Yourcare Limited

Knowle House Nursing Home

Inspection report

Knowle House Nursing Home
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Ratings

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

Overall summary

Knowle House Nursing Home is registered to accommodate up to 33 people who require support with personal and nursing care. It specialises in providing support to older people. At the time of our visit there were 23 people living at the service. The service had 19 single rooms and eight shared rooms. Only one of the shared rooms was occupied by two people who had lived at the service for a number of years. Accommodation is provided across three floors with the first and second floors accessed via a shaft lift. There is level access throughout the building and grounds.

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 and associated Regulations about how the service is run. In this service the registered manager is also the registered person.

Summary of findings

We carried out an unannounced comprehensive inspection of Knowle House Nursing Home on the 8 September 2015. As part of this inspection we checked what action had been taken to address the breaches of legal requirements we had identified at our last inspection on 19 November 2014. After our last inspection, the provider wrote to us to say what they would do to meet legal requirements and sent us an action plan detailing how they intended to ensure they met the requirements of the law. At this inspection we found improvements had been made and sustained and all the breaches previously identified had been addressed.

Without exception the feedback about the management of the service and the improvements made was positive. The provider had employed a new registered manager who started work at the service at the beginning of January 2015 who had overseen the implementation of the provider's action plan and taken steps to ensure the improvements were embedded into everyday practice. One relative said, "There were huge problems in the past with the management continually changing. Now they've got a permanent manager who is brilliant and a deputy, which they needed, it's great. The manager has made a huge difference". Another relative said, "There have been big improvements in the management. I'm very impressed with the place and the care and attention given. Other people seem happy and contented too". A staff member said, "I think the manager is really good. They're so easy to talk to and will always listen". Another staff member told us, "The manager is really friendly but at the same time, really clear that the residents come first. You know where you stand". Staff felt management were supportive. They told us there was a positive and open culture and enjoyed coming to work.

Improvements had been made in relation to the arrangements in place for people to give their views on the service. People and their relatives were able to contribute to meetings and make suggestions concerning their welfare and future service provision. One person told us, "We have club meetings about what we've done, do we want to improve it and make it better or do we want to scrap it all together. The secretary takes the minutes and gives us a leaflet about it for us to think about." A relative told following our last inspection the provider had called a residents and relatives meeting at which the provider, "Invited questions about the inspection and asked for suggestions from people about improvements they could make which they took on board."

Action had been taken to improve the safe management of people's medicines. The arrangements in place for the ordering, storage and administration of people's medicines were safe and people received their medicines when they needed them. A visitor told us their relative had their medicines on time and said, "I visit regularly and know the tablets are always given on time. The patches are given right down to the minute."

Improvements had been made in relation to the protecting people against the risk of abuse. People and their visitors told us they felt safe and raised no concerns about their safety. Staff were aware of what constitutes abuse and had completed relevant training. The registered manager and staff had a good understanding of the protocols for making a safeguarding referral. Incidents that affected people's safety had been recorded and investigated. A relative told us, "I've never heard or seen anything going on that I needed to say anything about and I would have no reservations in doing so." A staff member said, "If someone was handling someone roughly, then I would go straight to the manager or to Social Services if I had to".

Improvements had been made to the safety and delivery of care people received. Risks had been appropriately identified and robustly addressed in relation to people's specific needs. For example assessments of people's risk of falls and developing pressure areas had taken place and strategies were in place to reduce these risk. There was constant monitoring and reassessment of risks which ensured that staff took actions to protect people for example we saw staff reminding people who needed to use walking frames to use them.

Improvement had been made in relation to planning people's care. People and their representatives had been involved in the development of care plans which were centred on the person and detailed their likes and dislikes and where known, their personal histories. People's needs and preferences were detailed such as whether they needed assistance to brush their hair and whether they liked to wear makeup and jewellery. A visitor told us they and their relative had been fully involved in compiling the care plan they said, "The care plan has

Summary of findings

been signed, sealed and delivered. That was one of the problems there had been, care plans were out of date. That is one of the things (registered managers name) did; make sure they were all redone and brought up to date."

Improvements had been made in relation to making sure lawful consent had been gained from people for their care and treatment. Mental capacity assessments had been completed in line with legal requirements. Where people lacked the mental capacity to make decisions the management and staff were guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We found that the registered manager understood when an application should be made and how to submit one. Deprivations of Liberty Safeguards (DoLS) authorisations were in place and care plans clearly identified if someone was subject to a DoLS.

Staffing levels had improved and were based on the individual needs of people. Staff were seen spending individual time with people and responding to call bells and requests for assistance quickly. A relative told us, "Whenever I visit, there are plenty of people around and they seem to have to time to talk to people". One staff member told us, "We're lucky I suppose. We have enough staff to cope and to spend time with the residents". Staff recruitment ensured staff were suitable to work at the service. Relevant identity and security checks had been completed before staff were deployed to work.

