Coate Water Care Company (Church View Nursing Home) Limited

Church View Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection over three days on the 25, 26 January and 02 February 2017. The first day of the inspection was unannounced.

Church View Nursing home is registered to accommodate and provide nursing care to up to 43 people. If the twin rooms were used for single occupancy, 36 people could be accommodated. On the day of our inspection, there were 34 people living at the home. Church View Nursing Home has bedrooms on the ground and first floor. All rooms have en-suite facilities. A passenger lift is available for people with mobility difficulties. There is a communal lounge and dining area on each floor with a central kitchen and laundry room.

In May 2015, a comprehensive inspection identified the service was not meeting a number of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care was not consistently delivered in a safe and effective way and there were not always enough staff to effectively meet people's needs. In addition, quality auditing systems were not identifying shortfalls in the service. We issued four warning notices to the provider, as a result of the concerns we identified and the service was rated as inadequate. The service was placed into special measures. Special measures provides a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

In October 2015, we completed a focussed inspection to ensure improvements had been made. We found the provider had taken the immediate action necessary to improve the service. Another comprehensive inspection was undertaken in March 2016. Not all improvements had been sustained and further shortfalls were identified. Insufficient improvement had been made to enable the service to come out of special measures. As a result of this, we imposed a condition on the home's registration. This required the provider to undertake regular monitoring of the service and inform us of their findings.

The registered manager who was in post at the last inspection, left the company in October 2016. A new manager was recruited and started employment shortly after the previous manager left. This manager was available throughout the inspection and was in the process of registering with the Care Quality Commission, to become the registered manager. In addition to the manager, two senior managers including the Director of Operations and a supporting manager, were present during the inspection.

During this inspection, clear improvements had been made to the service. The manager and senior managers had taken the home "back to basics" and were confident the service was now safe, with effective leadership. Time was required to embed the changes and further work was being undertaken to offer care, which was more person centred. There had been additional training to develop staff's knowledge and more sessions were planned. Staff had been given an area of specialism, such as end of life care, which they were in the process of developing. Focus was being given to recruitment, to minimise the use of agency staff.

New systems and processes had been implemented. This included a comprehensive range of audits and on-going monitoring. The audits were working well and clear action plans were in place to ensure any shortfalls, were appropriately addressed. However, some aspects of service provision had not been identified as requiring additional focus. This included ensuring those people, who did not have the capacity to make certain decisions, were appropriately supported in line with the principles of the Mental Capacity Act 2005. After the inspection, the manager sent us documentation to show arrangements had been made for mental capacity assessments and best interest meetings to be undertaken.

A range of meetings had been introduced to ensure staff were fully informed and aware of their responsibilities. Staff felt well supported and were appreciative of the improvements, which had been made.

Improvements had been made to the management of risk and people's safety. This was particularly apparent in the monitoring of people's food and fluid intake. There were assessments, which identified potential risks and what action was required to manage them. However, one person was given an 'ordinary' meal at lunch time, when they required a soft diet. This increased the risk of them choking. Another person was prescribed a thickener for their drinks but this was not stated on their care plan. Clear focus had been given to the management of people's skin and the prevention of pressure ulceration. Records showed effective management of any wounds.

The planning and delivery of care had been improved upon. People looked comfortable and well supported although one person had stained clothing and another had fallen asleep over their breakfast. Staff had not provided these people with the support they needed. Care plans had been updated and were generally reflective of people's needs. However, information about continence and the care people wanted, whilst nearing the end of their life, lacked detail. This gave staff limited information about people's needs in these areas.

Improvements had been made to the management of people's medicines. However, there had been two errors in November 2016, where people had been given the wrong dose of their medicines. In addition, a relative stopped a member of staff from administering a dose of insulin, when it had already been given. All errors were appropriately managed although it was clear that staff had not followed procedures, for the errors to have occurred.

There were sufficient staff available to meet people's needs. The numbers of staff required during the day and night had been reviewed and amendments made. Consideration had been given to the deployment and skill mix of staff. Staff confirmed additional staff were deployed or the manager worked "on the floor" to assist, when required. Staff answered call bells and undertook people's requests, in a timely manner. They went about their work without rushing.

People told us they liked the food and had enough to eat and drink. There were positive comments about the quality and variety of food. Focus was given to those people at risk of losing weight. People told us they felt safe and liked the staff. Established relationships had been built and staff spoke about people with fondness. Staff gave people time and interacted in a friendly, caring and attentive manner. People's rights to privacy and dignity were maintained.

We found one breach in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we required the provider to take at the end of this report. However, due to the overall improvements which had been made, the service has been removed from special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Safe systems were in place to manage people's medicines but staff had not always followed procedures and errors had occurred.

The majority of potential risks were well managed due to improvements made. However, this was not so regarding two people and their risk of choking.

Sufficient staff were available to meet people's needs.

Safe recruitment practices were being followed.

Is the service effective?

Requires Improvement

The service was not always effective.

The principles of the Mental Capacity Act 2005 had not been consistently applied when assessing capacity and supporting people to make decisions.

Improvements had been made to the monitoring of people's food and fluid intake. People were happy with the quality and variety of the meals provided.

People were assisted by staff who were well supported. There had been in increase in staff training, which was improving practice and expertise.

People received good support from various health care professionals to help them remain healthy.

Is the service caring?

Good

The service was caring.

People spoke positively about the care they received and were complimentary about the staff.

People were encouraged to follow their preferred routines and

their rights to privacy and dignity were maintained.

