# Care UK Community Partnerships Limited

# Francis Court

## Inspection report

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## Ratings

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

## Overall summary

The inspection took place on 4 and 5 March 2015 and was unannounced.

Francis Court is registered to provide nursing and residential care for a maximum of 87 people but this number was restricted to 52 due to a condition imposed on the provider's registration. At the time of this inspection there were 52 people in residence including people who had general and complex nursing needs and people living with dementia, mental health and physical needs. The service provides long term and respite placements. Prior to this inspection we had received an application from the provider to remove this condition. We are considering the application in light of our inspection findings.

The service had a registered manager. 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

# Summary of findings

and associated Regulations about how the service is run. The manager had been in post for approximately four months and was newly registered. After a period of significant change, people, relatives and staff spoke positively of the new registered manager and the stability she had brought to the home.

People told us that they enjoyed living at Francis Court and that they received good support from staff. One described the staff as, "Top class". Another told us, "Everybody looks after us so well". Of the management, one person said, "I know the manager and she will talk on any issues and is very approachable". A member of staff told us, "The management is good. The team leaders and nurses they are all good to us". A significant number of new staff had been recruited and the home had reduced their reliance on agency staff to cover shifts. This had a positive impact on people as they were familiar with the staff supporting them. One member of staff told us, "So far everything is going in the right direction". A relative said, "In every way I am very pleased".

People, their relatives and staff felt involved in decisions relating to the home. The culture was one of collaboration. Staff felt empowered and this created a positive atmosphere. The management team listened to views and were quick to respond to suggestions or concerns.

There were enough staff on duty to meet people's needs safely. Staff were clear on what was expected of them and received training and supervision to help them deliver care to an appropriate standard. The registered manager was aware that staff were not up to date with their training and that supervisions and appraisals had fallen behind. This was being addressed and a clear plan of action was in place.

People were treated with kindness and respect. One person told us, "The staff talk to me and they would help without any doubt". There was a friendly atmosphere at the home. People and staff were seen to enjoy each other's company, to joke and laugh together. People were involved deciding how they wished to spend their time and staff were quick to notice when they required assistance or reassurance. Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Risks to people's safety were assessed and reviewed. Any accidents or incidents were recorded and reviewed in order to minimise the risk in future. Medicines were managed and administered safely. People had been involved in planning and reviewing their care and detailed care plans were in place. Where necessary, external healthcare professionals had been involved and their advice had been incorporated into the care plans.

Lunchtime was a sociable experience for most people. A menu was available for them to choose from and people told us that they enjoyed the food. People who required assistance to eat were supported. There was a varied activity programme and some events were attended by people from the local community. The home had recently arranged the use of a minibus and staff had taken their tests ready to take people on outings.

The home was well-led. A system was in place to monitor the quality of the service delivered and to ensure that necessary improvements were made. This included audits by the home and representatives of the provider.

**We have made a recommendation regarding the system for tracking staff training, supervision and appraisal.**

**We have made a recommendation concerning how people's care and support needs are recorded.**

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**
The service was safe.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Staff numbers were sufficient to meet people's needs safely.

Risk assessments were in place and regularly reviewed to ensure people were protected from harm.

Medicines were managed and administered safely.

**Good**

**Is the service effective?**
The service was not consistently effective.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles but had not always attended refresher courses, regular supervision or appraisal.

Care plans were detailed but there were inconsistencies between electronic and paper records.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to health care professionals to maintain good health.

**Requires Improvement**

**Is the service caring?**
The service was caring.

Staff were friendly and spent time with people.

People made decisions related to their daily needs and how they wished to spend their time.

People were treated with dignity and respect.

**Good**

**Is the service responsive?**
The service was responsive.

Staff provided personalised care that anticipated and met people's needs.

People, their representatives and staff were able to share their experiences and any concerns. Concerns were addressed promptly.

**Good**

# Summary of findings

**Is the service well-led?**

Good

The service was well-led.

The was a collaborative culture at the home. People and staff felt able to share ideas or concerns with the management.

The registered manager was proactive and was working to make improvements to the service.

