Integrated Nursing Homes Limited

Holmwood House Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The service was last inspected on 7 December 2015 and was rated good overall. We carried out this unannounced, comprehensive inspection on 25 January and 31 January 2018 and have rated the service requires improvement in Safe and Well Led and good in all other areas.

Holmwood House Care Centre is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided. The care home accommodates up to 59 people in one adapted building and was full at the time of this inspection. The three double rooms had been converted into single rooms. Most of the home is on one level; however, there are 6 bedrooms on the first floor in the main house accessible by a dedicated lift"   for residential and nursing, the other predominantly for people living with dementia. The home was on the outskirts of the market town of Swaffham and had a dominant position in the town with far reaching views across the garden. There was ample parking.

The service has a registered manager who is a registered nurse. There was also a deputy manager and a registered nurse working on each floor. 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.

Our overall finding for this service was positive but we did identify a number of areas for concern, which constituted a breach of Regulation 17 Good Governance. We have rated the key question for safe and well led as requires improvement because we found records did not always tell us what people's current needs were. Records were not always updated in a timely way when people's needs changed. The service was not always proactive in reviewing its records of accidents, incidents or hospital admissions to assess if they had taken all the action they could to lower or mitigate risks. We therefore could not see how lessons were learnt to improve people's safety and in ensuring good outcomes for people. There was a lack of management oversight for these areas although we saw the manager worked very hard and was a good organiser and communicator.

There were enough staff to provide timely care to people using the service and most of the staff had been at the service a long time. This meant they were familiar with people's needs and offered continuity of care. Staff had the necessary skills and told us they were well-supported and provided with lots of training opportunities. The service had a robust recruitment process, which helped to ensure that only suitable staff were employed.

Risks to people's safety were mostly mitigated. The environment was fit for purpose and free from hazards. Some people were identified as high risk of falls. This was clearly documented and actions had been taken to reduce the risks such as regularly monitoring people. The service ensured people had the right equipment and some beds were on a low setting with bedrails and, or crash mats. The service where possible

monitored and reduced risk and there were enough staff to keep people safe. However, record keeping in this area could be improved upon particularly in regards to how the service learnt from events and incidents.

People were supported to eat and drink enough for their needs. Where risks of dehydration or unplanned weight loss were identified there was some additional monitoring of people's needs. Food and fluid charts seen did not give enough information to be of any real value. For example, where people were on supplements these were not included on the charts and they did not always show quantities consumed or if snacks had been offered. We saw in practice this did happen but not recorded.

People received their medicines as intended by staff that were suitably trained. There were audits in place to help identify if people had received their medicines as required although we identified one error not picked up by the audit. .

The CQC is required to monitor the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) and report on what we find. We found people's rights were being upheld and staff supported people lawfully and in line with legislation around mental capacity and deprivation of liberties. Records keeping in this area could be improved.

Staff understood what constituted abuse and what actions they should take to safeguard people. They were confident in raising concerns and the registered manager made themselves available and was responsive to people's concerns or that of their friends and relatives.

The environment was appropriate to need and was maintained to a high standard. The environment was stimulating and designed in consideration of people's needs. There was access to outside space and sufficient private and communal space. Visitors were made welcome and could meet with their relatives in private.

Staff kept up to date with best practice and worked across the service to help ensure people received a seamless service. Staff worked in conjunction with other services and sought advice from other professionals as required. People's health was promoted and we saw staff had the necessary understanding and skills in relation to people's needs.

Staff were observed treating people well and with respect. Staff demonstrated patience and kindness and enhanced people's well –being through frequent and positive interactions. People were supported to live well and stay independent. Where people could, they were encouraged to join in different activities and socialise with others to reduce social isolation.

People were consulted about their care needs and relatives felt involved with the planning and reviewing of their family member's needs.

Care plans were not concise and did not always include relevant information or accurately demonstrate how a person's needs or risks were managed. However, staff knew people's needs well and provided good standards of care. Activities were organised around people's individual needs and were both spontaneous and planned ahead to help ensure people remained active.

Complaints and feedback about the service was acted upon and the service was responsive to issues raised.

The service had an established, experienced registered manager who staff held in high regard. The service

was for most part well planned and feedback received was positive. Risks were mostly mitigated but records were not as robust as they could be.

