Care Quality Commission

Naseby Care Home Limited

Naseby Care Home

Inspection report

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Date of inspection visit: 6 & 7 January 2016
Date of publication: 18/03/2016

Ratings

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

Overall summary

The inspection took place on the 6 and 7 January 2016. The inspection was unannounced on the first day and announced on the second. The inspection was carried out by two inspectors. At the last inspection in August 2014 the service was not meeting the regulatory requirements for care and welfare of people and records. We found during this inspection that improvements had been made and the service was now meeting these requirements.

Naseby Care Home is registered to provide accommodation and personal care for up to 21 people. At the time of our inspection there were 18 older people living at the service, some of whom were living with a dementia. Accommodation is provided over the ground and first floor. The managers' office is located on the second floor. The first floor is accessed by a lift and stairs, the stairs continue up to the second floor. All of the bedrooms are single occupancy. Two rooms have an en-suite wash basin and toilet. Three rooms on the first floor are not accessible from the lift or suitable for a hoist. There are three shower rooms, two on the ground floor and one on the first floor. There is one bathroom. On the ground floor there is a lounge area which leads into a

Summary of findings

conservatory that is used as a dining room. There is a well equipped kitchen, laundry and sluice room. The service has a secure well maintained garden at the rear of the building which is accessed across a gravel parking area.

The service has 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.

We found that the service was not always safe. We found that medicines were not always administered safely. We found that on the morning of the 16 December staff had signed to say that five separate medicines had been given to one person. We checked the medicine supply and found they were still in the pack and had not been given. We found three opened bottles of eye drops. Each stated that they expired 28 days after opening. None had a recorded date for when the bottles were opened. All three had prescription dates over 28 days old. We looked at records for one person who had a prescription for medicines that needed to be given as required. We checked the medicine and amounts given corresponded with the medicines remaining. A medicine administration record sheet is kept in bedrooms for creams with a body map that showed the areas any creams needed to be applied. We checked the charts for the week for one person and they had been completed correctly.

We found that the service did not review the amount of care workers needed to support people when they had to carry out additional domestic duties or were supporting people with increased care needs. On our arrival on the 6 January staffing consisted of the manager who was administering medicines and two care workers. People, their relatives and staff told us that at times it felt like there were not enough staff, particularly at weekends or if care staff were covering the laundry and kitchen. We asked how staffing levels are decided. The operations manager told us that the organisation has a management tool that when populated with people's levels of dependency calculates how many staff hours are required to support people safely. The registered manager told us that they would familiarise themselves with the tool immediately and use it to support decisions about staffing levels. We observed staff responding quickly to call bells. One person was receiving care in bed and not able to use their call bell. Records did not evidence how often they were checked by staff during the day or how they would be able to call for assistance.

We were told that some people at the service were living with a dementia. We observed potential hazards in the service that had not been risk assessed. The staircase had restricted access down from the first floor. A key pad had been fitted which prevented people accessing the stairs to the ground floor without a member of staff assisting. People had free access to the stairs from the ground floor and from the first to second floor of the building. The kitchen door was open both days of our inspection. This meant that people had free access into the kitchen area. The cook works alone and on one occasion we saw the door open and the kitchen unattended. The manager told us that she would complete a risk assessment and would look at restrictions to accessing areas of the kitchen that may be hazardous. We were told that a bolt would be fitted to the door immediately so that the door could be locked whenever staff were not in the kitchen.

Health and safety audits were completed monthly. Records showed us that staff had health and safety training every two years. Staff had not reported hazards to the manager. The manager told us that they would include staff in future health and safety audits to ensure they were competent in identifying hazards that could harm people.

We spoke with two care workers who were not able to demonstrate an understanding of whistleblowing. This meant that staff did not know what action to take if their senior staff were not responding to concerns being raised about the safety of the service. Staff meeting minutes showed us that whistleblowing had been discussed at a staff meeting in October 2015. We spoke with the manager who told us they would discuss with each member of staff to assess their level of understanding. Staff had completed safeguarding training. They were able to tell us how they would recognise abuse and the actions they would take.

Staff received fire safety training. We spoke to one care worker who was not able to explain what action they would take in the event of a fire. We discussed this with the manager who told us they would review the care workers fire safety competencies. A signing in book was in the foyer but did not have any empty pages for visitors to

Summary of findings

complete. This meant that there was no record of who was in the building in the event of an emergency. Each person had a personal fire evacuation plan. The service had an emergency contingency plan which contained information on how the service would keep people safe in the event of a major incident which affected the running of the service.