The provider and manager used a series of audits to monitor the delivery of care that people received and to make improvements.

# Francis Court

**Detailed findings**

## Background to this inspection

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

This inspection took place on 4 and 5 March 2015 and was unannounced.

Three inspectors, a nurse specialist advisor and an expert by experience in dementia care undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the Provider Information Return (PIR), two previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

We observed care and spoke with people, their relatives and staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We looked at eight care records, six staff files, staff training, supervision and appraisal records, medication administration records (MAR), monitoring records for food, fluid, weights and wound care, quality feedback surveys, accident and incident records, handover records, activity records, complaints, audits, minutes of meetings and staff rotas.

During our inspection, we spoke with ten people using the service, three relatives, the registered manager, a representative of the provider, three nurses, four care staff, two activities staff, the chef, the head housekeeper, a member of the laundry team and two administrators. We also spoke with a chiropodist who was visiting people who lived at the service. After the inspection, we contacted a Speech and Language Therapist (SALT), a Lead Fracture Liaison Nurse Specialist and the GP practice who had involvement with the service. We also received feedback from the Integrated Response Team (IRT) who had worked in the home for a period of ten weeks and a Minister who visited the service weekly. They consented to having their feedback published in this report.

Francis Court was last inspected in August 2014 and there were no concerns. Due to previous enforcement action, a registration condition remains in place, limiting the number of people the home can accommodate. Prior to this inspection we received an application from the provider to remove this condition. We are considering the application in light of our inspection findings.

Good

# Is the service safe?

## Our findings

People told us that they felt safe. One person said, "I have felt very safe and all my property also". Staff were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. They told us that they felt able to approach their line managers or the registered manager. One staff member said, "It is our duty to protect our residents. If I suspect harassment or abuse I'd report it immediately". A flow chart detailing the actions staff should take if they had concerns was displayed in the nurse office on each floor. Staff were able to direct us to this information.

Assessments had been carried out before people moved to the home. Where risks had been identified these had been detailed in the care plans and reviewed on a monthly basis, or more frequently if required. We saw examples of various assessments, including for the risk of falls, malnutrition, epileptic seizure, choking and development of pressure areas. Action had been taken to minimise the risk. Where people were at risk of developing pressure areas, they were assisted to change their position on a regular basis by staff and specialist equipment such as airflow mattresses was in place. Records demonstrated that staff checked these on a regular basis to ensure that they were functioning correctly. Accidents and incidents that occurred were documented and reviewed. Where necessary, input from other healthcare professionals was sought and their advice incorporated into the plan of care. Following a fall, one relative told us, "They have put in place a safety mat and carry out checks". We found that there were appropriate measures in place to assess and manage risks to people's safety and welfare.

People told us that the staff were helpful and available to assist them when needed. One said, "There's no problem with staff numbers". Another told us, "Yes, there are enough staff, they stop and chat". We observed that staff were available and that staff presence was maintained in communal areas to promote people's safety and wellbeing. Each floor was staffed by a team including a nurse, a team leader and care staff. In addition, the registered manager, deputy manager and clinical lead were also nurses and were available to step in if additional support was needed.

One member of care staff told us, "We have a brilliant relationship with the nurses". The care team was supported by two activity coordinators, housekeeping, kitchen, maintenance and administrative staff.

The home is registered to accommodate a maximum of 87 people but this number was restricted to 52 due to a condition on the provider's registration. At the time of our visit, there were 52 people in residence. The registered manager explained that they were recruiting with a view to the home reaching its maximum occupancy. The number of hours covered by agency staff had reduced by over 50% to the current level of 300-400 hours/week in the period since November 2014. We received positive feedback from the GP practice who told us that having the same nursing staff had led to better continuity of care. They told us, "Nurses seem to know their patients". A dependency tool had been introduced as a means of assessing the number of staff required to meet people's needs. At the time of our visit the home was staffed above the level calculated by the tool. The registered manager explained that this tool would be used to support the planned growth in the number of people living at Francis Court. We looked at the staff rotas for January and February 2015. These demonstrated that the home had maintained the staffing levels they described.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history, qualifications and with the Disclosure and Barring Service. This helped to ensure that new staff were safe to work with adults who may be at risk. In addition, two references were obtained from current and past employers and their eligibility to work in the UK was checked.

