Four Seasons (No 7) Limited

Norwood Green Care Home

Inspection report

Tentelow Lane
Southall
Middlesex
UB2 4JA

Tel: 02088138883
Website: www.fshc.co.uk

Date of inspection visit:
12 July 2016
14 July 2016

Date of publication:
12 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 12 and 14 July 2016. The visit on 12 July was unannounced and we told the provider we would return on 14 July to complete the inspection. The last inspection of the service was in August 2014 when we judged the service as Good for all of the areas we inspected.

Norwood Green Care Home provides accommodation, nursing and personal care for up to 92 older people, some of whom were living with dementia. When we visited, 85 people were using the service. The service is provided by Four Seasons (No 7) Ltd, a private company managing over 300 care homes in the UK. The service had a manager who was registered with the Care Quality Commission (CQC). 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.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not maintain satisfactorily all parts of the premises and most bath and shower rooms were not fit for purpose. You can see what action we told the provider to take at the back of the full version of the report.

People using the service and their relatives told us people were cared for safely. Nurses and care staff were familiar with the provider's safeguarding procedures and were able to tell us what they would do if they had any concerns about someone's safety or wellbeing.

People received the medicines they needed safely.

The provider deployed sufficient numbers of staff to meet the care needs of people using the service. They had systems to ensure new staff were suitable to work with people using the service, although these were not always implemented consistently.

People using the service and their relatives told us staff were well-trained to meet people's care needs.

The staff told us they felt well supported by the provider and managers in the service.

Managers and staff were working within the principles of the Mental Capacity Act 2005 and any conditions on authorisations to deprive a person of their liberty were being met.

Most people told us they enjoyed the food provided in the service.

People had access to the health care services they needed.

People using the service and their relatives told us the staff who cared for and supported them were caring and that they always treated people with respect.

We saw the staff caring for people were polite and kind.

The staff spoke a range of languages and they told me that at least one member of staff could speak the first language/preferred language of everyone who lived there.

People using the service and their relatives told us they received the care and support they needed.

Each person had a care plan that included an assessment of their health and social care needs.

People told us the provider arranged activities and outings and most people said they enjoyed these.

People also told us their family members and friends could visit them and they told us they looked forward to and enjoyed these visits.

The service had a manager who was registered with the Care Quality Commission. People using the service, their visitors and staff spoke positively about the manager.

Throughout the inspection, the atmosphere in the service was open, welcoming and inclusive.

The provider had systems to monitor quality in the service and to make improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Most bath and shower rooms in the service were not fit for purpose.

People using the service and their relatives told us people were cared for safely.

Nurses and care staff were familiar with the provider's safeguarding procedures and were able to tell us what they would do if they had any concerns about someone's safety or wellbeing.

People received the medicines they needed safely.

Is the service effective?

Good

The service was effective.

People using the service and their relatives told us staff were well-trained to meet people's care needs.

The staff told us they felt well supported by the provider and managers in the service.

Managers and staff were working within the principles of the Mental Capacity Act 2005 and any conditions on authorisations to deprive a person of their liberty were being met.

Most people told us they enjoyed the food provided in the service.

People had access to the health care services they needed.

Is the service caring?

Good

The service was caring.

People using the service and their relatives told us the staff who cared for and supported them were caring and that they always treated people with respect.

We saw the staff caring for people were polite and kind.

The staff spoke a range of languages and they told me that at least one member of staff could speak the first language/preferred language of everyone who lived there.

Is the service responsive?

Good

The service was responsive.

People using the service and their relatives told us they received the care and support they needed.

Each person had a care plan that included an assessment of their health and social care needs.

People told us the provider arranged activities and outings and most people said they enjoyed these.

People also told us their family members and friends could visit them and they told us they looked forward to and enjoyed these visits.

Is the service well-led?

Good

The service was well led.

The service had a manager who was registered with the Care Quality Commission. People using the service, their visitors and staff spoke positively about the manager.

Throughout the inspection, the atmosphere in the service was open, welcoming and inclusive.

The provider had systems to monitor quality in the service and to make improvements.

Norwood Green Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 12 and 14 July 2016. The visit on 12 July was unannounced and we told the provider we would return on 14 July to complete the inspection.

On 12 July the inspection team comprised two inspectors, a pharmacist inspector, a specialist professional advisor with experience of nursing care and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience for this inspection had cared for a family member living with dementia. On 14 July, one inspector returned to the service to complete the inspection.