People had risk assessments in place. We spoke with care workers who had a good understanding of people's risk and what they needed to do to minimise risk and support the person.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether 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 met. We found that the service was working within the principles of the MCA. People had mental capacity assessments completed. Where it was identified that they were unable to consent to a restriction on their freedoms a best interest decision was recorded and a DoLs application sent to the local authority to request authorisation. We observed staff asking people for their consent.

New care staff completed the Care Certificate induction course over their first three days of employment. The Care Certificate is a national induction for people working in health and social care who have not already had relevant training. Staff had received regular training to enable them to carry out their role. Training records were kept with review dates noted where required. Staff files contained certificates for completed courses.

We observed the manager and senior staff working alongside care workers when providing care and support to people.

People told us they enjoyed the food. We spoke with the cook who demonstrated a good knowledge of people's dietary needs and their allergies. One person required a specialist diet. . Staff had a good understanding of how to support the person effectively. Where necessary, people had charts to ensure that were eating and drinking enough. We found that staff were aware of who had charts and had completed them accurately.

People had good access to healthcare. Files evidenced that people had access to GP's, specialist health services, chiropodists, dentists, opticians and district nurses.

We found that the service was caring. People and their families told us the staff were caring, easy to talk with and listened to what they had to say. The manager and care workers had a detailed knowledge of each person. We observed interactions between staff and people. Staff patiently supported people and offered reassurance. They enabled people to maintain some control and independence whilst ensuring their safety. People felt their privacy and dignity were respected. People and their families were involved in decisions about their care. People had not been told about advocacy services that would be able to speak up on their behalf. We raised this with the manager who agreed to source this information and share it with people.

The service was responsive. Information had been gathered prior to a person moving to the service. Assessments had been carried out which included the person, their family and other professionals. This information had been used to identify risks and create an initial care plan. Care records were individual and included assessments and detailed support plans explaining how a person liked to receive their care. The plans gave clear guidance on how to ensure a person's dignity and independence. Plans included communication, mental wellbeing and the physical aspects of a persons' care and support needs. However people on short stay placements had limited care plans and if a risk had been identified a detailed care plan had not been produced that told staff what they needed to do to minimise risk and ensure consistent care. Plans were

Summary of findings

reviewed and updated regularly. People and their families did not always continue to be included. Staff identified and responded quickly to changes in people's care and health needs.

People's files contained information about social activities people enjoyed. We saw an activity folder which contained a record for each person and activities they had been offered each day. This included the group activities, family and friends visiting and one to one time with staff. People did not have individual activity plans. The manager told us that these will be introduced this year.

People were supported to maintain relationships with their families and friends. There were no restrictions on times people visited the service. The service did not provide opportunities for people to access the community. A secure fenced garden had been provided for people. The garden was not visible from most areas in the home and was accessed over a gravel parking area which reduced some people's opportunities to freely access the area.

People and their families felt they could raise concerns with staff. The service had a complaints process that included a concerns log. The complaints records showed us that complaints were investigated, actioned and outcomes reported back to the complainant. People were given information on how to appeal against outcomes.

The service was well-led. . Staff felt happy in their work and felt part of a team. They had a positive view of the service. People and their relatives told us the manager was effective and proactive. The manager felt supported by the organisation.

Staff felt included in decisions about the service and that they could share their ideas and concerns with the manager. The service had introduced a carer of the year award. In December three staff were nominated. The award demonstrated achievements in good care practice. The home had a small staff team and we saw the manager worked alongside staff throughout our inspection. Staff had a relaxed but respectful relationship with the manager. The manager demonstrated a good knowledge of people, their families and the staff team.

The manager completed regular audits to monitor the services performance. Actions from audits were completed and shared with staff.

The Manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner.

A quality assurance survey had been completed in August 2015. Forms had been sent to people, their families, staff and other professionals. The results had been analysed by the manager. The overall results were positive. The outcome of the survey was shared on the organisations web site but not within the service. The manager told us that they would arrange for the outcome of the survey to be shared with people, their families and staff.

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?

Requires improvement

The service was not always safe.

Medicines were not always administered safely. When an error occurred appropriate actions were taken.