Staff spoke fondly about people and were committed to their well-being.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements had been made to the planning and delivery of people's care. Care plans were up to date although some areas lacked clarity and detail.

Staff were generally responsive to people's needs and adhered to any requests promptly and in a caring manner.

People and their relatives knew how to make a complaint and were confident any issue would be dealt with effectively.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A comprehensive quality auditing system had been implemented and was working well. However, not all shortfalls had been fully identified and addressed.

There was a new manager and senior management team in post.

Clear improvements had been made to the overall service and an open culture had been developed. Further work was being undertaken to enable a more person centred approach.

There was strong leadership and a clear desire to improve the service and people's experiences.

Church View Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 was unannounced on the 25 January 2017 and continued on 26 January and 2 February 2017. The inspection was carried out by three inspectors. One inspector was present throughout the inspection and one attended on the first day. The third inspector undertook telephone interviews with staff. In addition to the inspectors, there was a specialist advisor, who was a nurse 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.

In order to gain people's experiences of the service, we spoke with 17 people, 7 relatives and three health/social care professionals. We spoke with two senior managers, a supporting manager, the manager and 15 staff. We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service.

Before our inspection, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Requires Improvement

Is the service safe?

Our findings

During the comprehensive inspection in May 2015, we identified people's medicines were not being safely managed. We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2015, we found immediate action had been taken to improve the medicine administration systems. During the inspection in March 2016, these improvements had been sustained but some shortfalls were identified in other areas.

During this inspection, improvements had been made to the management of people's medicines. However, there had been two errors in November 2016. These had involved people being given the wrong dose of a medicine. In addition, during December 2016, a relative had intervened and stopped a member of staff giving their family member a dose of insulin, which had already been given. Records showed all medicine errors were properly investigated and addressed. This included additional training, supervision, assessments of staff's competency and referral to the Nursing and Midwifery Council (NMC), as appropriate. However, it was clear that staff had not appropriately followed procedures for the errors to have initially occurred. As a result of the increased oversight with people's medicines, it was acknowledged that the risk of further errors had reduced.

During the inspection, staff administered people's medicines safely. There were safe systems in place for the receipt, storage and disposal of medicines. However, there was a conflict in the stock control of two medicines. Staff satisfactorily resolved this after it was brought to their attention. The temperatures of the refrigerator and the room, where medicines were stored, were regularly monitored. Although the temperatures were within appropriate ranges, guidance was not displayed to inform staff what they should do if this was not the case. The manager located this information and placed it in a prominent position for staff to see. Records showed staff had appropriately signed the medicine administration records to show they had administered people's medicines, as prescribed.

Regular audits of the medicine administration systems took place. Staff told us these occurred twice a day and again during the night and in more depth, on a monthly basis. There was a list of homely remedies, also known as "over the counter" medicines. The information was in line with clinical guidance and explained when the remedies should be taken. Some people were prescribed medicines to be taken "as required". Whilst information informed staff when these medicines should be administered, some of the protocols lacked detail and were not person centred. A visiting healthcare professional confirmed this and said they had also identified that additional detail with the protocols, would be of benefit. They said they had assessed the medicine administration systems as part of their role, after being asked by the manager to do so. The health care professional told us the systems in place for medicines had recently improved. They were working with the manager and staff to identify shortfalls and to make further improvements, as required.

One person told us they were happy with the way staff managed their medicines. Another person told us "medication has improved recently". A relative told us their family member required regular blood tests, which they found difficult. They told us staff had ordered a machine, to help make the procedure a more

comfortable and less distressing experience for them.

At the last inspection in March 2016, potential risks to people's safety had been identified. However, care documentation did not always inform staff how to minimise the risk effectively. In addition, one person who was at risk of choking was not fully supervised whilst eating their meal. At this inspection, improvements had been made to the management of risk. Senior managers confirmed this. They told us they had taken the home "back to basics" and had instigated systems and processes to ensure safety. Senior managers told us they believed this work had enabled a "safe service" which had been built upon "strong foundations".

Certain risks to people's safety were well managed. For example, records showed one person required supervision from staff when eating or drinking due to the risk of choking. This was given at all times, as required. Due to their poor eyesight, another person needed their environment free from clutter, with a clear unobstructed walkway around their room. This had been arranged and the room was free from trip hazards. However, staff told us one person required a soft diet and this was confirmed in their care plan. At lunch time, the record staff used to allocate meals, stated the person required a "normal/small meal". This was a conflict in their needs. The person was given a meal of pork casserole that was large in size and of 'normal' consistency. This increased the risk of the person choking and experiencing harm. There was a notice in another person's room, which stated they required a thickener added to all fluids. This was to minimise the risk of them choking. Staff were aware of this, as they told us the person required one spoonful of thickener in their drinks. Details of the thickener were not stated within the person's care plan.

There were assessments which identified potential risks to people. These included the risk of falling, pressure ulceration, choking and malnutrition. The assessments had been updated on a monthly basis. Confirmation of this had been sent to us, as part of the condition of the home's registration. Senior managers told us all care documentation was reviewed monthly. They said the systems would remind staff of the need to do this and if not done, an alert would be flagged. In addition, senior managers told us a new system called "Resident of the day" had been introduced, to further support the reviewing process.

Staff were aware of their responsibility to report a suspicion or allegation of abuse. They told us if they were concerned in anyway, they would raise this with a member of the senior management team. Safeguarding was regularly discussed in staff meetings and during staff supervision sessions. A copy of the whistleblowing procedure was displayed on notice boards throughout the home. The manager demonstrated they had reported issues appropriately to the local safeguarding team and if appropriate, to the Nursing and Midwifery Council (NMC).