Before the inspection we reviewed the information we held about the service. This included the last inspection report and notifications the provider sent us about significant events affecting people using the service.

During the inspection we spoke with 18 people using the service, four visitors and 25 staff. This included the registered manager, deputy manager, nurses, care staff and domestic staff. We reviewed the care records for 14 people and looked at other records, including Medication Administration Record sheets for 39 people, risk assessments, daily care notes, nutrition records, accidents and incident reports, complaints, quality assurance and health and safety checks. We also carried out a Short Observational Framework for Inspection (SOFI) observation in one dining room at lunchtime. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection, we contacted three community healthcare professionals who all commented positively on their experiences of working with the service.

Requires Improvement

Is the service safe?

Our findings

Some parts of the service were not suitable for the purpose for which they were used. On each floor there were two assisted bathrooms and two shower rooms. Staff recorded on sheets in each area when they used the bath or shower to support people with their personal care.

On the ground floor we saw both bathrooms were in a satisfactory condition but there was no record that either had been used. Staff we spoke with said they usually gave people a shower and did not use the bathrooms. One shower room had not been used for nine days, according to records the staff completed. The second shower room had a bad odour and had been used once on the day we visited. When we inspected, there were 28 people living on the ground floor.

On the first floor we saw a shower room which the staff told us was not in use. However the door was open and the room was easily accessed. The light to the room did not work. There were two pieces of damaged furniture, including a broken radiator cover, which had sharp metal edges, propped against the walls in this room. The second shower room on the first floor had damaged tiles and radiator. The floor was marked, the drain cover was missing, water had not drained away and there was a pool of dirty water. There were limescale deposits on the shower head. According to records of water temperatures situated on the door to the room, this shower had last been used at 7.00 am on the morning of our inspection. This was the only shower or bathroom on the floor that could be used. When we inspected, there were 28 people living on the first floor.

One of the assisted bathrooms on the first floor was used to store a cleaning trolley and other equipment. The bath was filled with unused items, including cushions and picture frames. When we asked a member of staff they told us they thought the bath was broken and could not be used. The second bathroom was clear of obstructions but there was a trip hazard where the floor covering was damaged, there was a dirty bath mat by the side of the bath and records staff completed showed the room was last used in September 2014.

On the second floor, one bathroom was used to store equipment and other items and could not be used. There was no evidence the second bathroom had been used recently. Both shower rooms on the second floor were used, although the floor in one was badly stained.

The majority of call bells cords in bathrooms, toilets and shower rooms were tied up so they could not be reached easily. Cords which were not tied were not long enough to be reached by someone who had fallen as they were approximately a meter from the ground at full length. Call bells in bedrooms were not always placed close to people who were in bed and some had been removed or were not easily accessible.

Most of the bathrooms and shower rooms we saw were bare and clinical in appearance. They did not provide a comfortable or welcoming environment where people could relax and enjoy support with their personal care. People using the service did not have a choice of whether they wanted a bath or a shower as all of the assisted bathrooms in the service were out of use.

These were breaches of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People using the service and their relatives told us people were cared for safely. Their comments included, "I do feel safe here. I feel I can trust people here," "I have been safe, no abuse," "Yes, I have felt safe, more or less," "I've felt very safe here" and "Yes, I'm safe." A relative told us, "Yes, my [family member] has been safe."

Nurses and care staff were familiar with the provider's safeguarding procedures and were able to tell us what they would do if they had any concerns about someone's safety or wellbeing. The staff had received training in safeguarding adults and they said this was updated regularly. In addition they had discussed safeguarding and whistle blowing at a team meeting in 2015 and they had had carried out a lesson learnt exercise after an incident when a person left the building without staff knowing.

The provider had assessed risks to people's safety. For example, people's care plans included assessments of risks related to moving around the home, falls, choking, nutrition and skin care. The staff had recorded detailed observations in each assessment and had updated these monthly. There were plans to minimise the risks and information for the staff about how to keep people safe in different situations. For example, to ensure the safety of a person following identified weight loss, the registered manager instructed staff to weigh the person weekly, rather than monthly and refer them to the dietician. The care records confirmed staff had followed this guidance.

The risk management plans were specific to the needs of each person and the documentation was clear and evidence based. Staff demonstrated a good understanding of their work and they had adequate knowledge regarding various precautions to take in order to ensure people were kept safe and received the care they needed. For example, they told us about infection control measures, including the use of personal protective equipment, hand hygiene and disposal of waste.