Staff training and support had improved. Staff had completed training that was relevant to their roles and which provided them with the skills they needed to meet people's needs. For example staff had completed training in the administration of medicines and supporting people living with dementia. One staff member told us, "I'd never done this type of work before so I did a lot of shadowing. I thought the induction was really good". Another staff member said, "I learned a lot from the induction. I felt quite confident afterwards". Staff received regular supervision where they could speak in confidence with their line manager about any concerns they may have and discuss their personal and professional development.

Improvements had been made to the quality assurance systems in place and internal audits the results of which were used to help drive improvements in the service. Accidents and incidents were recorded and the results analysed to identify and emerging themes and patterns, and action had been taken to reduce the risk of re-occurrence.

People's dignity and privacy was protected. For example we saw staff knocked on people's doors and waiting for a response before entering their rooms. Doors were shut when staff supported people with personal care and 'Do not disturb signs were hung on the door'. People were seen to be appropriately covered throughout hoisting procedures, and were referred to by their preferred term of address.

Staff knew people well and had formed strong bonds with them. One person said, "We get on well; I have a laugh with the girls." Another person said, "They are very lovely the girls so pleasant. They guide you and help you. A very happy bunch. Anyone can come in and have lunch with us if you want." A visitor told us, "I come in at all times of day and days of the week. They would never know when I might call in but many times when I've turned up there has been a carer holding mums hand or talking to her". They also said "They really did help me and mum to settle in. They built up her confidence bit by bit and eventually she started to come down (to the communal area) and now she's really settled here".

People were supported to make their own decisions and remain independent. One person told us, "I do things on my own and at my own speed, sometimes they chivvy me along but they don't interfere." A staff member told us, "I like to get people to make their own decisions if they can. For example, if someone doesn't want to do something, then it's up to them". Another staff member told us, "We have to remember it's their home. We won't go wrong if we remember that".

Visitors were welcomed and visiting times were not restricted. One visitor told us, "I really like the homeliness. They always ask me if I want a cup of tea or coffee. They keep me up to date when I visit or they ring me if anything has happened, they discuss everything with me. These girls are really caring".

Staff were kind and respectful when interacting with people giving them time and space to respond to questions, and were patient when people wanted to speak and struggled to say what they needed. People

Summary of findings

looked comfortable and they were supported to maintain their personal and physical appearance. For example, people were well dressed and groomed. People could bring their own furniture and personal belongings to help them feel at home. Thought had been given to the decoration of people's rooms and communal areas which had been decorated with wall paper which gave the rooms a domestic feel.

People enjoyed the meaningful activities provided. They liked the social aspect of activities and in particular when they took place in conservatory. One person told us, "The music's good, we sing together, I like that. The activities that (activity organisers name) does are really good. We can make suggestions and decide together what we want to do." A book of interest to the individual with a book mark stating, 'Please read this to (person's name) at every opportunity' had been placed in the room of each person who spent a lot of time in their room. There were raised beds in the garden to enable people who liked gardening to use and a vegetable plot where seedlings people had grown had been planted.

People had a choice of food at meal times and specialist diets were catered for. People who needed help to eat and drink were supported appropriately. People's weight was monitored and referrals were made for specialist health care support as needed. For example for Speech and Language Therapy and input from GP's.

People had been provided with a guide to the service and were aware of how to raise concerns and complaints and felt able to do so. Complaints received had been recorded and responded to appropriately in line with the provider's policy.

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 received their medicines safely and medicines were obtained, stored and disposed of appropriately.

There were sufficient numbers of staff on duty to keep people safe. Staff knew what action to take if they suspected abuse was taking place and the provider had systems in place to respond to concerns raised.

Recruitment systems ensured staff were suitable to work at the service.

Risks to people's safety were minimised and accident and incidents were recorded and responded to appropriately.

Good

Is the service effective?
The service was effective.

Staff supported people with their health care needs and associated services

and liaised with healthcare professionals as required.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people.

Staff understood and applied the requirements under the Mental Capacity Act (MCA) 2005 and their responsibilities with regard to Deprivation of Liberty Safeguards (DoLS).

Good

Is the service caring?
The service was caring.

People were supported to be as independent as possible by kind and caring staff.

People were treated with dignity and respect, encouraged to express their views and to be involved in decisions about their care.

Good

Is the service responsive?
The service was responsive.

People were supported to live the lifestyle of their choice and visitors were

welcomed into the service.

Personal centred plans provided staff with information about how to support people in a person-centred way. Staff were knowledgeable about people's support needs, interests and preferences and supported them to participate in activities that they enjoyed.

There were systems in place to respond to complaints.

Good

Summary of findings

Is the service well-led?