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.

Risks associated with people's care were mostly well documented but this was not always the case. Record keeping required improvement and an analysis of risk would help the service identify lessons learnt.

There was enough staff to deliver safe, effective care.

Recruitment processes were robust which helped ensure only suitable staff were employed.

Medicines were administered as intended by staff that were sufficiently trained.

Staff had a good understanding of safeguarding and knew how to recognise abuse and actions they should take if they suspected a person to be at risk of abuse.

Is the service effective?

Good

The service was effective.

Staff had the necessary skills and competencies to deliver safe care.

Staff understood the principles of the Mental Capacity Act 2015. People were consulted about their care and where unable to give consent. Staff followed the correct processes to support people lawfully.

People were supported to eat and drink sufficient to their needs. Food and fluid records were kept where a risk had been identified but these did not always reflect accurately people's intake.

People's health care needs were clearly documented and met by nursing staff in the home and other health care professionals.

The environment was conducive to people's needs and was not unduly restrictive.

Is the service caring?

Good

The service was caring.

Care staff were observed to be kind and attentive to people's individual needs.

Staff respected people and facilitated their independence.

People had opportunities to engage in different tasks and activities of daily living. People were involved in their care.

Is the service responsive?

Good

The service was responsive.

Care plans described people's needs well. However, we found a lot of information not relevant to people's needs. It was difficult to establish how staff supporting people would use the care plan to inform them of the persons care needs. The registered manager addressed this immediately.

The service provided suitable activities for people and tried hard to enhance people's well- being and encourage friendships and engagement.

The service took account of feedback from people in how the service was managed and their views on the care provided.

Is the service well-led?

Requires Improvement

The service was not always well led.

Record keeping was not always adequate. The analysis of risks in relation to accidents and incidents was not always clear in terms of lessons learnt.

The registered manager was experienced, knowledgeable and supported staff well.

The service took into account people's experiences and this helped in terms of planning and shaping the service.

Care Quality Commission

Holmwood House Care Centre

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 carried out this inspection over two dates: 25 January and 31 January 2018. The first date was unannounced but we arranged with the registered manager to come back on a second day to finish the inspection. On the first day of our inspection, we had an expert by experience and a specialist advisor with us. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a trained nurse.

Before the inspection, we reviewed information already held about this service including the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider. We also reviewed the statutory notifications we had received which relate to events that have happened in the service that the provider is required to tell us about by law. Information that had been sent to us by other agencies was also reviewed. We spoke with the Local Authority and the Clinical Commissioning Group who had no concerns with the service.

We spoke with the registered manager, the cook, the domestic, the laundry assistant, the activity coordinator, three registered nurses, a senior carer, three care staff, maintenance staff and the activities co-ordinator. We spoke with fifteen people using the service and spoke with six relatives. We spoke to two district nurses and a mental health nurse.

We observed the medicines round, made observations of care, looked at four care plans, medication records, staff records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

The last inspection of this service was carried out on 7 December 2015 and the home was rated as good in this key question.

At our inspection carried out on 25 and 31 January 2018, we found risks were mitigated as far as reasonably possible. The service had a clinical risk register, which was regularly updated and highlighted any immediate risks to people's health and safety and for those who were vulnerable and needed close monitoring or nursing intervention. However we found it did not include information about people who might be at increased risk of constipation and who needed close monitoring. Bowel monitoring records contained gaps of more than a few days for one person we case tracked and we could not see how this was monitored.

We did during this inspection have concerns about the accuracy and relevance of some care records. Care plans did not always contain up to date and relevant information, which could increase the risk of people receiving the wrong care. There were records of incidents/accidents and hospital admissions but the records did not always include a detailed analysis about what had occurred and if this could have been avoided. We raised a number of issues with the registered manager, which they dealt with straight away and sought to change practices within the service to ensure improvements in record keeping were made. They also completed a detailed root cause analysis for a person who had developed a pressure ulcer and had spent time in hospital for a possible avoidable condition. The analysis was robust and showed lessons learnt. We had considered whether this amounted to avoidable harm but there were other mitigating factors we took into consideration. .

The relatives we spoke with told us they were happy with how the service managed the risks associated with their family members. We saw for those service users who had been identified as at risk of falls, the service had mitigated this by ensuring appropriate equipment was in place and healthcare professionals involved.