People were satisfied with the way they received their medicines. One said, "I get my medication when I am expecting it. They do ask if I need painkillers". Another told us, "I've got diabetes and I have to have an injection. So far they've been alright". We observed part of the medicines round during the morning and at lunch time. The nurses provided information to people and supported them to take their medicines. Where people had been prescribed medicine on as 'as required' (PRN) basis there were clear instructions for staff. This helped to ensure that PRN medicine was administered consistently and not used as a long term treatment. People told us that they received their

Good

# Is the service safe?

medicines regularly and that they were offered pain relief. For people who required insulin to help manage diabetes there were clear records of the times for administration and regular checks to record blood glucose levels. Nurses competed six monthly training in medicine management and their competency had been assessed annually.

Medicines were securely stored in a locked cabinet inside a locked room. The room was temperature controlled and a medicines fridge was available. The temperature of the room and fridge was checked daily. Creams and liquids were dated on opening. These measures helped to ensure that medicine was stored in line with the manufacturer's guidelines and that it remained effective. Medicines, including controlled drugs (controlled drugs are drugs which are liable to abuse and misuse and are controlled by legislation), and topical creams were accurately recorded. Records for the disposal of medicines were up-to-date. There were clear systems in place to manage medicines and to check that people received their medicines safely.

Requires Improvement

# Is the service effective?

## Our findings

People were full of praise for the staff. They told us, "The nurses and the carers are well qualified. They are absolutely fantastic" and said "They'll do anything you ask". The Speech and Language Therapist (SALT) we spoke with said, "Staff are always exceedingly helpful. Care assistants seem to know what's going on with the residents".

New staff followed an induction programme which included a two week period of shadowing. The clinical lead explained, "New staff shadow team leaders for a period until they are confident and competent". Training for staff comprised both e-learning and classroom courses. Topics covered included safeguarding, moving and handling, fire safety, mental capacity, nutrition and infection control. Staff were satisfied with the training that they had received and told us that they felt equipped to support people living at Francis Court. In addition to training that the provider made compulsory for all staff, other training was available, including through the In Reach Team (IRT) who were working with the home. The administrator told us, "If staff request additional training we look to see if funding is available and will aim to support and contribute". One nurse told us, "Last year I had training in pressure sores, whatever I asked for in supervision they provided".

Staff were not up to date with their refresher training. We found that approximately half of the staff were overdue annual training in subjects including safeguarding and dementia awareness. This had been noted by the registered manager and actions were underway to ensure that this was completed. In the minutes of a staff meeting the day prior to our visit we read, 'We are going to target one course a week and if you have not completed you will be receiving a call on the Friday to say you have one week to complete the chosen course, you will then receive a follow up call the following Wednesday to see how you are getting on and this has to be completed by the Friday'. Staff were aware of this requirement.

Staff felt supported. One said, "We have a good team at the minute. We had new colleagues and we've glued together". Another told us, "From time to time we have agency but mainly we have our own staff. You get to have that relationship and people see the same faces". Supervision records showed that staff had attended supervision meetings but that these had not taken place on a two-monthly basis as stipulated in the provider's policy.

Appraisals were not up to date. At the time of our visit 15 of the 32 staff who had been in post for more than a year had attended an appraisal. Some staff had not had an appraisal in the past two years. Regular supervision and appraisal is important to ensure that staff are supported and equipped to deliver safe and effective care to people. The registered manager told us, "We are not thinking about appraisals yet, our priority is to get supervisions up to date, we have fallen off the wagon in regard to supervision, there is a schedule in place but this has not been followed and I am now monitoring this".