Staffing levels were not regularly reviewed to ensure that there were enough staff to meet the needs of the people living at the service.

Potential environmental hazards had not been identified and risk assessed.

Staff had received safeguarding training and understood how to recognise and report abuse. They were not able to demonstrate an understanding of whistleblowing.

Staff received fire training. People had personal fire evacuation plans. There was an emergency contingency plan containing information on how the service would keep people save in the event of a major incident.

Staff had a good understanding of people's risks and how to support them.

Is the service effective?

Good

The service was effective.

The service was working within the principles of the Mental Capacity Act.

Staff completed induction training and on-going mandatory and specialist training to enable them to carry out their role.

Staff had a good understanding of people's dietary needs and allergies and how to support people effectively.

People had good access to healthcare.

Is the service caring?

Good

The service was caring.

People had not been given information about advocacy services.

People and their families told us staff were caring and that they respected a person's privacy and dignity.

The manager and care workers had detailed knowledge of each person.

People felt involved in decisions about their care.

Summary of findings

Is the service responsive?

Good

The service was responsive.

Care records were individual and included clear details on how a person needed to be supported. Staff understood peoples risk and how to support them. People on short stay placements had shorter care plans which needed more detail when a risk was identified.

Group and individual activities took place each day. Care files contained information about social activities people enjoyed. People were supported to maintain relationships with families and friends. There were limited opportunities for people to access the community.

A complaints process was in place. Complaints were investigated, actioned and outcomes were shared with the complainant including information on how to appeal if they remain unsatisfied with the service.

Is the service well-led?

Good

The service was well led.

People, their families and staff all told us the service was well led.

Regular audits were carried out to monitor the quality of the service. Actions identified were completed and shared with staff.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and other regulators.

An annual quality assurance survey was carried out to gather peoples, families, staffs and other professional's views of the service. The outcome of the survey had been put onto the organisations website.

Naseby Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on the 6 January 2016 and was unannounced. It continued on the 7 January 2016 and was announced. The inspection was carried out by two inspectors.

Before the inspection we looked at notifications we had received about the service and we spoke with social care and health commissioners to get information on their experience of the service. We did not request a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from the provider during the inspection.

During our inspection we spoke with seven people who used the service and five people who were visiting. We spoke with the Operations Manager, Registered Manager, four care staff and the Cook. We spoke with two health professionals who had experience of the service.

We reviewed seven peoples care files and discussed with them and care workers their accuracy. We checked two staff files, health and safety records, maintenance records, medication records, management audits, staff meeting records and the results of quality assurance surveys.

We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires improvement

Is the service safe?

Our findings

The service was not always safe. We checked medicines audits the manager had completed in October and November 2015 and there were no reported concerns. The December audit was due to be completed. We checked the medicine administration records for two people. We found that on the morning of the 16 December staff had signed to say that five separate medicines had been given to one person. We checked the medicine supply and found they were still in the pack and had not been given. We spoke to the senior carer who agreed there had been an error and would investigate with the member of staff. We found one person had three opened bottles of eye drops. Each stated that they expired 28 days after opening. None had a recorded date for when the bottles were opened. All three had prescription dates over 28 days old. We discussed this with the senior carer who agreed there had been an error and promptly disposed of the opened bottles and contacted the pharmacy for replacements. Staff administering medicines had not identified these errors. We looked at records for one person who had a prescription for medicines that needed to be given as required. The medicine administration records recorded times the tablets had been offered and either declined or given. We checked the medicine and amounts given corresponded with the medicines remaining. Prescribed creams for people were kept in their bedrooms. We spoke with a care worker who had a good understanding of the creams people had. A medicine administration record sheet was kept in bedrooms for creams with a body map which showed the areas any creams needed to be applied. We checked the charts for the week for one person and they had been completed correctly. We observed medicines being administered to people. The staff member administering medicines waited with the person until the medicine had been completely taken before returning to sign the MAR sheets. Staff who administered medicines had received training in medicines administration.