The service's health and safety committee consisted of the registered manager, deputy manager, chef, nursing and housekeeping staff. Records showed the committee met on 11 July 2016 and the registered manager took action to address issues raised. For example, a new hoist was provided after staff identified increased dependency levels on one unit. Windows were secured with restricting devices which were regularly checked. There was information about fire safety and what to do in event of a fire on display in communal areas. Firefighting equipment was checked by an external company to make sure it was safe to use. The last service and tests took place in March 2016. The staff were able to tell us what they would do in event of a fire. They said they had regular training and fire drills. They had recently taken part in a training session where they had used the specialist equipment at the service to practice how they would support people to evacuate the building. However, we did not see Personal Emergency Evacuation Plans (PEEPs) for people using the service to give staff information on the support they needed in the event of a fire or other incident that meant the building needed to be evacuated.

During the first morning of our inspection we saw that a trolley left in a lounge where the door had been left open contained a selection of nail varnishes and a bottle of nail polish remover. These products were left in the room for over one hour. The nail polish remover did not have a safety lid and could easily be opened. This product could be harmful if it was ingested or used wrongly. We pointed this out to the registered manager who said they would ensure staff were reminded of the need to secure substances that could present a danger to people using the service.

The provider had suitable procedures for the recruitment of staff but these were not always implemented effectively. The manager told us that new staff were invited for formal interviews with them at the home.

These interviews were recorded and we saw evidence of this in the staff recruitment files we viewed. The provider carried out checks on potential staff's right to work in the United Kingdom, identity and criminal records. They also requested references from previous employers and verified the registration of nurses. We saw evidence of these checks in all the staff files we viewed. Checks had been made and received before the person started work at the service. However, only two of the six files included an application form. All six included a CV but two of the six were very basic and did not include a full employment history with dates and the employer details. We discussed this with the registered manager who told us the provider's policy was not to employ staff if they could not give an employment reference from the previous 12 months. However, this policy was not always implemented effectively.

The provider deployed sufficient numbers of staff to meet the care needs of people using the service. People's comments included, "I'm not sure about the numbers of staff," "When I call, they usually respond pretty quickly," "They may be short of staff. When I call the response can take a while," "Sometimes there are enough staff, at other times not. They do their best," "There are enough staff, they are good and kind" and "They are good with the new people." A relative commented, "There are shortages of staff at weekends but during the week it's usually OK. If there is a hospital run it takes staff away."

All of the staff we spoke with told us they felt there were enough of them to care for people and meet their needs. They said they were happy with the staffing levels and no one had to wait for care. They told us they helped each other out and all staff, including nurses and senior staff, helped when needed to make sure people's personal care needs were met. People requesting care did not have to wait. Call bells were answered promptly and there were always staff available in communal rooms and corridors. The staff told us they made regular checks on people who were in their bedrooms and we saw them doing this.

People received the medicines they needed safely. We observed that all people's current medicines were recorded on the Medication Administration Record (MAR) and copy prescriptions were kept with the MAR and these correlated with dosages and instructions on the MAR. The allergy status of people was clearly stated so that inappropriate medicines were not prescribed. We saw no omissions in records of administration on the MAR. When we counted 25 stocks of medicines all could be reconciled against the records of administration. This gave us assurance that people were receiving their medicines as prescribed.

Many people were prescribed medicines such as laxatives, pain killers and medicines for mood to be given as required. We saw individual protocols in place so that staff knew when, how often and in what circumstances these medicines should be given. When variable doses were prescribed the actual dose given was recorded accurately so that the prescriber could determine the effectiveness of the medicine. People prescribed the anticoagulant warfarin had records of regular blood tests and dosage changes were made as prescribed and our stock counts supported accurate recording and administration. Several people were not able to swallow and we saw the assessments and multidisciplinary agreements in place that it was in the person's best interest that their medicines should be given in food or be crushed. The home was using mortar and pestles to crush medicines. Two of them were wooden and could not be cleaned satisfactorily between uses. When we asked a nurse to clean one, the residue remained in the mortar. This meant there was a risk to a person in receiving contaminated medicines. We discussed this with the registered manager and she agreed to replace all of the mortars and pestles used in the service. When we returned for the second day of the inspection, the mortars and pestles had been replaced with tablet splitters and crushers.