The registered manager had identified the shortfall in staff refresher training, supervision and appraisal and had a clear plan in place to address this. At the time of our visit the registered manager had been in post for approximately four months. The administration team responsible for training was also new in post and a significant number of new staff had joined the team. We found that the records used to monitor staff training, supervision and appraisal contained gaps and were not an effective tracking tool. Information was not readily available. It took time to verify and to determine whether staff had attended particular trainings or whether supervisions had taken place. **We recommend that the system for tracking staff training, supervision and appraisal is reviewed to ensure that all staff receive regular training and support.**

People's needs were assessed before they moved to the home. Care plans were in place which detailed the support that people needed and those areas where they could manage independently. For example, in one we read, 'X can support herself to sit in the shower chair'. People and their relatives told us that they had been involved in determining the care provided but had not signed the care plans to demonstrate their agreement.

Staff knew people well and had a good understanding of how they liked to be supported. They told us that they kept up to date with changes via a system of handovers or by seeking advice from the team leader or nurse. Records were in place to monitor people's needs and to document the care delivered. These included blood sugar monitoring for people with diabetes, repositioning charts for those at risk of developing pressure areas, continence, oral hygiene, bath and shower records. These were completed and had usually been signed off by the team leader or nurse on a daily basis. We noted examples of how these records had

# Is the service effective?

been used to ensure that people's needs were met. For example, we read, 'Need to start PRN (name of a laxative) – frequent constipation'. Speaking about another person, the nurse told us, "They had two sachets of (name of laxative). If their bowels are not opened today, I will call the GP tomorrow". The MAR chart supported what the nurse told us. Wounds or bruises were monitored effectively, body maps were used and photographs were on file.

While monitoring records were of a good standard, we found that staff did not always have access to the most up-to-date care plan. The home used an electronic system to manage their care records. In addition, printed copies were kept on file and people had a quick reference file in their rooms. Where updates had been made on the electronic system, these had not always been transferred to the paper records. Staff that we spoke with provided consistent responses as to the support people needed and there was no indication that this had impacted upon people's care. However inconsistencies in records could put people at risk of receiving care that is inappropriate or unsafe. **We recommend that the recording of people's planned care and support is reviewed to ensure that staff have access to up-to-date information at all times.**

Staff understood how people's consent should be considered. We observed that staff gained agreement from people before proceeding with their support. In the records we saw that people had sometimes declined assistance, for example to have their hair washed, to wear a hearing aid or to allow blood to be taken. In one case we read, 'Feet and legs are still swollen and (name) has declined to have them elevated on a foot stool'. These decisions had been respected. Others had been involved in decisions such as to the use of bed rails for their safety. In the notes we read, 'X has mental capacity to consent and she has requested staff to put the side rails for her own safety while she is in bed'.

Where people did not have capacity to consent best interest meetings had been convened. A best interest meeting is when relevant professionals and relatives are invited to discuss and make a decision on behalf of a person who lacks capacity. Decisions had been made in this way to authorise the covert administration of medication for some people or to determine whether or not it would be in a person's best interest to be resuscitated if their heart stopped. In each case the GP had been involved, along with relatives and senior staff from the home. Some people had appointed a lasting power of attorney to make decisions on their behalf. The home had a clear record of this, although it was not updated on the electronic care system.

Staff were aware of the Mental Capacity Act (MCA) and had been given a pocket reference guide in a recent staff meeting. One said, "I'm due to have more mental capacity training. I know the legislation has changed". The registered manager was aware of a revised test for deprivation of liberty following a ruling by the Supreme Court in March 2014 and had taken action in respect of this. A deprivation of liberty occurs when the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements. The clinical lead showed us applications for Standard Deprivation of Liberty Safeguard (DoLS) Authorisations which they submitted to the local authority in October 2014. These were supported by completed mental capacity assessments and best interest decisions. We noted that the recording of the decision to be made and details of the assessment process in mental capacity assessments could be more individualised. We discussed this with the registered manager as a point of best practice to demonstrate that the service was acting in accordance with the requirements of the MCA legislation. The home had not yet received decisions on these applications from the local authority.

People were happy with the choice of food and drink available. One said, "The food is pretty good and I could ask for something else". Another told us, "We get enough to drink. They are always coming round with something to drink". We observed that menus were displayed and that the chef had a record of the menu choices that people had made for lunch on the day of our visit. When a person moved to the home, information about their dietary needs and preferences was shared with the chef using a 'diet notification form'. These had been updated when people's needs changed.