We noted one person had a bruised face following a fall and they were able to recall how it happened. The service had a 72-hour record which demonstrated how they provided additional monitoring and observation to a person following an accident/injury. Nurses said following a fall, they would check the person and would often seek a second opinion.

People had manual handling risk assessments in place, which documented what equipment was necessary to support people. However, we noted these did not include all the information we might expect to see such as the weight of the person, which is important when assessing sling size and individual mattress settings. People's weights were regularly monitored and static. Staff had a good understanding of people's needs and where to find information in relation to their weights.

Individual fire risk assessments were in place documenting what support people might require in the event of a fire evacuation or other given emergency. Hospital passports were in place to help ensure people received continuity of care should they require a stay in hospital.

The registered manager had an oversight of risk and kept records in relation to accidents and incidents and showed how they reviewed this to ensure actions taken were appropriate. When necessary information was used to update the risk register.

The service ensured equipment was safe to use and had their own maintenance staff. Audits were completed regularly and we looked at a sample of records in relation to fire safety, equipment checks and the identification and reduction of environmental risks, for example, regular water checks to help ensure temperatures from the taps were appropriate.

Staff confirmed they had received regular training to help them identify what might constitute abuse and what actions they should take to protect people from potential harm or actual abuse. Staff gave the scenario of conflicts, which could arise between people sometimes resulting in a physical altercation. Staff were confident about reporting concerns both internally and externally if they felt they needed to. Staff referred to adult protection policies and knew where to find them. Some of the nursing staff were less clear about duty of candour: reporting on when things go wrong and apologising for errors.

The registered manager told us they liaised with the Local Authority safeguarding team and investigated when advised to. The manager said they rarely received feedback from the safeguarding team so felt this was because all the actions they could take had been.

We did not identify any concerns with the cleanliness of the service. There were adequate numbers of domestic staff employed. We spoke with them and they were knowledgeable about their role and had received adequate training and told us about infection control procedures. They told us about a person who had developed influenza. They explained the procedures put in place to ensure infection was not spread and they said they managed to contain the infection. There were isolated odours in one area of the home but the registered manager was able to tell us how they were addressing this. Domestic staff told us how often they regularly deep cleaned the environment. The domestic staff told us how they worked as a team and their work was checked by the cleaning supervisor who they described as supportive.

During our inspection, we found the home to be well staffed with clear lines of responsibility for the different parts of the service i.e. care, domestic and catering support. Staff worked effectively together and there was good teamwork. Allocation sheets showed which staff were responsible for whose care and this meant there were clear lines of accountability. The registered manager told us there were no full time vacancies in the care team and they had a full complement of nursing staff. Agency staff were rarely used which meant people got continuity of care. Separate activity staff were employed and they were observed supporting care staff and ensuring people's well- being. The home had student nurses and student doctors on placement. On the first day of our inspection there were two student nurses working under the supervision of the nurse. They helped ensure people had the care that they needed.

Relatives spoken with mostly felt staffing was adequate and they were happy that people had continuity of care. They said they saw regular staff and were happy with the care delivered.

The registered manager told us that they had introduced a twilight shift between the hours of 6pm and 10pm as this was often a busy time. The registered manager said a staff member had recently left and they were trying to recruit to this post. We viewed the staffing rotas, which showed adequate planning for the service. The registered manager used a dependency tool to help them determine how many staff they needed based on the levels of dependency within the home. This included direct care hours and non- direct care hours, such as providing activities.

We saw staff administering medication safely and in line with good guidance. They explained to people what medicines they were administering and ensured people had taken it before signing to say it had been administered. One person was clearly in discomfort and was offered and given pain relief in a timely and considerate manner.

Medication audits helped to identify if medicines were available as required and administered as prescribed. We saw both an external audit completed by the supplying pharmacist and the homes monthly audit. A sample of medication records were looked at each month. No errors had been identified. However when we reviewed the incident record we did see a medication error which had occurred.

Training and supervision of new staff to carry out medication administration was in place. Only after staff had completed their training and signed off as competent were they able to administer medication. The nurse said both nurses and senior carers could administer the drugs and they were observed at least three times or as long as was necessary. They said training was updated annually.