Good

The service was well led.

The registered manager and staff were fully aware of their responsibilities under legislation that came into force in April 2015.

Staff were supported by the registered manager. There was open communication within the staff team and staff felt comfortable raising concerns.

The registered manager monitored the quality of the service provided and regularly checked people were happy with the service they were receiving.

Knowle House Nursing Home

Detailed findings

Background to this inspection

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

We undertook an unannounced comprehensive inspection of Knowle House Nursing Home on the 8 September 2015. As part of this inspection we checked that improvements had been made as planned by the provider after our comprehensive inspection of the 19 November 2014 at which breaches of legal requirements were found.

After our last comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements. As part of the planning for this inspection we reviewed all the information we held about the service including notifications that had been sent.

The inspection team for this inspection was made up of two inspectors. During the inspection we spoke with eight people who use the service and four visiting relatives. We also spoke with five health care assistants, two nurses the registered manager, the secretary and a visiting health care professional.

We viewed five people's care files in detail and other care records such as fluid, observation, mattress checking, and people's turning checks. We also observed care being delivered. We looked at medicine administration records, five staff recruitment files, records of staff training, and records of when staff supervision and appraisals had taken place. We also looked at compliments and complaints records, accident and incident records, the services' quality assurance audits, minutes of staff meetings and resident and relatives meetings and records relating to activities.

Good

Is the service safe?

Our findings

At the last comprehensive inspection on the 19 November 2014 we identified people were at significant risk of not receiving safe care and the provider was not meeting the requirements of the law in a number of areas. At this inspection we found these issues had been addressed, the provider was meeting the requirements of the law.

Previously we found the provider had not made suitable arrangements to protect people from the risk of abuse. This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

At our last inspection we found people were not adequately protected from the risk of abuse because staff did not have a good understanding of how to recognise abuse and the providers own policies and procedures in relation to safeguarding people had not always been followed. At this inspection we found The provider had taken action to ensure that as far as and possible people were protected from the risk of abuse. This is because staff were now aware of what constitutes abuse and how to recognise the signs that abuse may be occurring. All staff had undertaken adult safeguarding training within the last year and were able to identify the correct safeguarding procedures should they suspect abuse. Staff told us that their line manager would be informed and that a referral to the local authorities Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "I would speak to a staff member if I thought they were treating someone badly and I would definitely tell the manager". Another staff member said, "If someone was handling someone roughly, then I would go straight to the manager or to Social Services if I had to". A relative told us, "I've never heard or seen anything going on that I needed to say anything about and I would have no reservations in doing so." Another visitor told us, "Some people are quite demanding but the girls are so patient not at all brusque, they just get on with it. I've never heard a raised voice from them".

The registered manager and staff had a good understanding of the protocols for making a safeguarding referral and had obtained a copy of the local guidance. They told us they had not had cause to make any safeguarding referrals since our last inspection, but had contacted the local authority to discuss with them some incidents that had occurred in the service. People and their visitors told us they felt safe and raised no concerns about their safety. They told us they felt they were able to speak to staff about any problems they had.

Previously we found the provider had not made suitable arrangements that ensured people were protected by the safe management, administration and recording of medicines. This was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

Improvements had been made in relation to the management of people's medicines and embedded into day to day practice. There were adequate stocks of people's medicines and the arrangements for the ordering and storage of medicines was safe. Medicines were administered from a trolley in which they were stored securely. When not in use the trolley was stored securely in a locked room. Medicine administration was recorded on individual Medicine Administration Record (MAR) charts. Each MAR chart had a photograph of the person it applied to, supporting staff such as agency staff who may not have been familiar with the person. Each person had their own dedicated blister pack of medicines with a small number of boxed medicines. The medicines recorded on the MAR charts matched that recorded on the dispensing blister packs.

People received their medicines when they needed them. Medicine administration was completed by registered nurses who were assessed as competent to do so. The nurses knew people well and were able to describe to us what individual's as and when needed medicines were for and when to administer them. Pain assessment guidance documents were available to assist staff in assessing when as and when needed pain relieving medicines should be administered. Each person had a body map to indicate where on a person's body to apply topical creams, for example topical creams applied to prevent incontinence rash. A robust system for auditing medicines and MAR

Good

Is the service safe?

charts had been introduced and the reason for any errors had been investigated. Staff responsible for errors had received additional training or support to help reduce the risk of re-occurrence. Reminder memorandums had been issued to nursing staff to ensure they each had received the information about changes in medication administration practice that had come about following our last inspection. A visitor told us their relative had their medicines on time and said, "I visit regularly and know the tablets are always given on time. The patches are given right down to the minute."