We observed that the site of application for creams was recorded and specific charts were used to record their application. People with diabetes were recorded as having regular monitoring of their blood glucose.

We observed that several people had anticipatory medicines prescribed in case their health deteriorated

rapidly towards the end of their life. We looked at one care plan and saw that there had been referral to the palliative care team and a pain score chart was in use to score the persons level of pain. There was evidence of regular review and we saw that the dose of a patch pain killer was increased to reduce this person's pain. Staff recorded the site of the patch application on a separate chart. We heard about training in end of life and staff told us that they had had recent training in syringe drivers and did e-learning in safe medicines management. We heard also how they were supervised when giving medicines, when newly employed by the service.

There was evidence of monthly medicines audits by managers and all staff had signed their understanding of the provider's medicines policies and procedures.

Good

Is the service effective?

Our findings

People using the service and their relatives told us staff were well-trained to meet people's care needs. Their comments included, "They seem good at their jobs" and "The staff do their jobs well." A relative commented "The staff seem to get on with their duties without supervision."

The staff told us they felt well supported. They said they worked well as a team and supported one another. Some of their comments included, ''This is a happy place to work'' and ''We all help each other out, the nurses, the other care assistants, we work as a team.''

Staff also said they felt supported by the senior staff and manager. The staff told us the manager visited each floor of the home during the day to offer support. There were daily handovers of information where all of the staff were involved in finding out and checking the wellbeing of the people who they would be caring for that day. The staff told us this was helpful and they used communication books and diaries to help share additional information. The staff said that they had mini team meetings during these handovers to discuss any changes at the service. The team leaders, nurses, manager and housekeeper met at 11:00 am each day to discuss the service and any specific needs. Information from these meetings was shared with all staff. There were formal team meetings every six months for all of the staff. We looked at the minutes of these and saw that they included discussions around practice, procedures and gave the staff opportunities to raise their queries and ideas. The senior staff team had regular formal meetings to discuss the service, including care plans, staffing, night care, housekeeping and social activities.

The staff told us they had individual meetings with their manager every two to three months. They said that they could discuss their progress and request any additional support at these meetings. However, they said that the daily communication with the manager and senior staff was very good and they normally raised any queries and made requests when they needed them rather than wait for formal meetings. The staff said that they had annual appraisals where they reflected on their work. They had opportunities to develop their skills and try new things. For example, one member of staff told us they had been given the opportunity to learn to be a moving and handling trainer, so they could train and assess other staff. The registered manager recorded when all individual supervision and appraisal meetings took place and could identify when these were due. We looked at their records and saw that all staff had received regular supervision as planned.

We spoke with three members of staff who had been recruited in 2016. They told us that they had received all the information and support they needed. One of them told us, ''Compared to my last employer this organisation has been so good, I have had all the training and support I needed.'' The staff told us they had shadowed experienced staff when they started working at the service, getting to know the people who they cared for and learning about the role. They had also taken part in a range of training courses which they said were helpful. These included practical sessions such as moving people safely and computer based learning. All staff renewed their training regularly. The manager was able to view the progress of each member of staff's training, including when training updates were due. They showed us the system for monitoring staff training and told us that the staff were automatically sent email reminders when they needed to refresh their training.

Some of the staff we spoke with had recently been promoted to more senior roles. They told us they had received additional training regarding the role and that the manager and deputy manager had offered guidance and support.

The registered manager told us that new staff were enrolled on a training programme which included training in health and safety, safeguarding adults, the Mental Capacity Act 2005, first aid, food hygiene and infection control. Staff took part in a 12 week programme supported by a mentor to reflect on their learning. The manager and deputy managers mentored the new staff. This included face to face meetings, training and completing work books. Following completion of this induction programme the staff were encouraged to enrol on vocational qualifications and a number of the staff told us they were undertaking level 2 and level 3 qualifications.

The nursing staff had additional training and support to maintain their registration with the Nursing and Midwifery Council. The manager told us they had recently completed training in catherisation and wound management. The local tissue viability nursing team, speech and language therapist and dietitian had provided workshops for staff regarding healthcare and specific interventions. The local palliative care team provided training for staff each month on a topic chosen by the manager regarding end of life care. Recent training had included discussions around pain relieving medicines for people in the last stages of life.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met, and found that they were. The registered manager had a good understanding of the MCA and DoLS and ensured they applied to the local authority or the Court of Protection if necessary. Where people could not leave the home without support, we found that DoLS were in place, their care records contained information around mental capacity and clearly outlined where a decision had been made in their best interests.

