good". Records showed people were provided with food when they wanted it; for example, one person was often awake in the middle of the night and records showed they were given a sandwich and hot drink. Staff told us they could provide people with food at any time this was requested or required.

People appeared to receive the appropriate amount of support and encouragement to eat and drink. Staff were attentive to people and whilst promoting independence, noted when people required support. For example, we saw one person being helped by a staff member to decide if they should use a fork or a spoon to eat with. The person also had a plate guard to enable them to eat independently. This showed people were provided with the appropriate tools to help them overcome their difficulties. Where people required more support this was provided patiently, giving people time to finish one mouthful before they were offered more. The registered manager described practical training staff had received to ensure they supported people with meals in an appropriate and dignified way.

Two people were receiving their nutritional needs via a tube directly into their stomach as they had been assessed by the Speech and language Therapists (SaLT) as not being able to safely swallow. Care plans contained clear recommendations from the dietician as to how their nutritional needs should be met including the amount of fluid they should receive each day. We found for one person they were not always receiving the full amount of fluid they should have been provided with. The registered manager took immediate action to redesign the fluid recording sheet to make it easier for staff to record the additional fluid people were given.

Staff, including kitchen staff, were aware of the specific dietary needs of individual people. For example, kitchen staff were aware of which people required their meals in a softer format or had dietary restrictions

such as due to a medical condition. A staff member correctly told us a person required their meals in a softer texture and their drinks thickened to a specific consistency. Meals, including those which had been pureed, were pleasantly presented. Drinks were available throughout the day and staff prompted people to drink. Staff monitored the weight of people each month or more frequently if required due to concerns about low weight or unplanned weight loss and nutritional risk assessments were in place. Records of the amount people had eaten or drunk were kept. However, these were not always added up to help staff identify if people had received enough to drink. The registered manager told us they had identified that staff were not always maintaining records adequately and were planning record keeping training for all staff as part of a records and communication awareness week at the end of July 2016.

People were cared for by staff who had received appropriate training. New care staff completed an induction which covered a range of training including the care certificate. This is awarded to care staff who complete a learning programme designed to enable them to provide safe and compassionate care for people. The provider had recently reviewed their training systems and now contracted training to an external training provider. Staff confirmed they were provided with a range of relevant training. They told us that all staff, including those not working directly in nursing or care, undertook training to help them understand the needs of people living at the home such as dementia awareness. They told us this helped them understand the needs of people. Most care staff had obtained a care qualification or training to an equivalent level. The registered manager monitored staff training and showed us how they identified when staff were due for refresher training which was then booked. Nursing staff said they had attended specific training to meet the nursing needs of people including end of life care, the use of syringe drivers and skin and wound care training. Nursing staff told us they were being supported to meet their Nursing and Midwifery Council (NMC) requirements to maintain their registration.

Staff were supported in their work through the use of one to one supervision and received an annual appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. One staff member said about supervision "We have that regularly, although I can go to [the registered manager] anytime". The registered manager and deputy manager both supervised staff which occurred on a regular basis. We saw staff were able to approach either the deputy manager or registered manager to discuss any concerns on an informal basis in addition to the formal supervision sessions.

The environment was appropriate for the care of people living at Ward House. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. This would help people with dementia to settle in and feel at home. The provider had recently completed an extension to the ground floor at the rear of the home. This provided a spacious and bright communal room with dining and lounge area. Full height patio doors spanned the entire back wall meaning plenty of light was available. This also meant people could see out to the garden and the sea views beyond. One person told us "I have some sight issues but the bright light in here [in the lounge/dinner] helps". There was a choice of a bathroom or shower room, both suitably equipped to support people with high care needs. Decoration had considered guidance on environments to meet the needs of people living with dementia. The registered manager told us plans were in place to redecorate and refurbish bedrooms and corridors throughout the rest of the home. Work was being completed on the garden which would provide a level outside area suitable for people with limited mobility or requiring wheelchair access.

Good

Is the service caring?

Our findings

People were consistently positive about the way staff treated them saying that all the staff were kind and caring. One person said "They [staff] are very nice". When asked if they thought the staff were caring another person said "Yes". Relatives also felt staff were caring. One said "I like it here because I know everyone [staff]". Another visitor said "This place is a home. People bring in dogs and cats. We have cats at home so the cat here reminds [my relative] of home". Another visitor said "The staff are friendly and I am always made to feel very welcome".