Previously we found the provider had not protected people against the risk of receiving unsafe or inappropriate care and treatment. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

Risks to people's safety had been assessed and planned for. Each person's care plan was supported by risk assessments which detailed the extent of the risk, when the risk might occur, and how to minimise the risk. For example a pressure ulcer risk assessment had been completed for people using the service. This assessment took account of risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. Additional risk assessments were added when needed such as, infection control, use of bed rails and wound charts. These allowed staff to assess the risks and then plan how to alleviate the risk for example ensuring that the correct mattress is made available to support pressure area care.

Steps had been taken to minimise risks to people wherever possible without restricting their freedom and to make sure the equipment people needed to keep them be safe was available and safe to use. Bedrails were in place for some people who had been identified as being at risk of falling from bed. These were checked daily to ensure they were safely adjusted and inflated mattresses were checked to ensure they were set at the correct pressure and functioning correctly. Some people walked with the support of a walking frame. Environmental risk assessments had been carried out and identified how a clutter free environment was to be managed to aid their mobility.

Staff ensured people with mobility and stability issues were safe when moving around the building. We saw care plans directed staff to ensure people who moved around the service had support equipment with them. We saw staff remind people to use their walking frames when they were seen without them, guiding them to the item. We saw people were assisted to the dining table at lunch time and provided with the equipment they needed to eat and drink safely and independently.

The provider had taken steps to make sure the environment and the equipment was safe for people. A personal evacuation plan was in place for each person in case of an emergency. Safety checks had been completed for the service's equipment which had also been serviced as needed. There was a secure door entry system in place to ensure unauthorised people did not gain entry to the service. Accident and incidents had been recorded and an analysis had taken place to help identify any emerging themes or trends. Where concerns had been identified action had been taken to minimise any re-occurrence.

Staff demonstrated they had the skills they needed to use a hoist to lift and transfer people safely and understood some people felt anxious when being transferred in this way. We observed two members of staff supporting people to move from a chair to a wheel chair using a hoisting procedure. We saw staff calm the person reassuring them they would be ok throughout the procedure. We saw staff ensured this person was safe during the lift and the person responded positively to the reassurances from staff.

Appropriate checks were undertaken before staff began work. Relevant identity and security checks had been completed to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation, including character references, records of professional registration with the Nursing and Midwifery Council and Home Office Indefinite Leave to Remain certificates in staff files.

There were sufficient numbers of staff on duty to meet people's assessed needs. When asked if people thought there were enough staff on duty one person said, "Yes, definitely. I don't have to wait for anything". A relative told us, "Whenever I visit, there are plenty of people around and they seem to have to time to talk to people". One staff member told us, "We're lucky I suppose. We have enough staff to cope and to spend time with the residents". Another staff member said, "We have extra staff so if one person

Good

Is the service safe?

rings in sick at very short notice we can manage until a replacement is found. We don't tend to use agency staff". Our observations on the day confirmed this. The registered manager had used a formal assessment to assess each person's care needs which were re-assessed monthly and changes noted. Staffing levels were calculated in the light of this to ensure there were enough staff to deliver safe and appropriate care. People and their visitors told us they felt there were enough staff to meet people's needs. People had call bells in their room which they could use to alert staff to the fact they needed assistance.

Good

Is the service effective?

Our findings

At the last comprehensive inspection on the 19 November 2014 we identified the provider was not meeting the requirements of the law in a number of areas. We had concerns that the care people were receiving was not effective. At this inspection we found these issues had been addressed. The provider was now meeting the requirements of the law and good practices had been embedded into every day are.

Previously we found the provider had not made suitable arrangements that ensured people's rights to make decisions were fully protected were protected. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements made had been sustained.

Staff had received training on the Mental Capacity Act (MCA) and applied this training when working with people. There was information available for staff regarding assessing and detailing people's capacity to make decisions and give consent .Legal documents were in place to ensure the next of kin had the legal authority to make decisions on people's behalf. People's capacity to make decisions had been completed when needed. Consent had been sought by the people and relatives who had been appointed as their Lasting Power of Attorney (LPoA). An LPoA is someone who has been appointed by a person to make certain decisions on their behalf when they reach a point where they are no longer able to make decisions for themselves. A record of the involvement of the LPoA was in place.

Staff demonstrated they had an understanding of the MCA including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They described to us circumstances in which a best interest decision should be made. People told us staff always asked for their consent when supporting them and one person said, "If I don't want to do something, that's it. They never push me". We saw staff asking people for their consent throughout the day before delivering care. For example, we saw staff moving one person with a hoist, they explained what they were going to do and checked that the person understood and agreed to the process before they began. They provided re assurance to them throughout the procedure checking with them they remained happy with what was happening.