On our arrival on the 6 January staffing consisted of the manager who was administering medicines and two care workers. There was no housekeeper and the care workers were required to provide laundry and cleaning support to the service in addition to their care role. There was one person in the lounge area who was quite agitated and confused. We were told that they were at a high risk of falling. This person required constant supervision and support from a member of staff in order to keep them safe. In response to our visit the manager arranged for a senior care worker to come into work so that she was able to support with our inspection. During the morning with the additional member of staff the manager still needed to provide support to people due to the high workload and people's level of dependency. We looked at the staff rota for December 2015 and there had been eight days without a housekeeper. A care worker told us "Sometimes there is not enough staff. If at weekends you are covering the kitchen and laundry it can be very busy".

We looked at the results of the quality assurance survey carried out in August 2015. One person had written 'Sometimes it seems as though there are not enough staff, especially at weekends. It can take a long time sometimes for staff to get to my room'. Another person said "I feel there are enough staff, they come quickly day or night". One relative said "Not as many staff at weekends but I feel mums needs are met".

We found that the service did not review the amount of care hours needed to support people. When care staff were covering additional housekeeping duties, preparing meals or the dependency needs of people increased staffing hours had not been reviewed to ensure people's needs could be met safely. We shared our observations with the registered manager and the operations manager. We asked how staffing levels are decided. We were told by the operations manager that the organisation has a management tool that when populated with people's levels of dependency calculates how many staff hours are required to support people safely. The registered manager had been in post since May 2015. She was not aware of the tool and we were told it had last been completed prior to her taking up post. The registered manager told us that they would familiarise themselves with the tool immediately and use it to support decisions about staffing levels. We were told it would be reviewed each time the people living at the service changed or a persons' level of dependency changed. The operations manager told us that they would see whether the tool included people's social care needs and if it didn't they would raise at the organisations next policy meeting. On the second day of our inspection there remained no housekeeper. Staffing had increased to a senior carer and three care workers.

On both days of our inspection we observed staff responding quickly to call bells. One person used their bell

Is the service safe?

to call staff to help them from their bedroom to the lounge. Staff were aware of people at risk who had an alarm sensor mat. One person in the lounge activated their alarm mat many times during the first day of our inspection. On each occasion staff responded quickly. One person was receiving care in bed and not able to use their call bell. Records were kept for when the person was checked through the night but did not evidence how often they were checked by staff during the day or how they would be able to call for assistance.

We were told that some people at the service were living with a dementia. We observed potential hazards in the service that had not been risk assessed. The staircase had restricted access down from the first floor. A key pad had been fitted which prevented people accessing the stairs to the ground floor without a member of staff assisting. People had free access to the stairs from the ground floor and from the first to second floor of the building. We observed one person attempting to climb the stairs. A member of staff stopped them and encouraged them to come back down and use the lift. The registered manager said “They are safe to use the stairs but I would rather they didn’t”. The kitchen door was open both days of our inspection. This meant that people had free access into the kitchen area. The cook worked alone and on one occasion we saw the door open and the kitchen unattended. The manager told us that the kitchen had recently been refurbished. Before the refurbishment there had been a serving work bench and gate that restricted access to the kitchen work areas whilst allowing people the freedom to safely enter into the kitchen entrance. The manager told us that she would complete a risk assessment and would look at reinstating some restrictions to accessing areas of the kitchen that may be hazardous.

Health and safety audits were completed monthly. Records showed that issues identified had been actioned appropriately. However we observed a wardrobe that was leaning forward and appeared unstable. A dining room chair had a broken back rest and was being used by people. Records showed us that staff had health and safety training every two years. Staff had not reported these hazards to the manager. The manager told us that they would include staff in future health and safety audits to ensure they were competent in identifying hazards that could harm people.

We spoke with two care workers who did not have an understanding of whistleblowing. This meant that if they were concerned that senior staff had not acted appropriately when concerns were raised they did not know what actions they should take. Staff meeting minutes from 15 October included information about whistleblowing. We spoke with the manager who told us they would discuss with each member of staff to assess their level of understanding. Staff had completed safeguarding training. They were able to tell us how they would recognise abuse and the actions they would take. A safeguarding poster was displayed in the foyer with information and contact numbers. People and their families told us they felt safe. One relative said “I feel mum is safe, the staff are excellent”. Another person said “I feel safe living here, I’ve never felt frightened”.Staff received fire safety training as part of their three day corporate induction. Staff then completed local fire training at the service which included fire points and exits. We saw certificates in staff files confirming practical fire training had taken place in August 2015. We spoke to one care worker who was not able to explain what action they would take in the event of a fire. We discussed this with the manager who told us they would review the care workers fire safety competencies. A signing in book was in the foyer but did not have any empty pages for visitors to complete. This meant that there was no record of who was in the building in the event of an emergency. Each person had a personal fire evacuation plan. The service had an emergency contingency plan which contained information on how the service would keep people safe in the event of a major incident which affected the running of the service.We saw that people had risk assessments in place. One person had a risk assessment for their skin. We spoke with care workers who had a good understanding of the risk and what they needed to do to support the person. Their care plan said they needed an air mattress. We checked their room and an air mattress was in place and had been set at the correct setting. We saw a chart where staff had recorded times of repositioning the person in bed to prevent skin damage. Another person was at risk of choking. Care workers said “They have to have a soft diet. We always have to thicken their drinks”. We checked the care plan which confirmed what we had been told and observed practice at mealtimes.