The District Nurses visited the home to assess care staff for competency when the home had residential service users requiring Insulin or Clexane. This was carried out prior to any administration of the injections.

Recruitment processes were good and helped ensure only suitable staff were employed. We looked at a number of records and saw staff files were well organised. Staff files provided evidence of the date staff were appointed. Records demonstrated that appropriate checks were carried out. This helped to assess the staffs competency and suitability for the role such as completed application form, references, proof of identification and their address. Disclosure and barring checks were completed to ensure they had not committed an offence, which might make them unsuitable to work in care.

Good

Is the service effective?

Our findings

The last inspection of this service was carried out 7 December 2015 and the home was rated as good in this key question.

At our inspection carried out on 25 and 31 January 2018 we found staff supervision and annual appraisal were planned for the year and staff reported being very well supported by the registered manager and senior staff. Staff told us they received regular supervision and an annual appraisal of their performance. Surveys were completed each year, which included collating the views of the staff to see if any improvements were necessary and feedback about what was working well.

Nurses told us they were given time to keep up to date with their clinical practice and continuous professional development. They said the registered manager was supportive and they had regular one to one supervision and group supervision. Staff told us how reasonable adjustments were made to workloads following staff illness.

Staff had relevant training for their role and some staff had enhanced training for their specific areas of interest. Staff said they could request additional training depending on people's needs. The activities coordinator said they had done some autism training as some people had autism traits. They also said some of the strategies used with people with autism were effective for those living with dementia particularly around sensory issues. Another staff member told us they had done training around diabetes, insulin administration, end of life care, dignity and respect.

Staff supporting people living with dementia had a good understanding of how dementia might affect people. Staff had completed dementia training and there were dementia coaches who were staff who had done enhanced training so they could support other staff.

The registered manager had developed a training matrix so all staff training could be seen at a glance. Training was up to date with refresher training planned to ensure staff knowledge was up to date. The registered manager had a good oversight of the service and the training needs of their staff.

Staff records provided us evidence of how staff were supported when initially starting work. Staff completed the care certificate, which is a nationally recognised induction for staff working in adult social care and covers all the care components. Staff shadowed more experienced staff until they felt confident.

People's dietary and hydration needs were adequately met. People were complimentary about the food and said their individual needs were catered for. For example, one person told us, "They know I like a curry and always make sure that I get one when I want one". Another person had the same meal option on set days at their request. Another person with a very rigid diet had their own set menu.

The cook told us how they were always trying to come up with new initiatives and improve practices. They had come up with the idea of snack stations to try to stimulate people's appetites. They had a list of

people's preferences and dietary requirements and took into account people's cultural needs. The cook and the registered manager had developed an allergy folder. They had contacted food manufacturers and had developed a list of potential allergens.

We saw the snack stations and people helping themselves. In addition, people were offered sweets they could purchase. One relative told us their family member had lost some weight, and was reluctant to eat. They told us staff offered snacks and finger foods. We saw one person who had a selection of snacks rather than a main meal, which staff said they responded better to. Staff said they recorded where people had not eaten so something could be offered later in the day. Staff said when a person first moved in they were continuously assessed for the first 3 days and their food and fluid intake monitored. Staff said after 3 days they would know the person better and understand what their dietary needs were.

We observed lunch on both units. In the dementia unit, it was nice to see most people eating lunch together in a separate dining room. However, there was limited space for them to do so and at least one care staff did not have a chair to sit on when they were supporting a person. In addition, the room was a little crowded with walking frames and sticks which could have been a hazard. When people wanted to leave, they had to wait for other people to be assisted out of the way. Some people ate in the lounge. The support people received was appropriate to their needs and people were given a lot of encouragement when required. The dining room experience was relaxed and people were able to socialise with others and staff. There was a nice atmosphere and gentle music playing. Food was presented nicely and looked appetising. People were offered appropriate food choices and the cook who served peoples meals was aware of people's preferences. We saw that during the meal, one person asked for the toilet and that staff assisted them immediately.

We viewed a number of food and fluid records kept for those at risk of unplanned weight loss and/or dehydration. They showed people received a good intake of fluids but not an adequate record of what people were eating had been kept. Records did not include supplements people were taking or snacks they were offered. A more detailed record would be helpful in terms of analysing what people were having. However, we were assured that people's weight loss was being identified and prescribed supplements were recorded on people's MAR sheets and signed when given..