The Care Quality Commission (CQC) has a duty to monitor activity under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the Mental Capacity Act (2005). The purpose of DoLS is to ensure that a person who lacks the capacity to make their own decisions and, in this case, lives in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. The registered manager had a good understanding of DoLS and staff described to us the implications of this for the people they were supporting. People living at the service were being deprived of their liberty by way of locked doors, being under constant supervision and some people by way of the use of bed rails. Care plans indicated whether or not people had the capacity to consent to these restrictions and applications had been made for DoLS where applicable. One staff member told us, "We have a few people waiting for assessment. I think people are assessed because depriving people of their liberty is a last resort". Another staff member told us, "We do have some people here who can't make the big decisions for themselves. But that doesn't mean we take over. They can still decide some things and we try to encourage that".

We saw documents regarding people's decisions about whether or not they wanted to be resuscitated in the event of needing cardiopulmonary resuscitation (CPR). CPR is a lifesaving technique used in many emergencies, including heart attack, in which someone's breathing or heartbeat has stopped. Written consent had been sought and obtained in relation to the delivery of care. We also noted care plans contained mental capacity assessments, records of 'best interests' meetings and requests for DoLS authorisation, where appropriate.

Previously we found people were at risk because staff had not received appropriate training and support to ensure they had the skills to meet people's needs. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which

Good

Is the service effective?

corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements had been sustained.

Improvements had been made in relation to the support staff received. Staff received the training, supervision and appraisals they needed to make sure they obtained and maintained the skills they needed to undertake their roles. People told us they felt the staff were trained to be able to take care of their needs and staff told us they received training which enabled them to carry out their job role. One visitor told us, "I think it's brilliant here, I've never had a problem with the care in this home". They went on to say, "The manager has been able to set more training courses for the staff and better supervision".

On commencing employment, all staff now underwent a two week formal induction period. This process was structured around allowing staff to familiarise themselves with the practice's policies, protocols and working practices. Staff 'shadowed' more experienced staff until such time as they were confident to work alone. Staff told us they felt they were working in a safe environment during this time and felt well supported. One staff member told us, "I'd never done this type of work before so I did a lot of shadowing. I thought the induction was really good". Another staff member said, "I learned a lot from the induction. I felt quite confident afterwards". The provider also required all new care staff to complete the Care Certificate which is a nationally recognised qualification that provides staff with the competencies they need to undertake their role.

Staff were able to access training in subjects relevant to the care needs of the people they were supporting. Staff we spoke with were satisfied with the training opportunities on offer. One staff member said, "There is so much training here. It never stops". Another staff member told us, "The manager thinks training is very important. I don't think other places offer as much". Nursing staff training included medication management, equality and diversity, end of life care and wound care management.

Staff were now appropriately supported. Supervision sessions had been undertaken with all staff and annual staff appraisals had now been undertaken regularly or planned. Staff were happy with the supervision and appraisal process. One staff member said, "The manager is really keen on it. I like it as I can say what's on my mind and talk about things like training". Another staff member told us, "We have staff meetings but I prefer to talk about things in supervision. It's much easier for me". All of the staff members we spoke with felt well supported in their roles day-to-day and felt able to approach the manager with issues at any time. Staff meetings were held at which staff were able to contribute to the meeting and to make suggestions of importance to them.

People's health care needs were met and care and treatment was delivered in line with their preferences and care plan. Each person's weight was monitored monthly and more often if they had been identified as at risk of malnutrition. People who spent the majority of their day in bed were monitored by staff some required hourly checks, changing of position, barrier creams applied to prevent rashes and pressure ulcers. Staff were observed carrying out these checks, explaining the process to the person and completing records to ensure the care plan had been followed correctly.

Changes to people's care needs and condition had been documented and monitored. For example daily records were completed for day and night shifts, and provided a satisfactory account of how people's needs had been met. They detailed the assistance people had been given with personal care; if the person had eaten and drank sufficiently; what their mood was like; and if they had taken part in any social activities.

People's health care needs had been identified and met. Staff were aware of people's health needs and called in the GP and other health professionals as required. Referrals had been made to people such as dieticians, speech and language therapists, and physiotherapists and their recommendations had been included in the care plans. There was good communication in the management of people's care between the provider and external professionals such as GPs and community nurses. A visiting health professional confirmed that staff referred people to their service appropriately and followed any advice and guidance they had. A visitor told us, "They (the staff) made sure they got speech therapy input and kept me completely in the loop about everything. Any little thing and they are straight on it".

People were supported to eat and drink sufficient quantities. Most people were able to eat and drink independently. Nutritional risk assessments were

Good

Is the service effective?

supported by individual care plans identifying if the person needed help or encouragement to eat and drink or required a pureed or soft textured diet. Where concerns had been identified about a person's weight, nutrition, diet or swallowing difficulties a referral had been made to the relevant health care professional. Any advice they had given had been documented and was being followed. For example some people required a soft textured diet or their drinks to be thickened. One staff member told us, "We have good communication with kitchen staff. If there's any change in people's diets we will let them know". Another staff member said, "The chef is always trying new things and I know he talks to the residents a lot".