The staff had received training about the MCA, and were able to tell us some of the key principles. They understood that people had the right to make choices and that they should offer choices when providing care. We saw this happening and people's choices were respected. We asked the staff how they would support someone who was refusing care. They told us they would respect the person's choices but would find other ways to offer them the care, for example a different member of staff or returning later to the person to offer them care again in a different way. The provider was organising a number of training events for the staff about understanding dementia. As part of this the training included further information about the MCA and how the staff could apply this in their work with people who had dementia.

We spoke with the manager of the local authority's DoLS team and they told us the registered manager worked well with them to ensure they submitted applications whenever the service deprived people of their liberty. They told us the registered manager understood their responsibilities and ensured any authorisations were renewed appropriately.

Most people told us they enjoyed the food provided in the service. Their comments included, "The meals are

reasonable. We find out, what's on for lunch, in the morning. They may do an alternative if you ask," "They do bring tea and coffee round in the morning and afternoon," "The food's not bad, I don't like everything, but they will do something else," "I get enough to drink and they make me have it," "The food's alright. I'm a vegetarian and they do things for me," "We get enough liquids in the day," "I enjoyed the meal today" and "For me the food portions are small and the tea is cold sometimes." A relative commented, "The food's improved in recent times. They asked us all for our views, likes and dislikes with regard to food and changes were made."

Where people were on special diets, for example, a soft diet, a diabetic diet and texture modification of food, we saw up to date and clear dietitian recommendations. Staff demonstrated a good understanding of various types and texture of food people needed. Choking assessments and malnutrition risk assessments were in place and Speech And Language Therapist (SALT) guidelines were well documented.

At lunchtime on the first day of our inspection we carried out a Short Observational Framework for Inspection (SOFI) observation in a dining room while people had their meal. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We saw that people generally had a positive experience at lunchtime and they enjoyed the choice of food that was available. However, we did see that some people were frustrated as they waited 25 minutes at the dining table before the food arrived and was served, with no explanation from staff. We discussed this with the registered manager who told us there had been a problem in the kitchen on the day and said she would make sure staff communicated this to people if it happened in the future.

People told us they had access to the healthcare services they needed. Their comments included, "You get put on a list for the chiropodist," "If I'm not well, they would get help, like the doctor," "If I needed to go out for an appointment, they would organise it," "I've seen the optician and the chiropodist," "If I'm not well, they call the doctor in," "We get visits from the chiropodist and optician and the doctor if I'm not well," "They will call the doctor for you if you are not well."

Care records showed people had access to the GP who the registered manager told us visited the home at least twice each week. The GP recorded the outcomes of consultations with people and left guidance for staff on any treatment people required. Staff told us other healthcare professionals had regular input and we saw evidence of referrals to the SALT and dietitian. People's care plans also included advice and guidance from clinicians involved in the person's care.

Where people had a pressure sore, management plans were in place and records showed they were well responding to treatment. The involvement of the Tissue Viability Nurse was well recorded. Repositioning charts and skin care plans were up to date for people who were confined to their bed or chair. The service had the necessary equipment to relieve pressure on pressure areas, for example pressure mattresses or cushions. Pressure care risk assessments were in place and up to date. Body maps and wound photographs were also well documented.

Care records included people's specialist care and complex nursing needs and appropriate care plans were in place. For example, one person with a spinal cord injury had a care plan in place to meet their mobility / transfer needs, including the type of hoist to be used and the support they needed. The plan also highlighted what the person was able to do for themselves. A specific care plan for diabetes included evidence the person attended the diabetic clinic. We also saw specific care plans for a person with epilepsy, a person on warfarin and people who were living with the experience of dementia.

There was a record of prompt interventions and the involvement of other professionals, for example the

palliative care team, dietician, vascular clinic, optician, SALT, physiotherapist, tissue viability nurse, diabetic nurse, neurologist, GP, Practice Nurse and mental health team. We spoke with the GP who explained that there was regular access to the GP between 8:00 am and 8:00 pm daily and this included weekends. They told us they reviewed each person at least once in every three months. They also told us there was a pharmacist attached to the surgery who visited the service every month.

Good

Is the service caring?