People told us they felt safe. One person told us they had experienced a number of falls before coming into the home but they now felt safe and had not fallen at all. Another person told us "I'm safe enough". Relatives had no concerns about their family member's safety. Specific comments were "If I go away for a few days, I know she is safe", "I don't need to worry about her" and "I know he's safe. The staff are good to my Dad and they're very supportive to me".

During the comprehensive inspection in May 2015, we identified there were not enough staff to meet people's needs effectively.We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2015, we found immediate action had been taken to improve the deployment of staff. However, further concerns about staff shortages were raised during the inspection in March 2016.

During this inspection, there were sufficient staff to meet people's needs. Staff answered people's call bells without delay and undertook any requests, as required. The home was calm and staff went about their work,

without rushing. The manager told us staffing levels had been reviewed and were currently maintained at nine staff on duty during the day. This consisted of two registered nurses, one senior or unit leader, five care staff and additional ancillary staff. At night there were three care staff and a registered nurse. Senior managers confirmed these staffing levels. They told us the staffing allocation was regularly reviewed to ensure there were sufficient staff available to meet people's needs. This was evidenced on a monthly basis as part of the requirement to comply with the condition of the home's registration.

The manager told us a dependency tool was used to determine the numbers of staff required to support people effectively. In addition, they said they observed staff and the work they were undertaking. The manager told us "you don't need a dependency tool to tell you if staff are run off their feet. You can see it a mile off. If it gets busy, we help or bring more staff in. The staffing is flexible and adjusted according to need". Senior managers told us when they first started employment with the organisation, they reviewed working practices and deployed the "right staff to the right area". They said this had enabled staff to be more efficient in their work. Senior managers said the deputy manager post was now supernumerary and not integral to the working rota. This enabled greater flexibility, as the deputy manager was able to help out where needed. The manager told us recruitment was "going well" and new staff were being employed to fill existing vacancies. They said there was a strong focus to reduce the amount of agency staff being used.

People told us there were enough staff available to meet their needs although explained they were often "very busy". Specific comments were "I think the staff can get a little overwrought", "they are very busy and you have to wait your turn. You have to learn to have patience" and "during the nights it is a bit slower". Another person agreed with this and said "night call bells take a little longer for a response". Other comments were "I can't grumble", "they come as quickly as they can" and "I seldom have to wait". People told us staff answered their call bell without delay but if they could not help immediately, they would explain why. People told us staff would almost always, come back when they said they would. One person told us "I'm not keen on the agency staff as they don't know us very well. It makes it more difficult". In response to these views, senior managers confirmed a review of call bell response times had recently taken place. The home was satisfied the response to all call bells was within acceptable limits and no specific variation was noted between days and nights.

One relative told us "I think sometimes they could do with more staff" but all others spoken to, did not have any concerns about the numbers of staff on duty. One relative told us "there always seems to be staff around and they often pop their head in when they walk by to see if X's ok". Another relative told us "they are busy so there's not much time to sit and talk to the residents but they do if they can. They're very good. It's a bit quieter in the afternoon so there's more time then." Other relatives commented "I think there's enough of them", "there seems to be enough" and "I suppose there's always a need for more staff but I've got no concerns. They do what they need to do".

All except one member of staff told us there were enough staff to meet people's needs effectively. One member of staff told us "they've improved staffing levels and it's so much better now. We can care for people properly, which we couldn't do before". Another member of staff told us "they change the staffing levels if they can see it's getting difficult. One day, I told the manager people's needs were increasing and they arranged for another member of staff, just like that. I was shocked and thought I would need to argue my case". Other comments included "if it gets busy, they [the manager] will help out and get stuck in" and "staffing levels are so much better. We have time to care. I used to worry about it but I don't need to anymore". Another member of staff told us staff sickness had improved considerably. They told us "we are not as short anymore, as staff want to come to work. Staff sickness has come right down, as staff are committed now". One staff member told us staff were now able to readily attend training sessions, due to the improved staffing situation.

Safe recruitment procedures were in place, to ensure people were supported by staff with the appropriate experience and character. This included completing Disclosure and Barring Service (DBS) checks and contacting previous employers about the applicant's past performance and behaviour. A DBS check allows employers to check whether the applicant has any convictions or whether they have been barred from working with vulnerable people. All applicants provided evidence of his or her identity and were subject to a formal interview. The manager told us recent recruitment had worked well. They said they had recruited a number of skilled and experienced staff to join the team. The manager told us the new appointments, in addition to improving staffing numbers and consistency, had helped further develop the home.

Requires Improvement

Is the service effective?

Our findings

During the comprehensive inspection in May 2015, we identified the service was not meeting Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no evidence of consent or people's capacity to make decisions within their records. In addition, assessments did not demonstrate best interest decisions, which had been made. At the inspection in March 2016, improvements had been made but there remained some shortfalls.

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 legally authorised under the MCA. 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 are called the Deprivation of Liberty Safeguards (DoLS).