We observed lunch being served in the dining rooms. Staff asked people if they were happy with their choice and if it was what they wanted. Staff were seen describing the food to people and offering a choice of vegetables. Where people required support to eat, this was provided at a pace that suited the person. Some people ate their meals in their bedrooms. We heard staff chatting with people as they

Requires Improvement

# Is the service effective?

supported them. Throughout the day, staff maintained records of what people had eaten and had to drink. These included a record of any nutritional supplements prescribed to people who had been assessed as at risk of malnutrition. These charts were reviewed on a daily basis to monitor people's nutrition and hydration.

People had access to healthcare services and a GP visited the home on a weekly basis. One person told us, "I can see the doctor when I need to". A relative said, "The staff were very good at calling the doctor in to look at the pain in Mum's arm and it was dealt with very quickly". We saw that advice from healthcare professionals had been incorporated into people's care plans and risk assessments. For example, following referral to a SALT, one person's risk assessment for choking and aspiration had been updated to include information on recommended textures and high risk foods to avoid. Healthcare professionals that we spoke with told us that the home made appropriate referrals. They also told us that staff were keen to follow their advice. The chiropodist said, "They always follow up on what I've asked them to do".

Good

# Is the service caring?

## Our findings

People spoke positively about the staff. One said, "The staff are smashing, you couldn't hope for them to be nicer". Another told us, "The staff are very good, kind and caring". We observed that staff had a good rapport with the people they were supporting. Their approach was friendly, warm and unhurried. They appeared to enjoy people's company and were seen laughing with them. A minister who visited the service said, "Many of the conversations I have with residents testify to the excellent care given". We heard staff ask one person if they had slept well, they complimented another on their jewellery. On the second day of our visit preparations were underway to celebrate a birthday and activity staff were involving people in preparing decorations. One member of staff said, "When we are fully staffed we have time to chat". Another said, "I'm proud of my job".

Staff appeared to know people well and to anticipate their needs. During our observation, one person appeared reticent to have breakfast. The member of staff sat with them and chatted. They then suggested a breakfast option, pronouncing it in a way that amused the person and appeared to be a shared joke. The person soon began to enjoy their breakfast. On another occasion a person was anxious as to where they had left their handbag. Staff quickly reassured them and then assisted them to walk to their bedroom in order to check. One relative had commented on a feedback website, 'We have been very impressed with the standard of care. All the staff have such a caring attitude and are so approachable. We have always been made very welcome and nothing is too much trouble'.

Staff involved people in day to day decisions regarding their care and on how and where they wished to spend their time. We observed as one person was offered a choice of yoghurts. The person did not appear to understand the choice. The staff member proceeded to offer a taste of each flavour and the person was able to clearly indicate their preference. In the staff communication book we noted examples of requests people had made in relation to their care. One such request read, 'Has asked for ear syringing – faxed request'.

People's wishes and preferences were recorded. Care plans included specific details, such as whether or not a person preferred to be supported by male of female staff and whether they liked a light on at night. In one care plan we read, 'She wants to have a cup of coffee at 8am in her room'. Care plans included updates, for example on breakfast options and the time people liked to get up in the morning. Some people recalled being involved in planning their care. One said, "I know of my care plan, it's quite adequate". Another told us, "They do speak to me about my care". Staff told us that care plan reviews were organised on a quarterly basis. We saw records of these meetings which had involved relatives and where possible the person receiving care. Some people had devised advanced care plans, which documented their future care wishes regarding hospitalisation, pain management and resuscitation.

Staff treated people with respect. They took time to explain what they intended to do and to seek the person's agreement. One person who was wearing a skirt was being assisted to transfer using a hoist. Once staff had fitted the sling, they used a blanket to cover the person's knees and ensure that their dignity was not compromised. Another person told us, "If attending to me, they shut the door and draw curtains if necessary". The IRT shared an observation from their time working at the home. They wrote, "On one occasion a new staff member attending a resident spent a long time listening to him as he was trying to communicate something he had written down. She showed compassion, dignity and respect throughout the interaction". The chiropodist shared, "They always treat them with dignity and decorum".