Our findings

People using the service and their relatives told us the staff who cared for and supported them were caring and that they always treated people with respect. Their comments included, "The staff have a kind attitude, polite and attentive," "The staff are all the same, kind and they mean good," "I can have a shower when I want," "The staff are quite decent, kind and respectful and most are pleasant," "The staff are very kind when you are not well, they work hard," "The staff are polite and kind, they do the best they can, they are OK," "They come in and do things, with my permission," "When staff are doing personal things, like bathing, they are respectful," "They are respectful towards me," "They do respect my dignity" and "I'm very happy living here. I feel safe and staff are very supportive".

Relatives' comments included, "The staff are friendly, helpful, endearing and very loving," "The activities co-ordinator is exceptional, she works over and beyond the cause" and "They definitely give respect when dealing with her." Another relative told us the staff were very kind and caring. They said they were "exceptional" and "thank you" did not express how grateful they felt for the care they had given her relative. They added, "They are truly incredible, amazing, they have done so much. I love the staff – they make [my relative] feel like she is at her own home and that makes her happy."

The staff spoke fondly about the people who they were caring for. They were able to tell us details about people's preferences and personalities. They knew what made people happy and they wanted to give them good care. They told us they would be happy if their relatives lived in the home and one member of staff said, ''I treat them like they are my family, I love them and I love working with them.'' Another member of staff commented, ''Caring for people is the most important job and I need to be part of that.'' A third member of staff told us, ''This home is just like a big family.''

We saw the staff caring for people were polite and kind. They smiled when they approached people. They were polite. They made eye contact and held people's hands. People were happy to see them and smiling back at them. They spoke kindly and calmly. They knocked on doors and used people's preferred names. When one person was distressed they held their hand and let them spend time with the member of staff. The staff knew people well and spoke about them with genuine affection. They also spoke positively about the relatives and knew how important they were. The staff spoke a range of languages and they told me that at least one member of staff could speak the first language/preferred language of everyone who lived there.

Good

Is the service responsive?

Our findings

People using the service and their relatives told us they received the care and support they needed. Their comments included, "I do feel I get the service I should, I don't mind which person looks after me," "The choice of the gender of carer is given, but she does not mind who does it," "Yes, I think I get the medication and the other care I need," "I don't mind who looks after me," "I feel I get the care I should, I don't mind if women or men are looking after me," "I would say I get the care I should, they would be understanding which sex of carer would look after me" and "I do feel I get what I need here." A relative told us, "She [family member] is now getting the care she needs". Another visitor told us that they were involved in planning their relative's care. They said that the staff kept them informed of any changes. For example they told us, ''When [my relative] has had an injury the staff sent me and the GP a photograph straight away.'' Another relative told us, "They did an assessment at home before she came in, She has a care plan and we are involved in the reviews"

Each person had a care plan that included an assessment of their health and social care needs. Assessments covered people's medical needs, mobility, personal care, communication, mental health, continence and skin integrity. The assessments and care plans we saw were very detailed and although the service did have a short summary of the person's main care needs, staff did not always complete this fully. We discussed with the registered manager how new staff would understand a person's care needs when they first worked with them, without reading the detailed care plan. They told us new staff would always shadow a more experienced member of the staff team until they understood the care needs of people they supported.

People's care plans included person centred details with information on routines and preferences for example, the person's food likes and dislikes, their usual time of going to bed/waking up, social interests and other activities they enjoyed. Staff were able to tell us about people's individual needs and they were familiar with the different characteristics, routines and preferences of people using the service. For example, one plan included the person's wish to have a bottle of Guinness every day and go to the pub in the summer. This had been confirmed by their family members and we saw the person had a bottle of Guinness on their bedside table. Another care plan also indicated the person's religious wish to only eat halal meats and the staff we spoke with were aware of this.

The daily care records staff completed included information about people's health care needs, personal care and nutrition and showed that care was delivered in line with people's preferences and care plan.

People told us the provider arranged activities and outings and most people said they enjoyed these. Their comments included, "More or less the activities are alright," "We have visits from church ministers," "When I go, I do enjoy the entertainment" and "I do feel I have choice (of activities) here, I can do what I like and if I don't want to, I don't have to." A relative told us, "The staff try to put on activities for everyone, not an easy job" and "They do have clergy visiting." A member of staff said "We gather residents in one area to enjoy the entertainment. It is easier than getting the entertainer to move around. He has a lot of equipment."