At this inspection, there was evidence consideration had been given to people's capacity to make decisions. This was because care and treatment consent forms were in place. However, the information was not always specific. For example, one record stated the person "did not have capacity". The statement did not explain how this had been determined or what it related to. Other records showed potential restrictions such as the provision of bed rails or pressure mats. Pressure mats are used to alert staff to the person's movements by activating the call bell system, when stepped on. Records did not show how the person had been supported to consent to these restrictions, or what action had been taken to meet the requirements of the MCA if the person did not have capacity to consent. Another record showed a person was able to receive their medicines crushed and disguised in yoghurt. Information showed this decision had been verbally agreed. It did not state with whom or what other measures were in place, to enable the person to consent to taking their medicines. Some information showed relatives had made decisions on their family member's behalf. Details of relatives' legal authority to do this, were not stipulated. The manager told us they had some confirmation of relative's authority to make decisions on behalf of their family member, but not all. They said some relatives had been reluctant to provide this information. After the inspection, the manager sent us documentation to show arrangements had been made for mental capacity assessments and best interest meetings. They said consent for people's care and welfare had been gained and care plans would be updated with the relevant information. Senior managers confirmed that meeting the requirements of the MCA was "work in progress" but would be given increased focus.

The manager showed us a record of the applications, which had been submitted to the local authority to restrict some people's liberty under DoLS. They said some applications had been agreed and others were in the process of being considered by the local authority. The manager told us applications generally related to the interventions required to meet personal care needs and the individual's inability to safely leave the home unsupported. They confirmed no conditions within the agreed applications had been stipulated. During the morning of the inspection, a health/social care professional was visiting a person to assess their capacity in relation to a DoLS. Another health/social care professional told us they believed staff's

knowledge about MCA and DoLS was improving. The manager confirmed this and said all staff had undertaken or were in the processing of completing training in this area.

The principles of the MCA had been appropriately and well applied to one person. This was because the person preferred to sleep in an unconventional manner. Staff had respected the person's wishes and had provided support to promote safe practice. However, this was not the case with another person. The person was resistive to care and made unhealthy decisions about their diet, which potentially impacted on their health in a negative way. Records showed the person had capacity but documentation did not show the person understood the detrimental effect their decisions might have on their health. Whilst the person's freedom and choice were being enabled, the person's care plan did not detail how their resistance was to be managed in a safe way.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

People told us staff asked for their consent to care. One person told us "I have some control and they listen to me". Another person told us staff always asked them if they were ready to get up. They said if they were not ready, staff would return and never apply any pressure for them to go against their wishes. Staff confirmed they encouraged people to make decisions about their daily routines. They said this included what people wanted to wear and how they wanted to spend their day. They told us the manager would arrange for a meeting to take place to discuss any complex decisions people needed to make.

During the comprehensive inspection in May 2015, we identified people's risk of malnutrition had not always been effectively addressed. In addition, appropriate measures were not in place to increase the frequency of foods or calorie intake to those people at risk of malnutrition. We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2015, we found immediate action had been taken to address the shortfalls. However, at the inspection in March 2016, it was noted not all improvements had been consistently sustained.

During this inspection, clear focus had been given to improving people's food and fluid intake. Those people at risk of malnutrition or dehydration had charts in their rooms to monitor their intake. The manager reviewed all charts and their completion, twice a day. Any shortfalls in intake were identified and staff were informed to encourage people to take additional food or fluids, as required. Each chart detailed the person's recommended daily fluid intake. This gave staff clear information about what was required for the person to remain healthy. The records showed staff had regularly supported people to drink and there was a running total of consumption. This enabled staff to see "at a glance" if a person had minimal intake and prompt action could be taken. Despite this, some records regarding food intake, were difficult to follow as staff had documented some people's desserts, in the supplement section of the form. This meant it was not always possible to determine if people had been given their supplements as prescribed. Whilst the records were unclear, staff were aware of those people who had supplements and how often these were to be given. One member of staff told us arrangements had been made for all supplements to be reviewed by a GP. They said this would ensure people were prescribed the correct amount, in accordance with their needs.

People told us they liked the food and had enough to eat and drink. One person told us "the food is excellent. There is a good choice and variety". Another person told us "it's better than hotel food". Other comments were "there's no need to starve here. If you don't eat it, it's your fault", "there is always a good selection of veg" and "we get fed very well". One person told us they were looking forward to April when new menus were going to be introduced. They told us "it will be nice to have a change". Another person told us the food was excellent but there was often "too much". They said they always requested "'small helpings" but these were often the same size as "normal" portions. Another person told us they had requested more

fresh fruit. As a result, they said they had a bowl of fruit delivered to their room on a weekly basis. There were other bowls of apples and oranges in the dining rooms and lounges.

Relatives confirmed the food was good. One relative told us their family member did not eat or drink much. They appreciated that staff provided "lots of fluids, some fortified". The relative told us "staff log and monitor this carefully". Another relative told us "they have asked me what X likes to eat in order to try and improve her food intake". Other comments were "I always help X with their lunch and it looks good. I would eat it" and "they do very well with food here. It's nicely cooked and a good variety".

Staff told us they felt well supported. One member of staff said "if we need anything, we just ask and it's sorted. I was shocked, as I had been over something in my mind, time and time again. When I went to see the manager, they just "yes, that's fine". I couldn't believe it". Another staff member said "we're supported 100%. They listen. We only need to say and it's sorted. They always give us time and I think everyone feels valued now". Other comments were "they involve us and have increased morale", "they're very approachable" and "nothing's a problem. We talk about things and find the best way to deal with any challenges. They work on the floor so they know what issues we're facing. It's really good". Another member of staff told us "I feel supported, yes, now we can go to the manager. He'll always try to help as much as he can. Before, we did not get the support we needed. He's really good, if I don't know something".