Good

# Is the service responsive?

## Our findings

Staff were quick to respond to people's needs. We observed one person trying to get up from their armchair. A member of staff was immediately beside them and understood that they wished to go to the toilet. The member of staff remained with the person as they were at risk of falling and another staff member brought the hoist. The person later returned to the armchair, was given a cup of tea and looked very comfortable. Throughout our visit staff responded to call bells in a timely manner. One person told us, "They come in to see what's up". A relative said, "I set the alarm off by standing on the pressure mat and they responded within seconds". Healthcare professionals involved with the service told us that the staff responded to changes in people's needs. The Lead Fracture Liaison Nurse Specialist said, "Staff are attentive and do their best to foresee problems and discuss with senior staff or a GP".

Staff were keen to learn about people and to understand them. One person told us, "I get the care that I want. Staff know what they are doing and talk to you about it". A member of staff said, "Everyone brings new information. The families are really involved. They will give us little tips. Even if they have worries or give negative feedback it is useful as we then know how to improve". Feedback received by the provider from a relative in January read, 'From day one, Mum has really turned a corner, and has got back some of her Joie De Vivre! She is receiving the correct medical care for her condition, superb food, and great communication with all the staff who as a team, take care of all her needs'.

People told us that they enjoyed the activities at the home and were able to go out in the garden. One person said, "There's enough to interest me". Another told us, "I am quite happy here but I would like to go up and down the road in the summertime and be normal and go to the shop". The activity staff were in the process of speaking with people individually to understand their preferences for activities. The current programme was available for people to take a copy. It included arts and crafts, cooking, choir, gardening, seated aerobics and news reviews. A relative told us, "There could be more trips out but otherwise they do entertain them and there's always something for them". We noted that outings had been suggested in the relatives' survey conducted the previous year. The home had just recently agreed to share a minibus with another home run by the provider. Some staff we spoke with had taken their minibus test and were preparing to take people on outings. We found that the home had responded to feedback and that they were working to improve how they catered for people's individual preferences.

The registered manager and staff listened to concerns from people and their relatives. One person told us, "I've no complaints, you can't find a better home". Another said, "They would listen to resident concerns and would do something about it". A relatives' meeting had been arranged and a residents' meeting was advertised in the home for the following week. The registered manager had reviewed past relative and resident surveys and had discussed areas of concern or improvement. One relative told us, "Within the last three months there was a meeting for relatives and I received a very full set of minutes". Another had written to the registered manager expressing their thanks over a particular issue saying, 'We are very grateful to you for sorting out, in approximately one week, what hasn't been sorted out in the last six months'. We noted that some of the actions from the relatives' meeting had already been addressed, for example in response to feedback that it was difficult to identify who was who in the staff team, a pictorial guide had been produced and was available at reception.

Housekeeping or maintenance tasks or issues were logged in books on each floor. These were checked daily and there was evidence that tasks were quickly attended to. The housekeeper told us, "We're building up communications between housekeeping and the care staff. It's working really well". A suggestions box was available in reception.

People understood how to complain. We saw that this was explained during the last residents' meeting. The resident satisfaction survey conducted in September 2014 showed increased satisfaction with the way staff dealt with any complaints, up 10% on the previous year. The complaints procedure was displayed. Where complaints had been received, these had been investigated and responded to. One person told us, "I've never been in the position when I needed to complain but would if it's important". Another said, "I've no complaints".

Good

# Is the service well-led?

## Our findings

People, staff and relatives spoke positively about the new registered manager and were glad of the stability the post afforded. The home had been through a period of change and there was a feeling that things were settling down, with new staff recruited and a more stable staff team. There was a culture of collaboration. The registered manager had involved people, their relatives and staff and was keen to listen to their views. One person told us, "This is home and I like it here". A member of staff said, "We had a staff meeting and were exchanging ideas". There were events organised with the local community, a fundraising coffee morning and schools invited in to join an Easter egg hunt. Members from a local church visited on a regular basis and some were involved in the new 'community choir' at Francis Court. The registered manager had also addressed community meetings which recently included carers and bereaved groups. Events, including Valentine's Day celebrations and participation in the RSBP Bird Watch, had been reported in the local press and cuttings were available at reception.