The provider employed an activities coordinator who organised social activities. The care staff supported

them with facilitating activities. A second activities coordinator had been recruited and was due to start work shortly after the inspection. There were planned group activities each day, which included baking sessions, singing, music and gardening. The activities coordinator told us that people particularly enjoyed baking and singing. There was also a knitting club and regular game sessions. A physiotherapist visited the home each week to run an exercise session. The staff regularly included some of the basic exercises they had been shown for people when they were seated in the lounges or waiting for activities.

The activities coordinator told us that family members brought in pets and that there were also a number of regular entertainers. On the day of our inspection a musician visited the home and people enjoyed this. There was also a church service. People told us that they had regular church services and prayers. The day before our inspection a local school had visited the service to perform songs and a small play for people who lived there. The activities coordinator told us they had good links with the local schools and this was a regular event which was enjoyed by both the people who lived at the service and the children.

There were a number of different communal lounges; all of these contained a range of resources, such as books, magazines, games, music CDs and other items which people could access and help themselves to. In addition some of the lounges had specific roles. One of these was set up as a library with a large collection of books and an electric organ. Another of these rooms was a home cinema with a large screen television and a collection of DVDs. People were unrestricted to move around the floor they lived on and could access items as they chose. The staff confirmed this and told us that people enjoyed looking at the books and games. One member of staff told us they regularly supported a person to access the library as they enjoyed reading. The activities coordinator brought free local daily newspapers to the house each day and we saw a number of people reading these.

People also told us their family members and friends could visit them and they told us they looked forward to and enjoyed these visits. Their comments included, "There are no restrictions for my visitors. They can visit when they like," "The family visits anytime they like" and "My son visits and he can come when he likes."

Not all of the relatives we spoke with were aware of meeting arranged for them. One relative said, "There are regular meetings for residents and relatives" but another told us, "I'm not sure about residents' meetings." We saw records of relatives meetings, the last on 17 May 2016. Discussions covered the environment, food and activities and people had opportunities to ask questions and talk about what they wanted. The relatives who attended had given positive feedback about the staff in the meeting. The meeting before that was in January 2016.

People using the service and their relatives told us they knew how to complain about the services they received. Their comments included, "No, I've never needed to have a grumble," "I've not needed to complain, if I had a grumble, they would sort it out," "I've not complained, if something was not OK, I'd tell them" and "No, I've never made a complaint, if I'm unhappy about something, I would go to the manager". A relative told us, "No serious concerns, but I would go to the manager if I had any."

The provider had introduced tablet computers into the service to enable people and their relatives to feedback their experiences. Senior managers within the organisation had immediate access to people's comments and could track progress in responding to complaints. We looked at the system and saw that complaints, compliments and other comments were recorded and the provider responded in line with their procedures.

Good

Is the service well-led?

Our findings

The provider displayed the service's certificate of registration and the quality ratings from the last Care Quality Commission (CQC) inspection of the service in the main reception area.

The service had a registered manager who was a qualified nurse. They told us they had worked in the service for three and a half years, although they had a break of four months in 2015. They also said they completed the same training as the nurses and care staff in the service and had recently finished a Diploma in the leadership and management of care services. The service's deputy manager also told us they had recently started the Diploma training. The registered manager told us they kept up to date with developments in care practises by attending the palliative care and tissue viability forums arranged by the Clinical Commissioning Group (CCG), reading trade magazines and the CQC website.

Not all of the people using the service were sure about the management structure in the service. Their comments included, "I don't know the manager," "Yes, I know the manager, she pops in," "Mostly the management is OK," "I don't see the manager," "I'm not sure about the manager," "I think this place is reasonably well run but if I had a wish, it would be for a quicker response to calls," "She (the registered manager) does a good job running this place," "It's more or less alright here," "I would say the place is well run," "The manager is lovely, always smiling," "I am satisfied with the service here, the best thing is the staff and the care they give you," "I'm reasonably happy with things here, the facilities (condition of the home) could be better," "I've not needed to go to the management with any problems, but I think they would help," "I think they (management) would listen to residents," "They do ask for our views," "I think they listen to us, most are OK" and "I would say from what I have seen, they are a listening management".

Relatives' comments included, "The manager is approachable and she tries her utmost to resolve issues," "The home seems to be run well, if I had a wish, the staffing levels could be better" and "They do ask our views and it's done electronically"

Staff spoke positively about the manager. Their comments included, "She is very supportive", "I can ask her anything I need and she is very helpful," "The manager is first class, very good" and ''[The manager] is very visible and available when we need her."