Staff told us in addition to informal support on a day to day basis, they regularly met with their manager. This was to discuss performance, training needs and any challenges or concerns they had. The manager told us they had a set agenda and undertook all sessions to ensure the same messages were given to all staff. There was a supervision matrix which showed the supervision sessions which had taken place, in line with company policy. However, records to show the topics discussed with staff were disorganised. This did not enable the on-going development of staff to be clearly shown. In addition, the records did not detail specific action plans, to monitor and improve practice. The manager told us despite this, they were familiar with each member of staff's practice and any requirements needed. The manager undertook the reorganisation of some staff supervision records during the inspection.

Senior managers told us they had "dismantled the staff team. Made amendments and put it back together again". They said this was because they wanted to "start again" and direct staff to work in a way they wanted them to. Senior managers told us they had very clear expectations of the standards they required. They said they explained these to staff, gave clear guidance and directed individuals into a certain way of working. Any staff member who did not adhere to required practice was managed through more formal human resources procedures such as disciplinary or performance management. Staff confirmed this. One member of staff said "they were very clear and told us what they expected. They explained everything and helped us understand what was going wrong". Another member of staff told us "there is no doubt that we're all working in the right direction now. We know what we have to do and they expect us to do it. We are all part of the changes and if we don't want to be, we shouldn't be here". Senior managers told us schemes such as "carer of the month" were in place to value staff. A photograph of the most recent saff member to receive this award was displayed in the entrance area of the home.

The manager told us they had arranged a range of formal training sessions for staff. These had included topics such as the use of syringe drivers, to manage pain and agitation towards the end of a person's life. They told us in addition to the formal sessions, "on the job" training had been regularly undertaken. The manager told us this had involved working directly with staff to promote practice but also to resolve any particular challenges with people's support. This included the best way to move a person safely. Staff confirmed this. They said their knowledge had increased since the senior management team had been in post. One member of staff told us "it's been good, as they're shared their knowledge and explained

everything to us so we're really clear and understand where they're coming from". Another member of staff said "they involve us with everything and communicate really well so we know what we have to do". Staff told us they had completed a range of recent training. Newly appointed staff told us they had completed topics such as moving people safely, health and safety and first aid, as part of their induction. They told us they 'shadowed' more experienced members of staff until they were confident to work on their own. Another member of staff told us staff had been able to choose an area of specialism. To increase their expertise in their chosen area, additional training had or was in the process of being given. For example, one member of staff who had the lead for end of life care, had undertaken recent training at the local hospice.

One healthcare professional told us they had seen a recent development in staff's knowledge. They told us they did not feel staff previously had a good understanding of dementia. However, this was now better and staff were more aware of the issues dementia could present. Another healthcare professional told us staff were more knowledgeable, with two named staff described as "excellent". They said they felt this level of knowledge and competence should be consistent across the staff team, with chronic health conditions requiring further focus. This was evidenced within the inspection, as two members of staff were not able to discuss the management of diabetes in detail. In addition, a person with diabetes had blood glucose levels, which were consistently higher than a normal range. Whilst this was being monitored three times a day, further advice from the Specialist Diabetic Nursing Service, had not been sought. Once pointed out to them, staff made arrangements for this to take place. Another healthcare professional told us more recently, staff were more approachable and had a greater awareness of any issues people had. They said staff were able to provide them with the information about people, they needed.

People received support to remain healthy, from a range of healthcare professionals. Records of consultations and appointments were maintained. One healthcare professional told us a representative from their surgery visited people on a weekly basis. This meant people's health care needs were consistently reviewed. The healthcare professional told us the system worked well. They were given a list of people to see before their visit. They were then able to prepare and bring the person's notes with them. At the time of the inspection, there were seven people with chest infections. The healthcare professional told us this was similar to those people within other care establishments and not uncommon for this time of year. They said the systems in place enabled people to be treated efficiently and then monitored, to ensure an improvement in their health. Staff told us they had access to specialised services such as speech and language therapy and a tissue viability specialist nurse. They said they had developed relationships and worked well with the local hospice. During the inspection, staff responded appropriately to any ill health. This included responding to one person who was "off their food" and "more sleepy than usual". Staff undertook the person's basic observations such as blood pressure and temperature and reported these to the GP. It was found the person had a urinary tract infection (UTI) and was started on a course of antibiotics. Staff told us they were aware of the National Early Warning Signs guidance. This information details signs and symptoms, which require urgent medical assistance. A copy of the guidance was located on people's care files.

Good

Is the service caring?

Our findings

There were many positive interactions between staff and people who used the service. One person was assisted to move from their armchair to a wheelchair using a hoist. Staff showed compassion and explained the procedure throughout. They gave reassurance and said "well done" to the person once they were settled. Another person was assisted to eat. Staff gave the person time and explained the contents of the meal. They were attentive and regularly asked the person if they were alright, whilst gently stroking their hand. Staff asked another person if they were comfortable or wanted to get up. They explained they would get the items they needed ready and would then return to assist. Staff did this and then once more, knocked on the person's door before entering. The member of staff was friendly, cheerful and showed a caring manner. Another member of staff sang with a person, as they accompanied them along the corridor. There were general conversations about music that was playing on the radio and when family would be visiting. One conversation led to preferences about particular artists and the songs they sang.

People were encouraged to bring items of their furniture and personal possessions with them on their admission to the home. One relative told us "we brought her chair, that little table and chest, as well as all the pictures and ornaments. It's helped her settle, knowing she had her things around her". Another relative told us "they encourage you to make it as homely as possible and personalise it. You can move the furniture around if you want. They don't mind". Some rooms contained high levels of personal possessions including piles of newspapers and magazines. This showed people's personal preferences were promoted and respected. "This is Me" posters were displayed in some people's rooms. The posters included information about important aspects of the person's life including family members, hobbies and previous history. One member of staff told us they had worked with relatives to gain consent and develop the information, particularly if their family member had difficulties with communicating their needs and wishes. The staff member felt it was important for information about people to be recognised and celebrated, subject to them wanting this.