We observed staff over the course of our inspection and found staff were caring and kind. Staff spoke to people in a respectful but friendly manner and people responded in a similar manner. Staff had a good awareness of people's needs and there was a great deal of warmth evident between staff and people. Staff responded to people in a caring way that also protected their dignity. For example, a privacy blanket was put over a person's lap when staff used moving and handling equipment in a communal area. We observed staff supporting people with their meals in ways that were kind and patient. Staff did not rush people and they spoke with them about the food and how it was prepared. This ensured, where people were being supported to eat in their own bedrooms, they enjoyed a social occasion rather than a task being completed. When staff were clearing plates at the end of the meal we saw that if there was food on the plate they asked the person if they had finished before the plate was removed.

People were supported without restricting their independence. One person was supported to continue to manage their own medicines. They had been provided with a secure place to store their medicines and nursing staff had completed a formal assessment of their ability to manage their medicines independently. Some people required specialised cutlery and crockery to enable them to remain independent with eating and this was provided.

Care was individual and centred on each person. People received care and support from staff who knew and understood their history, likes, preferences and needs. One person asked us for their spectacles, we could not find them so asked a member of the care staff. They explained that the person did not have spectacles, however because we were wearing them they wanted some. The care staff member was able to reassure the person that they did not have or need spectacles. This demonstrated that staff had a good knowledge of people, their needs and how to correct a misconception without embarrassing the person. Another person had been supported to bring their own cat with them when they moved to Ward House. The cat was being kept in the person's bedroom until it had become used to the home and staff were attending to the litter tray. A staff member said "I don't mind doing that, I mean it's not pleasant but [the person] wouldn't have come into the home without their cat. This way they can get the care they need."

Staff knew about people and what was important to them. One staff member said "We know everyone well, their life history. Their care plans have information which tells us about their jobs, preferences, family etc." Another staff member told us "We've all got really nice friendships with the residents." They described how they formed caring relationships with people and said, "The way you speak to them, sitting down with them." Another staff member said "We chat to people, talk to them about their family". We observed a care

staff member discussing relatives with a person, demonstrating that the care staff member knew about people who were important to the person.

When staff were asking people about their lunch time meal choices one person said "I don't like carrots". At lunch time we saw everyone else had carrots except this person. This demonstrated that people had choice about their meals and that this was met. We saw staff helping a person decide what they wanted for pudding. Staff knew the person did not like treacle tart which was the main pudding option. Staff said "Would you like cream and peaches?" the person declined. "How about biscuits, fig rolls or spaceships (these were Jaffa cakes)?" After negotiation the person had fig rolls and Jaffa cakes. The interaction showed the staff member knew what the person liked and was able to offer them choices in a way they could respond to. The registered manager identified that there were areas where staff could further support people with making choices such as the use of pictures to help some people make meal choices.

Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. Each month a Christian minister visited the home and the registered manager was aware of how to contact other religious leaders if required. They described how they had found a specific religious leader to visit a person when this became necessary at night. The actions taken to find the correct minister showed an awareness of the specific needs of the person at that time and had ensured they were met.

People's dignity was protected during the provision of care. From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Care staff told us which people preferred care from staff of a specific gender. They told us this was always met. Care plans identified if people had a preference for the gender of staff providing personal care. Staff described how they promoted dignity and privacy, such as ensuring doors were closed and people were covered as far as possible during personal care. One care staff member said "We make sure people are covered and promote independence for them to do as much as they can".

In February 2016 the home had held a dignity awareness week. All staff had been encouraged to write on a poster what this meant to them. For example, one staff member had written 'respect people's wishes and choices' and another had written 'respect privacy'. Staff had considered how they would like care to be provided for themselves and people and relatives had been asked for their views on what dignity meant to them. Staff were positive about the dignity week and said that it had made them consider dignity more in their everyday work. The registered manager said they felt staff had been reminded of some important aspects of dignity which was reflected in the way staff cared for people. For example, staff spoke more with people when they were assisting with meals. Dignity was also protected as confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

People were supported to express their views and were involved in making decisions about their care, treatment and support. When asked what was good about Ward House one person said "Sometimes they [staff] just let me be". A relative told us "Staff help her choose from her wardrobe and they help her choose her jewellery". The person had communication needs and therefore staff would have needed to spend time with them so they could make these choices. Staff described how they involved people in choices. One said "We ask them, or we pick some bits from their wardrobe and show them". People who wanted to leave their bedrooms were able to use the communal rooms as the home had suitable seating for everyone's needs. For example, we saw one person in the communal lounge sleeping in a recliner wheelchair. Staff were positive about the range of wheeled lounge style chairs and said these meant people did not need to be hoisted more often than was necessary. One care staff member said, "[Name person] doesn't like the hoist, so we use this chair as we only have to hoist them once then can bring them to the lounge and they don't

have to be moved again". This showed consideration had been given to people's needs when furniture was purchased.