The registered manager explained that she wanted to create a community. In the home's philosophy of care we read, 'We believe that diversity of our residents is our greatest asset and that through the formation of positive relationships they can continue to be part of a vibrant community'. A minister involved with the service said, "There is a definite sense of direction conveyed for even further improvement. I am struck by the humane attitude of the manager, whose vision embodies a community of people, where friendships can form, where residents feel listened to and valued and where able, given encouragement to be active participants. The manager is an excellent ambassador for Care UK especially in her discernment of how to build community relationships".

People praised the new registered manager. One person told us, "She visits the floor frequently". A relative said, "The manager is very good and I'm impressed with her" and, "Since she came, everyone is more on the ball". Staff were equally positive, telling us, "It's a lot better now we have a permanent manager" and, "She's very approachable". One said, "It's more organised and more disciplined, it's definitely improved". A new deputy manager and clinical lead had been appointed from within the staff team. One member of staff said, "I think it's a very good team. Their door is always open if I need advice or information". A new sign had been mounted in reception to show who was in charge on a daily basis. This had been arranged in response to relative feedback. A minister who visited the service weekly said, "In my opinion the standard of leadership over this last year has been of an increasingly high calibre - it continues to be so with the newest manager. This is evident in the delegated management on each of the floors. You can tell now who is in charge and that the team on each floor operates well".

Staff told us that communication had improved. One said, "We find solutions, we talk as a team". Another told us, "The new manager has made a vast difference". There were regular staff meetings. We saw examples of clinical meetings, nurse meetings, heads of department and all-staff meetings. The minutes demonstrated that ideas and concerns were openly discussed and that agreed actions were followed up. To support the staff team, a member of the provider's HR team visited on a weekly basis. Staff had also been encouraged to join the provider's staff consultation and listening forum entitled, 'colleague voices' and representatives from Francis Court had been appointed. A dedicated mobile telephone line held by the registered manager, named the 'sick phone' ,had been introduced as a means of managing sickness absence and providing support to staff. As a result of this initiative, the registered manager told us, "Sickness is coming down every week".

The registered manager had signed up to become a dementia champion, part of the Alzheimer's Society 'Dementia Friends' initiative. She told us about plans to hold dementia friends training events in the home. Staff were also looking at the environment and how it could be improved to support people living with dementia. The IRT explained that they had recommended the home self-referred to the Care Home in Reach team for support with residents living with Dementia and that this was completed immediately. The six to eight week programme of support was scheduled for April 2015. This demonstrated that the registered manager was keen to make improvements to enhance the quality of care they provided.

The management team at the home used a variety of checks and audits to monitor the quality of the service. There were monthly audits of medication, health and safety and the kitchen. Housekeeping carried out

Good

# Is the service well-led?

fortnightly spot checks throughout the home. There were also visits, including at night, by the registered manager or members of the management team. One member of staff told us, "She is a very nice manager, even on the weekend she goes in to check it's all going well". We saw that actions for immediate attention were noted in the communication book. For example, we read, 'Medication daily counts are not always completed'. Trends noted from the incident analysis, such as an increase in falls due to environmental hazards like equipment being left in communal areas, were promptly addressed through discussion in a staff meeting.

There was an annual self-audit schedule produced by the provider. In 2015 to-date this had included health and safety and medication management. The registered manager was following the schedule and had created a service improvement plan where actions from all of the home's audits and meetings were recorded and tracked. She told us, "I just want everything in one place, otherwise I haven't got sight of it". In addition, the registered manager sent a monthly report to the provider and was visited each month by a representative of the provider. These visits included a review of a care plans, complaints, incidents, medication and a tour of the premises. Actions from the previous visit were reviewed each time and the sample that we checked had been completed. In February 2015, the provider had conducted a regulatory governance audit, an annual review. Actions from this visit were recorded in the registered manager's service improvement plan. We found that there was a system in place to identify shortfalls in service provision, to monitor actions and ensure that improvements were implemented.