Staff spoke about people with fondness. One member of staff told us "I'm still here because of the residents. We have some lovely people here and we owe it to them to give them a good service". Another member of staff told us "it's been hard but the residents have kept me here. I stayed with it because of them. It makes me really upset knowing we couldn't give people what they deserved. I felt we'd failed people. It's so much better now and I'm proud to work here". Another member of staff told us "I love working here. My heart belongs here. I have a really good relationship with people and staff". Other comments were "we are here for them", "we owe it to people to give a good service. They deserve it" and "it's a privilege to work with people. We are very lucky". One member of staff told us they sat with a person whilst they deteriorated and came to the end of their life. They told us "I stroked their hair and held their hand. It was hard but so lovely and what a privilege". Some staff were tearful when they spoke about changes in the home and the improvements that had been made. One member of staff told us "I get emotional just thinking about it". Staff told us now that improvements had been made, they would be happy to place one of their relatives at the home.

Staff told us they always promoted people's rights to privacy, dignity and independence. One staff member told us "it's what we do. We always talk to people in a respectful way. Ask them what they want and make

sure any care is given in private". Another member of staff told us "I always think about what I would want and how I would want to be treated. I don't think you can go too wrong then". Another member of staff told us "its about promoting independence, giving people space and not taking over. I think we promote privacy and dignity well".

People were complimentary about the staff. Specific comments were "they are very understanding and sympathetic", "its lovely here, everyone is so lovely and kind' and "they do the best they can". One person told us staff asked them what they liked to be called when they first entered the home. Another person told us they had made friends with another person who used the service. They said staff encouraged this and enabled them to sit together in the lounge and at mealtimes.

Relatives gave us similar views about the staff. One relative told us "their care is genuine. There are certain staff that shine". Another relative said "they are always welcoming and ask me how I am. They're very caring and know what X likes". Other comments were "they will talk to her and encourage her" and "they really help X to maintain her independence. I like that, it's important". One relative told us "they look after me as well as X". Another relative told us "if X goes out for the day or goes to hospital, the staff are always genuinely pleased to see him back".

Requires Improvement

Is the service responsive?

Our findings

During the comprehensive inspection in May 2015, we identified the planning and delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. In addition, proper interventions were not in place to ensure each person's wound and skin pressure area care was managed effectively. We issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2015, we found immediate action had been taken to improve these areas. However, at the inspection in March 2016, whilst some areas of improvement had been maintained, other shortfalls were identified.

During this inspection, further improvements had been made to the planning and delivery of people's care. Additional work was planned to enable the service to be more person centred. The majority of information within care plans was up to date and reflective of people's needs. However, the assistance people required to manage their continence was not always clearly documented. In addition, one daily record did not show staff had provided a person with sufficient support in this area. For example, staff had identified the person's continence aid was wet but the person declined assistance. They declined further throughout the day and had still not accepted help at 5.10pm. This did not promote the person's dignity but also increased the risk of damage to their skin. There was no other information to inform staff how they should manage any resistance, to enable the person to remain comfortable and dry.

One member of staff told us assisting people to maintain their continence, was an area they felt could be improved upon. They said this was because people with continence needs, often needed to be changed during the early evening, as they had last received assistance before their evening meal. Senior managers strongly disagreed with this view. They explained people were given assistance with their continence at varying times, dependent on their need. The manager confirmed this and said assistance was given in a person centred way, throughout the day and night, not at set times "on mass".

There was limited information about people's preferred care, towards the end of their life. Staff had documented statements such as "would like to be comfortable and pain free", "to stay at the home and not go into hospital" and "not for CPR. For X to have a peaceful end to her life". The information did not detail people's particular wishes about the care they wanted, as their health deteriorated. Senior managers told us they felt this was a shortfall in recording rather than of people's care. They said staff were knowledgeable about people's wishes and they had seen these applied in practice. They said this included enabling people to listen to their favourite music and using aromatherapy oils to produce certain fragrances.

The manager and staff told us one person was sometimes resistive to care and did not like to be repositioned to minimise their risk of pressure ulceration. Care records showed how the risk of pressure damage would be minimised but it did not specifically relate to the person's resistance. This meant the person's care plan was not specifically related to their needs. Staff recognised this and said they would address the content of the plan, without delay. Other care records were more accurate and showed the preventative measures required. This included the use of equipment, topical creams and repositioning regimes. There were care charts, known as "physical intervention" records in place. Staff had consistently

completed these to show the care they had given. All information reflected people's needs in relation to the timing and detail of the interventions. Staff were able to discuss in detail, how they supported people to maintain healthy skin.

One person had a chart, which showed particular behaviours they had shown. The information was not always factual or objective. For example, on one occasion, a member of staff had described the person's behaviour as "grumpy". The record continued to state, "can get gently agitated". There was no explanation as to what this meant, what triggered the person's anxiety or how it was managed. Another care plan had identified a link between a person's pain and increase in confusion. However, this association had not been explored when the person's behavioural charts had been monitored.