Accommodation was designed around people's needs. There were two separate units and a number of bedrooms upstairs with lift access. One unit, the Woodlands suite, was predominantly for people living with dementia. This was all on one level and corridors had handrails, which we saw people using. Communal lounges were spacious and people had chairs arranged in a way to encourage socialisation. People had access to a kitchenette so they could help themselves to food and drink. The unit had memory boxes for people and their bedrooms were personalised. There were pictures/ names to help people identify their own room and the home was logically laid out. There was signage to show different areas of the home and help with orientation.

There was lots of information around the service to inform people and their relatives what was going on. For example dates of relative meetings, forthcoming events and information about the service. The service was secure with no obvious hazards. It was surrounded by extensive grounds and gardens laid to lawn. From the day room in the Woodland suite, there were panoramic views. Staff reported regular sighting of wildlife including deer. The ground floor was accessible with good wheel chair and hoist access. We were able to confirm that the home had enough hoists and these were situated in different parts of the service.

Staff said there was a good relationship between them and other health care professionals. They said the GP practices were responsive and their first point of call was the GP matron. The service accommodated people

who were funded for residential or nursing care. The registered manager said that there were sometimes delays in assessing people whose needs had changed from residential to nursing care. Whilst people did not receive gaps in provision this put a strain on the nursing staff in the home who were potentially overseeing the needs of people who had not yet been assessed as needing nursing care. The district nurses were expected to respond to the needs of people receiving a residential service but this was not always clear-cut.

A concern was raised to us by a person using the service about the supply of continence pads commissioned by the NHS. They said only a limited number of continence pads were made available. We raised this with the registered manager so they could ask for a new continence assessment to be completed.

A relative told us that their family member came from another home. They said on admission they had ulcerated legs. They said since being here their health had improved considerably.

Daily notes indicated people saw health care professionals as required including the dentist and the optician. Care plans included details about maintaining good oral health and any sensory impairment a person might have and what, if anything, was in place such as if a person wore glasses or hearing aids.

We met a number of health care professionals during our inspection. One had not been to the service before so where not able to comment. However, they said they found staff friendly and knowledgeable. We met another health care professional who had come to do an assessment and they were complimentary about the home, the staff, the levels of professionalism and the records, which they found informative.

Staff told us they were supported well by the mental health team and received training in dementia care but not necessarily how to deescalate difficult situations. The nurse told us they kept records on any negative behaviours and possible causes and how these had been managed. The nurse said the mental health team reviewed these and advised staff accordingly.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being meet and they were.

Mental capacity assessments were undertaken to establish if people had capacity to make specific decisions. Best interest checklists were in place but we could not always see the rationale for these or if a mental capacity, assessment had been completed first. Some forms did not include date and time. Details were recorded of people's next of kin or who else should be involved in decision making to help ensure decisions were taken in people's best interest. We saw family members were consulted as appropriate. Consent was sought for treatment such as flu jabs and support provided by staff such as medication administration. This meant people were consulted about their care.

Good

Is the service caring?

Our findings

The service was last inspected on 7 December 2015 and was rated good for this key question.

At our inspection carried out on 25 and 31 January 2018, people were complimentary about the service they received. One person told us, "I couldn't manage any longer. I was fearful knowing this would be my last destination." They told us the moment they walked through the door they, "Felt at home…completely at ease…I feel part of the family." They told us they were going for sherry and cake as part of a birthday celebration. A family of the relative whose birthday it was said, "They can have whatever they want to eat and drink on their birthday." A special meal was cooked for them and a celebration held.

Throughout the inspection, we saw staff relaxed and working effectively with people. There was a real sense of enjoyment and meaningful relationships between staff and people using the service. Relatives spoken with were complimentary about the service and there was a nice family atmosphere. Staff and people were laughing and joking with each other and there were a number of tender moments with staff giving people good eye contact and communicating effectively. Staff sang to people, which clearly enhanced their wellbeing.

We saw staff were patient in their approach and showed understanding of people's difficulties when articulating their needs. Staff were supportive of relatives and recognised when relatives left this could distress family members. Staff were supportive around this. People were treated with respect and dignity.