A choice of home cooked food was available at each meal times. People told us and we saw they enjoyed the food and that they could always request something different it they did not want any of the choices on offer. Hot and cold drinks were available at regular intervals throughout the day and people could request additional drinks and snacks as they chose. People could choose for themselves where to eat. Some people ate at the dining tables in the conservatory whilst others less mobile had lunch in the sitting room or in their own rooms. We saw people who needed help to eat receiving support from staff at lunch time. A visitor told us their relative had never reported any problems with the food and that they were weighed regularly.

Good

Is the service caring?

Our findings

At the last comprehensive inspection on the 19 November 2014 we had concerns that some people had not been supported to express their views. We recommended the provider seek advice about supporting people to express their views and actively involve them in decisions about their care and treatment. At this inspection we found the registered manager had implemented good practice in relation to supporting people to express their views and involving them in decisions about their care and this practice had been embedded.

People and their relatives were involved in making decisions about things that mattered to them. People's care plans were individualised and had been written in consultation with the person and their relatives. This helped to ensure that staff had the guidance they needed to provide personalised care in a consistent way. Three people we spoke confirmed they regularly met with staff to go over their care plans. One visitor told us they and their relative had been fully involved in compiling the care plan they said, "The care plan has been signed, sealed and delivered. That was one of the problems there had been, care plans were out of date. That is one of the things (registered managers name) did, make sure they were all redone and brought up to date."

People were supported to make their own decisions and remain independent. One person told us, "I do things on my own and at my own speed, sometimes they chivvy me along but they don't interfere." A staff member told us, "I like to get people to make their own decisions if they can. For example, if someone doesn't want to do something, then it's up to them". Another staff member told us, "We have to remember it's their home. We won't go wrong if we remember that". A third staff member said, "I don't interfere if I think someone can do something for themselves". A visitor told us their relative who used a wheelchair was able to access all areas of the ground floor and garden independently and that they appreciated not having to ask for assistance or permission to do this.

All the relatives we spoke with told us they were happy with the service and care their family member received. They told us they were able to visit when they chose and staff were always friendly and kind to their family member when they saw them. Relatives told us they did not need to call in advance; they could arrive, sign in and carry out their visit. They told us whenever they visited staff were available to talk to if they needed to. One visitor told us, "I really like the homeliness. They always ask me if I want a cup of tea or coffee. They keep me up to date when I visit or they ring me if anything has happened, they discuss everything with me. These girls are really caring". Our observations confirmed visitors were able to come and go as they chose. We observed staff had formed positive relationships with relatives of people in the service recognising who they were and who they had come to visit.

Staff were caring toward people, and had formed a good relationship with them. One person said, "We get on well; if you need any jobs doing they do it straight away. I have a laugh with the girls." Another person said, "They are very lovely the girls so pleasant. They guide you and help you. A very happy bunch. Anyone can come in and have lunch with us if you want it". Two visitors told us they regularly visited and found their relatives to be well cared for and comfortable. One visitor told us, "I come in at all times of day and days of the week. They would never know when I might call in but many times when I've turned up there has been a carer holding mums hand or talking to her". They told us staff always kept them informed of how their relative had been feeling and said, "They always let me know if mum has been feeling sad". They told us their relative had stayed in their room all the time when they first moved into the service. They said, "They really did help me and mum to settle in. They built up her confidence bit by bit and eventually she started to come down and now she's really settled here".

Staff demonstrated respect for people's privacy and dignity. Our observations during our visit confirmed people's dignity and privacy were maintained, for example by adjusting people's clothing when being hoisted and ensuring doors closed when staff were delivering personal care. We saw that, 'Do not disturb' signs were hung on the outside of people's doors when personal care was being delivered to ensure people did not just walk in.

Staff demonstrated respect when delivering personal care to people. For example staff knocked on people's doors and waited for a response before entering and addressed people by their preferred name. We saw staff were kind and respectful when interacting with people treating people with dignity and communicating with people in a manner which was appropriate. They gave people time and space to respond to questions, and were patient when people

Good

Is the service caring?

wanted to speak and struggled to say what they needed for example when a person's medical condition had affected their speech. We observed they had formed strong bonds with people and were able to tell us about their history, their family, previous jobs they had held and their likes and dislikes. For example staff knew where people preferred to sit, how they liked their tea and coffee, and the pastimes they enjoyed. They were able to tell us how some people liked to sit in the quite area of the communal lounge to listen to calming music and how other people liked to reminisce about their working life or spend time looking at photographs of family and friends.