People generally looked well supported and cared for. Those people who were being nursed in bed looked comfortable, with clean bedding. One person was seated in an armchair but had pillows around them to enable greater comfort. Staff gave them a blanket, which was important for them to hold. However, one person had fallen asleep over their breakfast in a communal area. Staff were in the vicinity of the person but did not offer assistance. This did not promote the person's dignity. Another person had debris around their mouth and on their clothes after eating their breakfast. Staff assisted the person to wipe their mouth but a stain on their clothing remained throughout the day.

In other ways, staff were responsive to people's needs. One care plan stated the person was unable to follow instruction or retain information when being transferred with the hoist. The information stated "staff must explain what they are doing". Staff did this and consistently gave reassurance during the intervention. They praised the person for doing so well. Another care plan stated the person needed to be spoken to in a clear voice whilst maintaining eye contact at all times. Staff communicated with the person in this way. Staff told us another person responded in a different language, if they did not want to be supported. They explained how they had deciphered the content of the person's phrases and now responded in the same language. Another person told us they liked to have a rest on their bed in the afternoon. They said staff always assisted them to do this, "without fail". They told us they could ring their call bell when they were ready to get up and staff responded quickly. The person told us staff always adhered to their wishes and did what was asked of them. Another person asked to be taken back to their room. Staff did this straight away and in a friendly, caring manner.

People told us they were happy with the care they received. One person said "they look after me beautifully". Another person told us "they will do anything I ask them to. I am very comfortable here". Relatives gave us similar views. One relative said "X is being better looked after well. The care's improved. It's a lot better than it was. The staff are more friendly". Another relative said "I'm very happy with how things are going. I'm still very much involved, which I like and get comfort from. The staff don't mind at all. We work together to achieve what's best for X". One relative told us "they know what X needs and what he likes. There's a fine balance and they manage it well".

Staff were aware of people's needs and personal preferences. One member of staff told us about a person's favourite food and how they liked a particular type and flavour of fortified drink. Another member of staff spoke about a person's preferred times of getting up and going to bed. They told us "they're definitely not a morning person" and proceeded to explain how staff respected this. Within one care plan, it was stated the person did not like water. There was an instruction for staff to "make sure the flannel has almost no water on it just enough to wash with". Staff were not aware of the reason for the person disliking water but knew how to support them appropriately.

People and their relatives told us they would have no hesitation in raising a complaint if they needed to. One

person told us "they'd know if I wasn't happy. I'd tell them". Another person told us "complain. I haven't got anything to complain about". Relatives were confident any concerns would be satisfactorily resolved. One relative told us "I haven't tried it as I've been happy with everything but they listen, so I know they'd address anything I needed them to". Another relative told us "we met with the managers and they're really committed to improving the service. They wanted to hear our views so their approach to complaints is good". The manager confirmed they had no outstanding complaints and all had been dealt with to the person's satisfaction. They said they ensured an "open culture" and "lessons learnt" were part of the complaints process. Staff and people's relatives told us they were given personal contact details of the manager and senior managers. This was so they could be contacted at any time, out of office hours.

A record of complaints was maintained. This showed there had been three complaints in November 2016 about people's care. The concerns related to people being in soiled bedding and a lack of understanding and competence of staff regarding a person's percutaneous endoscopic gastrostomy (PEG). In addition, there was a complaint about a person's behaviour and the challenges this gave. In December 2016, there was a complaint about a staff member not assisting a person with a shower. Records showed an open approach to complaints. All had been thoroughly investigated and action taken. A letter explaining the conclusion of the investigation was sent to the person who had raised the concern. This encouraged the person to discuss their concerns with the manager if they remained dissatisfied or unhappy with the complaint's conclusion.

Requires Improvement

Is the service well-led?

Our findings

During the comprehensive inspection in May 2015, there was a lack of auditing, which did not enable shortfalls to be identified and addressed. Following the inspection, we issued a warning notice to ensure the provider made improvements. During the focussed inspection in October 2015, we found immediate action had been taken to improve the monitoring of the service. At the inspection in March 2016, shortfalls in the service continued not to be identified or fully addressed.

Since the last inspection, there had been a new manager and senior management team. The manager started employment at the home on 24 October 2016. They were in the process of registering with us to become the Registered Manager. Since their appointment, the senior management team had clearly focused on improving the service and had worked in a strong, committed way to do so. They said they had worked hard to ensure people's safety and were now confident the service was safe and had clear leadership. Senior managers told us further developments were to take place, which included the implementation of more "person centred" care. Other areas to be further developed were staff recruitment to minimise the use of agency staff and staff training. Whilst it was acknowledged a large amount of work had been undertaken to improve the service in a short amount of time, further time was required to embed the changes.

In addition to the senior management team, the manager had been supported in their role by another care home manager. The manager said this had been invaluable and enabled the sharing of ideas. The senior management team described themselves as "effective, strong and cohesive". They said they were passionate about the service and 100% committed to its success. They said they had experience of successfully "turning services around" and were working with the aim of gaining an outstanding rating from the Care Quality Commission. Senior managers told us they had asked all of their registered managers to think about what they needed, to help them to gain an increased rating in their service. They told us any requests would be seriously considered and implemented if practicable.

During this inspection, the manager and senior managers had a clear overview of the service. They had identified what was not working and had implemented a comprehensive range of systems and processes to ensure improvement. A "flash" meeting had been introduced on a daily basis at 10am. This was chaired by the manager and attended by heads of department. The meeting was aimed at keeping staff fully informed and updated with what what was going on in the home. Topics discussed included any ill health, appointments, particular events or matters, such as blood test results, which needed to be followed up. Within the meetings, staff were also encouraged to raise any concerns or discuss anything they were not sure of.