People were complimentary about the care they received and the staff that supported them. One person told us, "The care we get here is very good. Nothing is too much trouble and the staff are all very polite and respectful. I am able to do what I want when I want to and I can go out with my family when I want." Another person said, "The staff here are very caring and nothing is too much trouble for them. They are lovely and are always smiling. They are always polite and always use my first name. I would like to go out, but I don't know if I can." One relative told us, "The staff here are very caring. One in particular has really engaged my mother to come out of her shell. She has certainly turned around since coming here. The staff are all very kind and treat her as though she is one of their family. She got into doing things here, which is nice, and we can take her out."

Overwhelmingly the people we spoke with said staff were kind and responsive; however, two people spoken with by our expert by experience said staff could sometimes be a bit impatient but were not able to give specific examples. We saw no evidence of this on the day of inspection but it is something the registered manager needed to be aware of.

We saw call bells were answered quickly throughout the day. In one instance, the call bell took three minutes for the carer to respond. The carer was observed reassuring the person who was confused and distressed. The carer provided understanding and empathy and was able to reduce the person's anxiety.

All the staff spoken with reported on how well the staff got on and how well supported they felt. They all had

time regardless of their role for people using the service. They told us they got to know people and their families well particularly peoples past history.

The environment helped to support people's well- being with plenty of space and a clean, stimulating environment.

People and their families were consulted about the care provided. The registered manager said communication with relatives was frequent and they did try to encourage them to participate in the service. They gave an example of how a lecturer who had written a book came in and gave a presentation to relatives on dementia and its effects. They said this was well received and attended by relatives. One person told us they had no reason to complain and said every month or so received a questionnaire to see what they thought about the care. Relatives told us that staff kept them up to date with changes to their family member's needs and health. A relative said, "I can remember seeing a care plan when [relative] first came, but we have not really had a chance to update it. I will need to ask." People we spoke with referred to their needs but when asked about their care plans, said that their families dealt with those.

Good

Is the service responsive?

Our findings

The last inspection carried out at this service was on 7 December 2015 and the home was rated as good in this key question.

At our inspection carried out on 25 and 31 January 2018, we found the service was responsive to people's needs. This was demonstrated in a number of ways and included staffs observed responses to people's needs and the timeliness of them, the positive staff engagement at meal times and the support with activities and at other times of the day.

One person's relative described the home, as, "The Ritz" when compared to other homes. A relative told us, "When the family ask for something to be done, it's done".

Staff were able to describe in detail the needs of the people they were supporting and any relevant information about their likes and dislikes, their family and past occupation.

The environment accommodated people's individual needs. In the entrance of the home, there was a sweet shop. Throughout the day, we saw staff go round asking people if they wanted sweets. This was well received and sparked conversations about people's preferences and childhood. One person was unwell and staff were sitting with them and ensuring they were well, hydrated and warm enough. We saw interactions like this throughout the service.

Staff were responsive to people's needs. For example, one person said they were cold; staff responded immediately and got them a blanket. Another person said they were hungry and immediately offered some biscuits, other snacks were available. Staff acknowledged people regularly. One person was becoming quite anxious and repeatedly questioned staff. Staff never showed any frustration and constantly reassured the person and distracted them when appropriate to do so. We observed another person who was not able to understand what staff were asking them to do. Staff were very calm and patient supporting the person appropriately to help get them in a comfortable position.

Care records were accessible but held securely. Records were kept in different places and it was hard to track through. We also found records bulky and not all the information relevant to the person's current needs. This created some ambiguity. For example, records described one person as having a pressure ulcer but when checked with staff were assured this had healed. Records described the person, as needing both a normal and soft diet and it was clear reading their whole record that their needs had changed. However, we found staff were knowledgeable about people's needs. The registered manager responded to our concerns immediately and by the second day of our visit had already begun going through care records and archiving records, which were no longer necessary to keep. We also raised concern about poor monitoring of when people prone to constipation had their bowels open and this could carry significant risks. Again, the registered manager addressed this with the staff team to ensure staff were completing records contemporaneously and were aware of the risks associated with poor record keeping.