People, and when appropriate relatives, were involved in care planning and reviews of care. Nursing staff told us that when six monthly reviews were held, copies of care plans were provided to people or, where appropriate, their relatives. Family members told us they were always kept up to date with any changes to the health of their relatives. Contact with family members was recorded in care records. One relative said, "They [staff] tell us of any changes; for example, the nurse rings us if [person's name] is on antibiotics". Another visitor said of the staff, "All have been very good and keep us informed". We saw a relative had been informed that a GP had been requested to visit and that they were kept up to date with the change in time following a phone call from the GP. Where appropriate, relatives were supported to continue to provide some care for their loved one. We saw a visitor supporting a person with their lunch showing that they were enabled to maintain their relationship and feel that they were involved in the care of their relative.

At the end of their life people received appropriate care to have a comfortable, dignified and pain free death. Nursing staff had attended training to enable them to better manager symptoms people may have at the end of their life. The registered manager was aware of who they could contact for additional support if required. They told us about a situation where they and nursing staff had been unsure about the pain control a person was receiving. Support had been accessed and staff were then able to ensure the person received the necessary care they required. The registered manager represented local nursing homes at a joint NHS and independent provider group related to end of life care. They felt this role was important and enabled them to always be aware of best practice and ensure people at Ward House received this. Information about people's preferences for their end of life care were included within care files. Nurses were aware of how to obtain and administer symptom management medicines should these be required.

Good

Is the service responsive?

Our findings

Nursing and care staff were able to describe the care and support required by individual people. For example, they were able to describe the support people required to meet nutritional needs. Although care plans were well organised and provided comprehensive individualised information for staff, they did not always correspond to the care people were receiving. For example, one person required a fluid thickener to be added to their drinks to enable them to swallow safely. Their care plan stated drinks should be thickened to a stage 3 texture which could only be taken by spoon. In their bedroom there was another care file which stated the person should receive thinner, stage 1 fluids, which could be drunk from a cup. Staff told us the person required stage 2 fluids which was what we saw they were receiving in their bedroom. Other parts of this person's care plan, which had not been updated since March 2015, also did not reflect the care they now required and were receiving. Between the two days of the inspection the registered manager arranged for the person's care plan to be reviewed and updated to accurately reflect the care they required and were receiving. Other care plans viewed reflected the care people required and which we saw they were receiving.

Staff responded appropriately when people's health needs changed. We saw a member of care staff asking the nurse to "check [name person] as they are clammy and look ill". The nurse immediately went to check the person and later told us the action they had taken. This had involved giving an 'as required' dose of paracetamol for pain and temperature symptoms and contacting the GP to request a visit. The GP later attended and prescribed antibiotics for an infection. The nurse was able to arrange for the antibiotics to be received the same day and these were commenced as soon as they were delivered by the pharmacy.

Staff were responsive to people's individual needs. We heard staff reminding a person to let them know if they wanted to go back to bed. The person was clear they were happy where they were and the staff member made sure they were warm enough. Staff told us the person was unwell but wanted to sit by the window and look at the sea. We saw staff continued to check on the person throughout the morning to ensure they were happy and had not changed their mind. One person told us they had always had a disturbed sleep pattern and said, "The night staff have got used to me not sleeping so they give me tea during the night and if I get peckish they often give me something to eat at about 5.30 am." This showed staff were responsive to people's individual needs during the day and at night. One visitor told us their relative had been losing weight. In the afternoon, when the relative had gone home, we saw a care staff member assisting the person to eat chocolate cake. This showed that staff were aware which people needed additional food between meal times and that this was provided.

Staff had information as to how they should respond to medical emergencies. For example, one care plan contained information about the support a person should receive if they had an epileptic seizure. This included the use of a monitoring mat and guidance for staff as to when to call paramedics or administer rescue medicine. Staff were kept up to date about people's needs and any changes to these through a formal handover meeting at the start of each shift.