The atmosphere in the service was calm and relaxing. Throughout the day people were spending time as they chose in their bedrooms and the communal areas. Staff were regularly checking on people ensuring they were comfortable. We saw staff sitting and interacting with people and checking on their well-being. People looked comfortable and they were supported to maintain their personal and physical appearance. For example, people were dressed in accordance with their personalities and lifestyles including some people who liked to wear jewellery. People told us and showed us they had brought their own belongings, such as photographs and ornaments, to personalise their rooms and help them feel at home. Thought had been given to the decoration of people's rooms and communal areas which had been decorated with wall paper which gave the rooms a domestic feel. Two television aerial sockets were provided in each people's rooms so they had a choice of where they positioned their television and their bed.

Good

Is the service responsive?

Our findings

At the last comprehensive inspection on the 19 November 2014 we had concerns that the care people were receiving was not responsive and identified the provider was not meeting the requirements of the law in a number of areas. At this inspection we found these issues had been addressed and the provider was meeting the requirements of the law.

Previously we had found the planning of people' care and treatment was not person centred. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements made had been sustained.

Improvements had been made in relation to the assessments of people's needs and the planning of their care. These improvements were embedded in day to day practice. People's needs had been assessed before they moved into the service and person centred care plans had been developed to address individual needs. Person centred care plans provide staff with guidance on providing care that is responsive to individual personal preferences, needs and values. These plans detailed how a person should be supported and the rational for these directions. They included the activities of daily living such as communication, people's personal hygiene needs, continence, moving and mobility, nutrition and hydration, breathing, pain control, sleeping, medication and mental health needs. People who were incontinent had individualised care plans identifying their needs for example, how often they required assistance with personal hygiene and what topical creams were to be applied to help prevent incontinence rash. They included details about the support people required with personal hygiene care such as brushing their teeth, cleaning their dentures, brushing their hair, shaving, wearing spectacles and dressing. They provided guidance for staff to follow for how to deliver care to people in line with their preferences and prompted them to assess, plan, evaluate, record and review people's care as required.

Care plans were kept under review. Plans had been reviewed and updated on a monthly basis, involving professional support where required for example input from a physiotherapist or dietician and any changes to the care plan as a result of this review had been recorded. They had been reviewed monthly or more frequently if required so they were up to date.

People's care plans had been written and reviewed in consultation with the person and their relatives. People and their relatives confirmed they regularly met with staff to go over their care plans. They contained detailed information about people's personal histories, likes and dislikes. People's choices and preferences were also documented. The daily records showed that people's preferences were taken into account when people received care, for example, in their choices of food and drink.

Activities were provided every day of the week and were organised in line with people's personal preferences. They included a preferred activities plan identifying individual preferences for activities such as listening to the radio, reading the newspaper or talking to other people. Several people wished to continue with their faith and we saw that they were supported to do this. One person told us staff supported them to go to the local church and that they also enjoyed the in house activities provided by the activity organiser. The registered manager told us, that everybody was given a choice around activities and we saw a varied range of activities on offer for example singing, exercises, arts and crafts, gardening and films. We saw there was an old fashioned typewriter in the communal area. We were told it had been identified that some people had used this sort of machine in their previous job roles and it was for them to use or as a prompt for discussion. We saw there was a quiet area in the communal room with a flat screen television that was used to play relaxing music with pictures of relaxing scenes such as fish or a fire. It was also used to play videos of interest for people such as steam trains.

The activities co-ordinator recorded the activities that people attended and gained their feedback, to assist with planning future activities that were relevant and popular. People told us they liked the social aspect of activities and in particular when they took place in the conservatory that was also used by people as a place to meet and chat. One person told us, "The music's good, we sing together, I like that. The activities that (activity organisers name) does are really good. We can make suggestions and decide together what we want to do."

Good

Is the service responsive?

The staff ensured that people who remained in their rooms and may be at risk of social isolation were included in activities and received social interaction. We saw that staff spent one to one time in people's rooms. Each person, who spent all or a lot of their time in their own rooms, had a book of interest in their room with a book mark stating, 'Please read this to (person's name) at every opportunity'. The registered manager explained books were chosen by the person or based on what they know of the person's interests. There were raised beds in the garden to enable people who liked gardening to use and a vegetable plot where seedlings people had grown had been planted. There was also a frame from which frying pans were hung for people to bang as a sensory activity and a range of bird feeders. One visitor told us their relative had previously worked as a bird ringer and had a keen interest in birds. They told us they both enjoyed refilling the feeders and watching the birds that visited them.

People were satisfied with the availability of social opportunities and activities. One person told us, "Yes, a lot is happening here but you don't have to join in if you don't want to". A copy of the activities planner which outlined a variety of social events on offer was available in each person's room. The staff also had links with the wider community, such as local schools for inter-generational activities.