Requires improvement

Is the service safe?

We recommend that the service seek guidance on the proper and safe management of medicines. That policies and procedures are in line with current legislation and that staff responsible for medicine management are trained and competent.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether 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 met.

The service was working within the principles of the MCA. People had mental capacity assessments completed. Where it was identified that they were unable to consent to a restriction on their freedoms a best interest decision was recorded and a DoLs application sent to the local authority to request authorisation. Records of best interest decisions demonstrated that different communication methods were used. One person had been involved in a decision about having bed rails. To help the person understand what that meant staff had put the bed rails up and down several times to enable the person to reach their own decision. One person was receiving their medication covertly. The best interest decision had involved the GP and the details had been recorded in the persons care file and in their medicines records. The completed best interest decision forms did not have the agreed outcome recorded. We discussed with the manager who rectified this immediately. Two people had a sensor mat to alert staff when they left their room as they were disorientated around the building. They had not consented to this arrangement. An assessment of whether this was in the persons best interests had not been carried out. However, the manager arranged for an assessment to be carried out when we highlighted this to them.

We observed staff asking people for their consent. Staff explained to people how they would like to support them and waited for the person to respond. Staff frequently checked with the person that they were happy to be supported. We saw one person not consent to support with their care. The care worker said “That’s OK, I will come and see you again in a little while”.

New care staff completed the Care Certificate induction course over their first three days of employment. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training. On the fourth day they had a local induction which included meeting people, other staff, building security, infection control and care paperwork. They then worked three shifts before commencing full duties. We spoke with a care worker who said, “I had training in another place for three days. Very good. Feel I had time to get to know people. The staff are very helpful”.

Staff had received regular training to enable them to carry out their role. Training records were kept with review dates noted where required. Staff files contained certificates for completed courses. Staff received dementia awareness training. The manager told us that staff will be completing a more comprehensive 16 week dementia course over the coming year

A care worker said “Feel very supported by the Manager; I feel I can ask her anything”. We observed the manager and senior staff working alongside care workers when providing care and support to people and guiding and observing their practice. The manager told us that they had not begun carrying out planned formal supervision with staff but that this was part of her plan for the coming year.

People told us they enjoyed the food. One person said “The gravy is really tasty. You get good choices every day”. Another person told us “If you’re not well you can have your meal in your room. If you fancy something different you can ask for something else”. One person hadn’t wanted the roast dinner and had opted to have a roast meat sandwich. We observed a care worker supporting a person with their meal. The meal was offered at a pace that was comfortable for the person. We saw one person using a plate guard and a beaker with a straw. This enabled the person to enjoy their meal independently. We spoke with the chef who demonstrated a good knowledge of people’s dietary needs and their allergies. One person required a specialist diet. Staff told us the person had a soft diet and their drinks thickened. They had a good understanding of how to support the person effectively. Most people had their main

Good

Is the service effective?

meals in the dining room. One relative said, “It’s so nice to see more and more people eating in the dining room. It wasn’t always the case a lot of people used to have their meals in the lounge”. Where necessary, people had charts to ensure that were eating and drinking enough. We found that staff were aware of who had charts and had completed them accurately.

People had good access to healthcare. Files evidenced that people had access to GP’s, specialist health services, chiropodists, dentists, opticians and district nurses.

Good

Is the service caring?

Our findings

The service was caring. The manager and care workers had a detailed knowledge of each person. We spoke to one care worker about a person living at the home. They had a good understanding of how they liked to receive their care, the persons family history, how they liked to spend their time and likes and dislikes. We spoke with a visiting health professional who said "Staff have a good understanding of people who live here".