Staff were skilled at communicating with people. Many people living at Ward House had some level of communication difficulty. We saw how staff used short sentences and basic sign language to assist people

to express their needs and wishes. For example, one person was told "Thumbs up if this is OK?". The person was seen to smile and gave a thumbs up sign. Care plans contained a section relating to communication and gave staff guidance as to how they should communicate with people. For example, one guided staff to use short, closed sentences and ensure eye contact and we observed staff doing this when they communicated with the person.

Staff monitored and were responsive to other needs of people. We saw the temperature was monitored every half hour in the main communal room because the windows were liable to heat the area quickly. The record of temperature checks recorded the action taken when required to reduce the temperature.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded. Forms showed that, where necessary, external medical advice was sought and action was taken to monitor the person for any signs of deterioration. Action was taken to reduce the risk of repeat incidents such as through the use of movement alert equipment for a person who was at risk of falling. Should people require to be transferred to other care settings, such as hospital, the registered manager stated that a member of staff would always accompany the person. This meant the person was supported and individual information which would be helpful to others who may be required to provide care could be passed on.

People were offered a range of activities suited to their individual needs and interests. One person said "I don't get bored". The interests, hobbies and backgrounds of people were recorded in their care plans and known to staff. For example, staff were able to tell us the sporting interests of people and we saw they were supported to follow these. An activities coordinator was employed. We saw they arranged group and individual activities to suit the needs and wishes of people living at Ward House. They told us they were flexible in the activities they provided depending on people's health and abilities. People were also supported to attend local clubs such as for singing and socialising. The activities coordinator was aware of people's preferences, for example they told us how one person did not like to join in activities but did enjoy listening to them. We saw people enjoyed the activities and interactions from the activities staff member. They interacted individually with people demonstrating a good knowledge of people and their needs. The activities coordinator told us they had a budget for equipment which could also be used to pay external entertainers to perform at the home. The activities coordinator told us of their plans to develop the activities provided when they had access to the garden area.

People's views about the service they received at Ward House were sought though formal meetings and surveys and informally by the registered manager. In March 2016 a residents and relatives meeting was held. Topics such as the menu were discussed and people were informed about changes to the home and staffing, for example the appointment of a new activities coordinator. People's views had been sought about colours for the decoration of the communal lounge and dining area. The registered manager said they discussed the minutes with people who had been unable to attend and a copy was placed in the entrance hall and on all floors of the home so that people or relatives could read these. People's views were also sought when the home was considering purchasing special diets from a specialist provider. Samples of the meals were provided for people, relatives and staff. These were not well received and as a consequence the registered manager decided not to pursue this option. The registered manager said the next planned meeting was to discuss a proposed water feature in the garden. Money had been donated and various options had been identified which people and relatives would be asked to vote on.

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints if they were dissatisfied with the service they received. People and visitors said they would make any complaints to the registered manager or the nurse. No one we spoke with had ever had cause to

formally complain. Information about how to formally complain was available for people or visitors on notice boards in the entrance hall. There were complaints, complements and comments forms in the front hall with a secure box these could be placed in. This would enable complaints to be made anonymously if preferred. There were systems in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. The complaints file showed that where complaints had been received these had been investigated and the result of that investigation fed back to the person concerned.

Good

Is the service well-led?

Our findings

People, relatives and staff felt Ward House was well-led. Staff said of the registered manager "She is lovely, you can go to her and she will sort anything out." Another said the registered manager would "help [care staff] if needed, as will the nurses". They told us the registered manager and the nurses were always saying "If you are running behind I'll help you". Two visiting health professionals said they had no concerns about Ward House. Another visiting health professional said they had not had previous involvement with Ward House but had been "very impressed with how flexible the manager had been when [a person] had needed an emergency placement".

People were cared for by staff who were well motivated and led by an established management team. The registered manager told us they undertook some nursing shifts, including night duties, which they felt helped them understand the pressures felt by staff and enabled them to directly monitor the quality of care provided. Staff understood their roles and worked well as a team. They praised the management who they described as "approachable" and said they were encouraged to raise any issues or concerns. We saw all staff worked as a team; for example, care staff were assisting the housekeepers to take a delivery to the cellar for storage. Although this was not their role they said they were doing it "because it needs doing". The registered manager said they were proud of how staff worked as a team and always put the "residents first and foremost".