Staff received a detailed "handover" at the start of their shift. This included any dressing changes, changes in a person's condition or their medicines. Staff told us they were given a daily plan of the day, so they were aware of their responsibilities. Other staff meetings had been reinstated and were taking place. These included meetings for people who used the service and relatives. Staff meetings were held according to role and particular subjects such as clinical matters and health and safety. Records of the meetings were

maintained and displayed for people to see. Staff told us the communication within the home had significantly improved. They said they felt involved and were clear of their responsibilities and people's needs.

An extensive quality auditing system and regular, on going monitoring had been implemented. For example, there were a range of audits at varying frequencies targeted to address all areas of service provision. Topics included care delivery, health and safety, infection control, medicine administration, catering arrangements and staffing. There were specific action plans to address shortfalls, which had been identified. These detailed what action was required and within what timescale. The action plans were regularly reviewed to ensure all work was undertaken and improvements were made. If there were any difficulties in completing any action, this was clearly stipulated and a further review date was stated.

Records showed the manager was required to submit a monthly report to senior managers. This was detailed and gave an overview of the service. The information identified those people who had lost weight, sustained a wound, experienced a fall or were subject to a safeguarding referral. Other information showed the amount of agency usage, staff sickness and supervision sessions which had been undertaken. The reports were comprehensive and enabled effective monitoring. In addition, senior managers had requested further information to clarify certain areas.

Whilst detailed auditing took place, some areas had not received sufficient attention. This included enabling people to make their own decisions, with support if required, in line with the Mental Capacity Act 2005. In addition, further focus was required to clarify the management of resistance to care, the promotion of continence and people's preferred wishes towards the end of their life.

Each person had a "Service User's Guide" in their room. This provided people with information about the home and what they could expect to receive. Whilst the information was detailed, it was not up to date. There was some information which described staff as keyworkers, but these individuals had left the home's employment. Senior managers told us they were aware of this but other developments had taken priority. They said they would update the information, as soon as possible. People's care records other than physical intervention charts, were stored electronically. This meant if there was a fault with the system, information about people and their needs would not be accessible. This presented a risk of inappropriate or unsafe care. The manager told us they would ensure "one page profiles" would be developed. They said these would include the main information about people and be placed in their room, for easy accessibility.

To assist with further monitoring of the service, a "Resident of the Day" system had been introduced. One person referred to this as a "Pamper Day". Senior managers explained each person was allocated a day in the month, when staff would give added focus to their care and overall wellbeing. For example, they would meet with the cook to arrange what they wanted for their meals and discuss with the activities organiser, how they would like to spend their day. In addition, their room would be deep cleaned and their care would be formally reviewed. People and staff told us this system worked well and had enabled clear focus to be placed on each individual. Only one person was more negative, as they said they did not like leaving their room for their carpet to be cleaned. Senior managers told us they would look into this. They said staff should work with the person to find an agreeable solution, to getting tasks done .

Improvements had been made to the environment. One person said "it all looks bright and looked after. It's better. I like it". A relative told us "they're certainly doing a lot here. It looks a lot fresher so it makes you feel better. It's looking more cosy, more homely". A member of staff told us "it's transforming the place. It's more welcoming and I think it helps morale. It's better for the residents, as it looks nice and that's what we're here for". On the day of the inspection, the upstairs corridor was being redecorated and wallpaper was being

applied. Staff told us the dining room had been redecorated and a detailed programme of refurbishment was planned for people's rooms. One member of staff told us in time, it was expected that all areas of the home would be redecorated. Another member of staff told us a bathroom and the room where people's medicines were stored, had been refurbished. This had included new flooring, the installation of a hand wash basin and redecoration.

The manager and senior managers were visible throughout the inspection and consistently seen talking to people and staff. Staff confirmed this was usual practice. They said the manager regularly "worked on the floor", knew people well and were able to suggest different strategies to help with any challenges they experienced. Whilst staff viewed this positively, there was some reliance on the manager. For example, one person's foot had slipped off of the footplate, on their wheelchair. Staff had not identified this but the manager immediately noticed and helped the person to become more comfortable. Another person had refused their lunch. The manager told staff to ensure they offered the person an alternative and report back what they had eaten. Within the "flash" meeting, the manager showed a direct approach. They informed staff of people who needed to see the GP or other health care professionals and what test results required follow up. Staff then agreed to complete such tasks.

There were many positive comments about the manager, senior managers and the changes they had implemented. One person told us "I wasn't happy when I first came but it has changed". A member of staff told us "they have changed the place beyond recognition. It's totally different and it's all down to them. It's so much better". Another member of staff said "we are now in a good place. We couldn't have done it without them. Their leadership has been strong and we now know where it was going wrong. They put the residents first all the time". Other comments were "things are very transparent now", "lessons have been learnt", "I have nothing but praise for the owners. They are lovely people, respectful and nice employers" and "care is 100% better. I have never known it this good". One member of staff told us "X [the manager] is very firm. He tells it as it is and kicked our backsides. It's what we needed. Some staff weren't doing their job but they are now". A health/social care professional told us senior management had been good at recognising what had gone wrong and what needed to change. Another healthcare professional told us "there has been a real culture change. They want to get it right and will ask for opinions and help, rather than believing everything is alright. There's no cover up. The change has been very refreshing". This view was evidenced during the inspection, as any issues brought to the manager or staff's attention, were immediately addressed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Documentation did not show those people who did not have the capacity to make certain decisions, were supported in line with the Mental Capacity Act 2005.