We observed interactions between staff and people. Staff were patiently supporting people and offering reassurance. One person had fallen and staff provided clear, simple directions about what they were doing and what the person needed to do. Staff supported a person to mobilise. They calmly reminded the person not to sit down too fast, to walk a little further and then turn to ensure they sat safely. They enabled the person to maintain some control and independence whilst ensuring their safety. Staff were observed asking a person if the sun was too bright. They offered to turn their chair slightly to reduce the brightness and the person agreed. Interactions between people and the staff were relaxed and at times light hearted.

One person said "I'm quite happy with the staff. They listen to what you have to say, your little complaints. I feel that's very important". Another person said "I was poorly in the night. The staff are really good. They've been popping in and out checking on me all morning".

People and their visitors told us they were able to speak to staff. One person said "I can talk to all of them" A relative said "staff are very good and the manager and one of the senior carers are spot on". Visitors were welcomed at any time. One persons' relative was invited to stay for lunch and they enjoyed a meal together in the dining room. The cook told us that it had been a person's birthday the previous day. A birthday party had been arranged with a cake and buffet tea to share with family, friends and other people living at the service.

People and their families told us they felt involved in decisions. We were told by staff that one person had no family. Arrangements had been formally made for the local authority to support them with their finances. People living at the home had not been told about advocacy services that would be able to speak up on their behalf. We raised this with the manager who agreed to source this information and share it with people.

People felt their privacy and dignity were respected. One person said when they received care "it's very, very private when they help to wash me". We observed staff knocking on people's bedroom doors before entering their rooms. A relative said "Mum's skirt was dirty. The minute staff noticed they changed it immediately. The care is excellent". Staff were respectful when speaking with people. Staff were observed crouching down to speak with people seated at the tables, choices were offered about where they sat and what they had to drink. Staff spoke with people using their preferred name.

Good

Is the service responsive?

Our findings

When the service was last inspected in August 2014 we had found gaps in people's risk assessment reviews, lack of information in care plans and plans not being followed by staff. People's social and emotional needs were not being met. We found that the service had made improvements in all these areas and was responsive to people's needs.

People and their families were involved in decisions. Information was gathered prior to a person moving to the service. Assessments had been carried out which included the person, their family and other professionals. This information had been used to identify risks and create an initial care plan. Care records were individual and included assessments and detailed support plans explaining how a person liked to receive their care. The plans gave clear guidance on how to ensure a person's dignity and independence. Plans included communication, mental wellbeing and the physical aspects of a persons' care and support needs. Care plans were reviewed and updated regularly but people and their families did not always continue to be included. One relative said "I haven't been told anything; I assume it's still the same". Another relative we spoke with said "We're involved and included in any changes to care planning". One care plan review demonstrated how people and their families were involved in planning their care.

One person chose to have all their meals in bed. They slipped down the bed which made eating difficult. A meeting had been held with the person, their family and staff to talk about how they could safely respect the persons' wishes. The meeting resulted in the person agreeing to be supported into a sitting position and a member of staff staying with them during the meal in case they slipped back down the bed. The plan was reviewed the next month and recorded all parties were happy with the outcome.

One person had been admitted in December for a short stay. An assessment had been carried out by a social worker before admission which identified the person had a high risk of falls. A falls risk assessment had been completed on the 16 December and 6 January. Both assessments identified a medium risk of falling. A sensor alarm mat had been placed in front of them. Each time they stood up it alerted staff who would come to provide support with walking. During our inspection the person had a fall. The person was not able to get up off the floor independently. Staff made a decision to use a hoist and sling to get the person back into a chair. A care plan was not in place to explain to staff how to minimise the persons' risk of falling or provide moving and handling guidance. However staff had demonstrated they understood this persons' risk and how to support them. After our inspection we spoke with an occupational therapist and they told us that the hoist and sling used would have been suitable for this person. During our inspection, in light of the fall, the manager completed another review of the falls assessment and produced a detailed care plan which identified actions needed to minimise risk. They also made a referral to the occupational therapist service for a moving and handling assessment. People who stayed at the service for less than four weeks had less detailed care plans. We discussed this with the manager. The manager told us that in the future if a risk is identified prior to admission or during a short stay a full care plan will be available to staff explaining actions needed to minimise the risk.