Staff told us there were regular staff meetings. They said that if they were unable to attend the registered manager would ask if there was anything they wanted to say. Staff told us meetings were held at different times so all staff could attend. For example, one was held at 7.30pm for night staff. There were also specific meetings for some staff groups such as the nurses and ancillary staff. The registered manager had introduced weekly meetings with department heads and the team leader of the week "to ensure everyone's views are known and any issues addressed in an efficient manner".

There was an open and transparent culture within the home. Visitors were welcomed, there were good working relationships with external professionals and the registered manager notified CQC of all significant events. Relatives told us the registered manager, nurses and other staff were "approachable" and "caring". We saw one relative asked to speak with the registered manager about a question they had about funding care. Staff felt able to make suggestions for the benefit of people. We saw the activities staff member request money to purchase some larger board games as they had identified that some people with limited vision were unable to participate in the games that were currently available. They were planning to purchase the items in their own time showing staff were committed to the home. Relatives felt able to raise issues and were confident these would be sorted out. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. For example, care staff told us they could approach the local authority or CQC if they felt it was necessary.

The registered manager described the home's values as being "person centred, respecting and valuing each person as an individual". One care staff member described the home's values and purpose as being to "Make the best possible quality of life [for people], to provide comfortable, person centred care". Another

staff member said the home's values were "To treat people as human beings, how I would want to be treated". A third staff member said the home was "resident based; if they're happy that's what matters". All staff said they would be happy for a member of their own family to receive care at Ward House.

Ward House aimed to involve itself in the local community and most staff and people were from the local area. Each month children from a local nursery were invited to visit the home and participate in an activity, such as craft or music, with people living at Ward House. Once the garden was completed we were told the children were going to paint a picture on a wall to one side of the garden. The registered manager told us they would like to increase their involvement in the local community by offering day care and described how they had supported a person living near them when a carer had required some daytime respite. They also had other ideas as to how they could support local people which they were developing.

Auditing of all aspects of the service, including care planning, medicines, infection control and staff training was conducted regularly and was effective. The formalised quality assurance system also included systems to monitor other indicators, such as accidents or incidents. We saw there were few accidents or incidents and when this occurred consideration was taken as to what action could be taken to reduce the risk of recurrence. For example, movement alert mats were used where people had fallen or were at risk of falling. Following another incident a person was supported to purchase a cigarette substitute device until they were well enough to go outside to smoke. The registered manager had investigated when bruising had been noted on a person. The investigation was thorough and showed two staff had failed to use correct moving and handling techniques and equipment. The registered manager had followed the provider's procedures and ensured staff had received further training. The registered manager was aware of their responsibilities under the duty of candour requirements. We saw that they had informed a person's relative following an accident.

The registered manager told us they ensured the quality of the service provided by talking to people, relatives and staff. More formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to people, visitors and staff. The surveys could be completed anonymously and those already completed showed everyone was happy with the service provided at Ward House. The provider had contracted with an external quality monitoring company who visited the home monthly to undertake a monitoring visit. We saw this was comprehensive and covered all aspects of the home from the environment to meals and medicines management. The registered manager was provided with a report following these monitoring visits which would detail any actions required. These would be reviewed at the subsequent monitoring visit.

The registered manager told us they kept up to date with current best practice and was keen to develop the service for the benefit of people. For example, they were involved in a trial for a health monitoring system with the local NHS. The registered manager completed the Provider Information Return (PIR) to a high standard and demonstrated an understanding of legislation related to the running of the service. Although they did not need further qualifications for their roles the registered manager and deputy manager were undertaking level 5 qualifications in leadership in health and social care. The registered manager was aware of key strengths and areas for improvement, in respect of the home. For example, they had led a dignity awareness week and, after identifying a need to improve record keeping, were organising a record keeping and communication week at the end of July 2016. On the first day of the inspection we identified minor areas which could improve the service, and we saw action had been taken regarding these matters when we returned a week later. The registered manager had developed links with nearby care homes and was a member of the local care homes and nursing homes association.

The provider had an extensive range of policies and procedures which had been adapted to the home and

service provided. We saw these were available for staff in the office and were told policies were reviewed yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run. The registered manager said they also received updates from websites about any medical or equipment alerts.