Throughout the inspection, the atmosphere in the service was open, welcoming and inclusive. Managers, nurses and care staff spoke to people in a kind and friendly way and we saw many positive interactions between staff and people who used the service.

The provider encouraged staff to give their views and contribute to the development of the service. They arranged general staff meetings, clinical meetings and health and safety meetings. The general meetings had opportunities for all staff to contribute and the staff confirmed this, saying they could always give ideas and suggestions for improvements. The clinical meetings included discussion of nursing practices and lessons learnt from incidents. For example, a person left the building without staff knowing and they reflected on this and put together a risk management plan for the future. Recent staff meetings included

discussions about safeguarding and whistle blowing. Where meetings discussed policies and procedures, the staff had to sign to show they had read and discussed these.

People using the service and their visitors were able to comment on the care and treatment they received using tablet computers the provider had made available. The registered manager and senior managers in the organisation had access and could respond to individual comments or identify themes. We looked at some recent feedback and saw that from August 2015 – July 2016, all of the 27 people who commented said they felt safe and secure in the service. There were also 31 comments from relatives in the period January – July 2016 with 93% saying that overall they were satisfied with the service. Six out of 20 people who commented said they had noticed a malodour when they visited. We also noted this in one area on the first day of our inspection but this had been dealt with by the time we returned for the second day.

The provider had systems to monitor quality in the service and to make improvements. They recorded accidents and incidents involving people using the service and analysed these to identify trends and ways of mitigating risks. For example, following a number of falls, the registered manager arranged for staff from the local falls clinic to visit the service to train staff. They had held three sessions and a fourth was arranged for September 2016. Analysis the registered manager carried out following the training showed the number of falls had declined.

The provider's regional manager carried out monthly, unannounced monitoring visits to the service. Records showed they reviewed records and the environment, spoke with people using their service, their visitors and staff. We noted one recent visit had taken place at the weekend.

We also saw the provider, registered manager and staff carried out a number of audits and checks to monitor the day to day running of the service. These included clinical governance meetings, infection control audits, kitchen safety audits, an audit of people's experiences at mealtimes and food safety audits. Where the audits identified areas that the provider needed to address, they took action. For example, Infection control audits completed in June and July 2016 identified some of the inspection team had about the suitability and availability of bath and shower rooms for people using the service. The registered manager told us this had been escalated to the provider's estates management team and a visit was planned to look at the affected areas.

The registered manager told us about a new initiative by the provider, the Dementia Care Framework and we spoke with one of the provider's facilitators who was providing training for staff during our inspection. The facilitator told us their role was to train the staff, to implement the framework and to monitor how the home is doing. There were four key areas, training for the staff, a quality of life programme, resident and relative charters and accreditation of the home.

The home had 18 weeks to implement the framework and this was starting in September 2016 but they were delivering the training in advance. The scheme is updated and changed with feedback from people using the service, their relatives and staff. A resident and relative charter was due to be coproduced with people using the service and their relatives and would include suggestions from a large group of people across the organisation. People would have the opportunity to feedback via tablet computers about their experiences. This feedback went straight to the registered manager, area manager and regional director and they could track what happens and any response.

All staff who worked on or could work on units where people are living with the experience of dementia had to complete a full set of training which consisted of five on-line courses and four face to face training sessions. This included managers in the service, nurses, care staff, domestic, catering and maintenance staff.

All other staff in the organisation who did not specifically work with people living with dementia had to complete one face to face and one on line course. Part of the staff training was an assessment of their thoughts and opinions about dementia before and after the training. Staff completed questionnaires which showed their opinions and then the provider would assess how much their perception had changed and how the training had helped them.

The training for staff covered dementia awareness, communications, activities and engagement, distress reactions and dementia and the law. The training session that took place during our inspection was about the dementia experience – staff put on goggles, listened to distracting noises, had over sized gloves and had to remember and complete tasks. They then had to reflect on how this felt and then discuss how it must feel to be a person with dementia. The facilitator told us staff had already completed the training where they supported each other to eat, supported each other to move around the service in wheelchairs and hoisted each other. The courses linked into each other and the trainer told us they had received very positive feedback from the courses.

Once the framework has been implemented in the service, there will be sets of standards and key performance indicators the service has to meet. The facilitators will return to check and feedback from the computer system will be used to work towards levels of accreditation. The facilitator told us that feedback from staff was that they had got to know people using the service better and felt that they had provided better care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance. Regulation 15 (1) (e).