The home supported people for as long as possible and we saw evidence of end of life planning. This helped ensure people's wishes were known and upheld by staff. It also helped staff anticipate people's needs and plan accordingly. Some records were blank, but records did state that the person or their family did not wish to discuss end of life care. It was good that staff recorded it and said they would try to discuss later.

Some staff said they had received training in end of life care but nothing recently. Some had done e-learning courses and nurses had completed syringe driver training to help support people with their pain management. Staff told us how they supported families. Families were asked to contribute to developing memory boxes for their loved ones. They were asked for the person's life story so staff could support the person appropriately. Staff told us they liked to pay their last respects and attended funerals when they could. The registered manager said staffing would be looked at when considering if a person was approaching end of life to ensure staff were available to sit with them.

People received sufficient activity. One person said, "The activities are really good here and they are always looking for things to keep them stimulated". Another said, "I like the mix of residents here and we get on well. I have had a trip out to a farm which was really nice." One family member said about their mother, "They have really come out of their shell since being here." On the day of our inspection a person was celebrating their 93rd birthday and seen to be eating a vegetable curry which they had requested. The birthday cake made by the cook was a surprise for them and beautifully decorated.

We spoke with a relative who told us they were a regular visitor to the service and they had never encountered any problems. They said, "Everyone has been so nice. They are looked after well." There was a hairdressing salon and the hairdresser visited twice a week. People looked nicely dressed and cared for.

The home had an appointed activities coordinator who was observed as being skilled and accomplished at what they did. This was their fourth year and they had previously been a senior carer. They knew people well and were observed providing leadership and support to care staff and students and worked with confidence. They told us they were the manual handling trainer. They had also completed an enhanced dementia care course. They said they brought families together so they could support each other and share their experiences. They said they liaised with the schools and schoolchildren came in and read poetry and made forget me knots.

The activities coordinator was employed for 40 hours and helped in other roles as required. A second part time activities coordinator worked one day a week and every other Saturday. The care coordinators had not had any formal training in providing activities. However, the registered manager was trying to access appropriate training to support them. They were well supported by the registered manager but did not have regular contact with other activity coordinators who they could share ideas with.
People's records included details of the person's life before coming into a care setting including their family tree. This helped staff familiarise themselves with people's needs and support them in the way they would want to be supported.

There was a list of planned activities but these were provided flexibly according to people's needs and wishes. Many people responded better to one to one interaction and these were plentiful. We observed different interactions throughout the day including a balloon game, which people really enjoyed. A chocolate fountain and marshmallows was an activity provided that again people enjoyed. Short burst of activities were effective. In the lounges, we observed appropriate programmes being played and subtle music throughout the service. Activities were planned throughout the year and included outside entertainers, which needed to be booked in advance. Staff fundraised for different events and had plans to improve the service further such as developing the gardens with raised beds and a greenhouse. There was a

generous budget, which enabled staff to plan for parties and events for Christmas, Easter and birthdays. Trips were occasionally planned into town or to the local theatre or other local attractions. Regular organised activities such as knit and natter was popular.

The service had a clearly established complaints procedure, which was advertised around the service. The registered manager told us they acted on feedback about the service. In reality, the registered manager said they dealt with concerns relatives might have immediately so had very few formal complaints. There was a notice board, which had many compliment cards. Families confirmed communication within the home was very good and they were kept informed and involved in care reviews.

Requires Improvement

Is the service well-led?

Our findings

The last inspection to this service was carried out on 7 December 2015 and the home was rated as good in this key question.

At this inspection carried out on 25 and 31 January 2018, Throughout our inspection, we identified lots of positive care. We did however identify concerns with the record keeping in the service. Care plans were sufficiently detailed but did not always include up to date information about people's needs. Records dating back some years were still in people's records, which were no longer relevant and could lead to inappropriate care being given. For example where a person had changed from a normal diet to a soft diet. By the second day of our inspection, the registered manager had already started to address this.