Previously we found the systems in place to obtain people's feedback on the service were ineffective. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider had followed their action plan, this breach had been addressed and the improvements made had been sustained.

People were now able to give their views on the service through various ways and these were acted upon. It was evident from the minutes of recently held residents' meetings that people and their relatives and representatives were able to contribute to meetings and make suggestions concerning their welfare and future service provision. The minutes contained a review of the action plan of the previous meeting to ensure that all items had been addressed. They also contained a plan to decide what action would be taken as a result of the current meeting, by when and by whom. One person told us, "We have club meetings about what we've done, do we want to improve it and make it better or do we want to scrap it all together. The secretary takes the minutes and gives us a leaflet about it for us to think about." A relative told us there were two or three relatives meetings a year which were well attended. They said following our last inspection the provider had called residents and relatives meeting at which the provider, "Invited questions about the inspection and asked for suggestions from people about improvements they could make which they took on board." For example in relation to the activities provided.

There were systems in place for people to raise complaints. The provider's complaints policy and procedure was available to people when they moved into the service and was on display in a communal area. People and their relatives told us they knew who they could speak to if they had any concerns and would feel confident they would be listened to. The complaints policy included clear guidelines on how and by when issues should be addressed. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. The complaints log showed that previous complaints had been investigated and the addressed to the person's satisfaction.

Good

Is the service well-led?

Our findings

At the last inspection on 19 November 2014 We identified the provider was not meeting the requirements of the law because they had breached the Health and Social Care Act 2008 (regulated Activities) Regulations 2010 in respect of the Regulation 10 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. This was because quality assurance audits had not effectively identified areas that needed to improve. For example shortfalls in care planning and risk assessments had not been identified and shortfalls in the management of medicines had not been picked up through medicines audits. In addition could not see how the results of the audits that had been completed were used to make improvements to the service. At this inspection we found the provider had made the improvements needed and the breach had been addressed and that the improvements were now embedded into every day practice.

Following our last inspection the provider sent us an action plan detailing the improvements they planned to make to ensure the service was fully meeting the requirements of the law. At this inspection we found the provider had followed their action plan and all the breaches identified at the last inspection had been addressed. The provider had employed a new registered manager at the beginning of January 2015 who had overseen the implementation of the provider's action plan and taken steps to ensure the improvements made were embedded into day to day practice. It was evident some of the improvements had been made immediately after the last inspection whilst others, such as the development of new care plans, had been implemented over several months. All the improvements made had been completed and sustained.

Systems of quality monitoring that were in place to identify, assess and manage risks to the health, safety and welfare of people were robust, as was other audit activity around areas such as health and safety, infection control, care plans, accidents and incidents. For example care plans were audited on a monthly basis. The audit monitored the completion of care records, evaluated the care delivered and monitored the completion of all supporting documentation such as food and fluid charts, daily bed rail checks, mattress checks, observation records, and people's daily plans. The feedback from the audit was delivered at staff meetings and at handover if appropriate allowing for continuous review of service user records and care delivered.

People and their visitors felt the service had improved and was well managed. One relative said, "There were huge problems in the past with the management continually changing. Now they've got a permanent manager who is brilliant and a deputy, which they needed, it's great. The manager has made a huge difference". Staff told us the registered manager was fair and approachable. Another relative said, "There have been big improvements in the management. I'm very impressed with the place, the care and attention given. Other people seem happy and contented too". A staff member said, "I think the manager is really good. They're so easy to talk to and will always listen". Another staff member told us, "The manager is really friendly but at the same time, really clear that the residents come first. You know where you stand". Staff meetings were held and the meeting minutes reflected information and updates had been passed onto staff as required. We noted that some of the staff that usually worked nights had attended staff meetings and we were told that copies of the minutes were made available to staff that had not attended the meeting to read.

It was evident from conversations with the registered manager they were aware of the full extent of the Care Act regulations and their responsibilities within the Act which came into force in April 2015. The registered manager explained they had obtained the CQC's publication 'Guidance for providers on how to meet the regulations' and had passed information about the changes to their staff team. For example, staff had been informed about the Duty of Candour regulation that had come into force in April 2015 and the new responsibilities that came with that.

Staff told us they thought the service was well managed and the registered manager was a visible presence. We were told they were approachable and would always have time to talk to staff. One staff member said, "I can always go to them (the registered manager) if I need anything". People also recognised the manager as being in charge of the service and had confidence the manager would listen to their concerns. The registered manager knew people well. For example they knew the name of people and their relatives and could describe to us their care needs, likes and dislikes.

Good

Is the service well-led?

All staff spoken to confirmed that they enjoyed coming to work, that senior staff and management were supportive. They were aware of the concerns that had been noted at our last inspection and reported to us a lot of changes had been made since then. They all told us there was a positive and open culture and were happy with their working arrangements.