Staff identified and responded quickly to changes in people's care and health needs. A relative said "Staff realised mum had a toothache before we did. They responded quickly and organised a dentist".

People's files contained information about social activities they enjoyed. Each afternoon a group activity took place in the lounge area. We observed one day 10 people participating in a quiz. For each letter of the alphabet they had to think of people's names. People interacted with the quiz and were enjoying the activity. Some names led to conversations about famous people or family. We were told by a professional visiting the service that they had observed people enjoying a game of lounge bowls. We saw an activity folder which contained a record for each person and activities they had been offered each day. This included the main afternoon activity, family and friends visiting and any one to one time with staff. We looked at December and entries had been made for each day. There were no entries for January 2016 although people told us that activities had taken place. Entries included brief descriptions of a conversation, reading a newspaper or having a manicure. Entries included whether the person had declined. Photographs had been taken of social activities. This included photos of people enjoying a visit from an entertainer with live owls and people enjoying being involved in the Christmas tree being decorated. One person enjoyed knitting and had included other people in a

Good

Is the service responsive?

knitting circle. The registered manager told us their next plan for activities is to involve people and their families in gathering more information about people's lives so that activities can be more person centred.

People were supported to maintain relationships with their families and friends. There were no restrictions on times people visited the service. The organisation provided access to a mini bus but this had not been utilised by the service. The registered manager told us that they are planning to use the mini bus monthly so that people can have trips into the local area. A secure fenced garden had been provided for people. People used the garden when family visited or a member of staff could support them. Two people had access directly into the garden from their rooms. The garden was not visible from any other areas in the home and was accessed over a gravel parking area. We spoke with one person who said "We haven't got a garden just the gravel area and you get cars parked there". We described the garden across the gravel behind the fence. They believed that belonged to houses behind the garden and wasn't part of their home. The position of the garden meant that some people were restricted from freely accessing the outside space.

People and their families felt they could raise concerns with staff. The service had a complaints process that included a concerns log. One person had asked for their commode to be emptied earlier in the morning. Arrangements had been made that the night staff undertook this task. The person was happy with the outcome. One person had lost their glasses. Staff had carried out a search and had found them. One relative told us "Complained as mum's room was being used as a dumping ground. The problem was quickly resolved". The complaints records showed us that complaints were investigated, actions taken and outcomes reported back to complainant. People were given information on how to appeal if they were not happy with how the complaint had been managed.

Good

Is the service well-led?

Our findings

The service was well-led. A care worker said “Feel really supported by the manager and deputy. The manager is really good and will help with everything”. One person said “The manager is very efficient. The manager and deputy work very well together”. A relative said “The manager is helpful and proactive”. Staff felt happy in their work and felt part of a team. They had a positive view of the service.

The manager felt supported by the organisation. The operations manager visited the service weekly. Every other month the registered manager attended a two day managers meeting. They told us “The second day is training. Managers can request training. We’ve just done best interest decisions. It’s really helpful as you can see other people’s perspectives”.

Staff felt included in decisions about the service and that they could share their ideas and concerns with the manager. One care worker said “I feel you can raise things with the manager. One person had been here a week and I realised they had no spare clothes. I told the manager and it was immediately sorted out”. The service had introduced a carer of the year award. In December three staff were nominated. The award was to demonstrate achievements in good care practice.

The home had a small staff team and we saw the manager worked alongside staff throughout our inspection. Staff had a relaxed but respectful relationship with the manager. The manager demonstrated a good knowledge of people, their families and the staff team.

The manager completed regular audits. A medication audit had included speaking to staff about how they would recognise when a person was experiencing pain if they had problems with communicating their needs. The audit identified that staff were unsure. The manager responded by organising a training session for staff which included guidance for pain. A health and safety audit had identified poor practice with cleaning products. The outcome was that staff revisited their training and checks on cleaning products and safe practice were increased. We saw evidence that actions from audits were shared with staff and included in staff meetings.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

A quality assurance survey had been completed in August 2015. Forms had been sent to people, their families, staff and other professionals. The results had been analysed by the organisation. The overall results were positive. One relative had raised an issue and the manager had addressed this directly with the person. The outcome of the survey was shared on the organisations web page but not within the service. The manager told us that they would arrange for the outcome of the survey to be shared with people, their families and staff.