When reviewing people's needs we found people's records were kept in at least three different folders and/or locations. Records were often disorganised and sometimes information was missing. This increased the risk of poor communication around meeting people's needs. Staff told us they recorded information contemporaneously but staff told us records were sometimes written at the end of the shift. This could increase the risk of poor care being provided. All the information was kept at the nurse's station and not in people's rooms where the care was being delivered. However we were told that care records could disappear if left in people's rooms,

We saw a person had been admitted to hospital with a potentially avoidable condition. There were concerns that the person was dehydrated. Records showed they had received adequate fluid up to the date of their admission to hospital. It is possible that between the time of them seeing the matron at home to being transferred to hospital they became dehydrated. However, other vital records such as bowel functioning was not clear prior to admission or discharge. We would of expected the registered manager to complete a detailed analysis in regards to this persons care to help identify if there were any omissions in care and to see how care practices might improve. Without adequate recording, it was not possible to see if the person got the care they should. By the second day of our inspection improvements in recording had been made and the registered manager had completed a detailed analysis which gave us confidence going forward.

The registered manager had showed us their clinical risk register, which looked at risks relating to nutrition/hydration, falls and developing pressure ulcers. It did not however include information about managing constipation. The registered manager said this information would now be added to ensure they were closely monitoring people.

Other incidents and accidents had not been fully investigated to help ensure staff responses were appropriate and to help establish if the accident/incident could have been avoided. For example, a person got their leg caught in a bedrail resulting in a large skin-tear. The maintenance person told us and showed us records of monthly bedrails checks. However, they were not aware of the incident. The record relating to this skin tear did not make it clear how it had happened or what actions were taken to prevent it happening again. Bedrails when in situ should not have gaps where people could become entrapped and should be

fitted with bumpers. There was no guidance in people's care plans about carrying out daily visual checks. Another incident involved a person taking a medicine alongside another medicine that were not compatible and could cause unwanted side effects. This was picked up by the community nurse but not until the person had been taking both medicines for a week. It is not possible to apportion blame; however, the incident record did not show any actions/investigations on part of the care home.

Audits completed were not always recorded. For example, the registered manager said they did spot checks on the night shift but this was not documented so we could not see what, if anything had been identified

These concerns constituted a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoken with said they were content with the service and this was supported by our observations on both days of our inspection. One person said, "I'm happy here. I have never needed to speak to the office, as the staff are so helpful." Another said, "On the rare occasion when I have had to speak to the office they have been helpful. I think the home is run well."

The registered manager had been at the service for eight years and was well liked and respected. Prior to coming into post, they had been the area manager. They were well supported by administration staff, a head of care, a clinical lead and nursing staff. There was also a head of cleaning services, a catering manager and separate activity staff. Staff told us the registered manager was approachable and visible. Staff said they walked round the home every day and knew what was going on. Their office was located by the main entrance and visitors were able to pop in to chat and raise anything they wanted. One staff member said, "The doors never closed."

We found there was a good atmosphere in the home and staff communicated effectively. The home ran well with people getting their needs met in a timely way with a calm atmosphere throughout. Some people at times became distressed particularly where people were living with dementia and unable to understand their situation or anticipate their needs. Staff were patient, kind, and supported people appropriately.

Relatives spoken with were happy about the home and knew the registered manager who they said was visible throughout the home. One relative seems surprised that there were relative meetings but these were displayed at the front entrance. It might help if they were displayed in both the individual units.

We identified some good staff practices and asked the registered manager how they identified and encouraged good practice across the service.
In 2014 the home was nominated in the category for "Best Activities" and came first in this category.In February 2018, the home was again nominated, this time for "Excellence in Delivering Dementia Care" and reached the final three in this category. Internal awards were not in place but they did have employee of the month. The registered manager said the employers did recognise staff's hard work and gave gifts at Christmas.

The registered manager told us they were supported by their team and there were staff employed to carry out checks on the service. For example, group health and safety officers visited each month to do an audit. This service had a number of homes and standardised auditing tools were in place. If concerns or good practice were identified in one home this could be addressed and shared across other homes. For example the registered manager said inspection findings would be shared across the group to see how improvements identified could be adopted. We looked at audits including regular call bell audits, equipment and infection control audits.

As part of the overall quality assurance, system people and their relative were involved in care plans updates every six months. Resident/ relative surveys were completed annually and results were wholly positive. There were regular resident /relative meetings and food surveys were completed six-monthly.

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 17 HSCA RA Regulations 2014 Good governance There was not always sufficient actions taken to review individuals risks to people's health and safety to help ensure risks were mitigated as far as reasonably possible and lessons were learnt from incidents, accidents and adverse events.