Nightingale Group Limited

Nightingale Group ltd. Trentham Care Centre

Inspection report

Longton Road
Trentham
Stoke On Trent
Staffordshire
ST4 8FF

Tel: 01782644800
Website: www.nghc.co.uk

Date of inspection visit:
07 March 2018
08 March 2018

Date of publication:
25 April 2018

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 7 and 8 March 2018 and was unannounced. At the last inspection completed on 14 and 15 November 2016 we found the service was rated Requires Improvement and the provider was not meeting the regulations for safe care and treatment, consent, person centred care and governance. At this inspection we found the service had made improvements and were meeting the regulations but further improvements were needed.

Nightingale Group ltd. Trentham Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Nightingale Group ltd. Trentham Care Centre accommodates 155 people in three adapted buildings, with five units within these buildings. At the time of our inspection there were 136 people living at the home.

There was a registered manager in post at the time of the inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Peoples risk assessments were not consistently followed by staff. Guidance for administering some medicines lacked detail for staff to follow. Checks required on controlled drugs were not always carried out. People did not consistently receive personalised care and were not consistently able to access social stimulation. The governance arrangements were not consistently being followed by staff.

People were supported by staff that could recognise abuse and understood how to safeguard them. People were supported by sufficient suitably recruited staff. People received their prescribed medicines. People were protected from the risk of infection. Incidents were reviewed to ensure learning when things went wrong.

People's individual needs were assessed and care plans were in place to meet their needs. Staff were trained and demonstrated a knowledge of how to support people and provided consistent care. People were supported to have enough to eat and drink and could make choices about their meals. People had equipment and adaptations to enable staff to support them effectively. People were supported to access health professionals. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and the policies and systems in the service supported this practice.

People received support from caring staff that knew them well. People were able to make informed choices and had their individual communication needs met. People were supported in a way that maintained their dignity and staff were respectful and ensured they had their privacy protected.

People's preferences were understood by staff when they provided support. People were supported to maintain their religious beliefs. People understood how to complain and the registered manager ensured all complaints were responded to. People were supported with dignity at the end of their lives.

The registered manager was accessible and people and their relatives were able to share their views about the service. There were quality audits in place which enabled the registered manager to check people had received the care and support they needed. Lessons were learned when things went wrong and people and their relatives felt involved in the service.

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 consistently safe.

Guidance for how people had their 'as required' medicines was not always clear. Risk assessments were not consistently followed for people. People were supported by sufficient suitably recruited staff in a clean environment. People were protected from harm and when things went wrong lessons were learnt.

Is the service effective?

Good

The service is effective.

People's needs were assessed and individual plans of care were in place. Staff received training to enable them to meet people's needs. People received their care consistently. People had enough to eat and drink and were supported in an adapted building. People had their health needs met. People's rights were protected by staff.

Is the service caring?

Good

The service is caring.

People were supported by caring staff. People were involved in making decisions and choices and had their communication needs met. People's privacy and dignity was maintained and they were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive personalised care. People were not always able to access social stimulation. Peoples preferences were understood by staff and complaints were investigated and responded to. People were supported to plan for their end of life care.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The governance arrangements were not always followed by staff. The registered manager was approachable and people felt involved in the service. Staff felt supported and there were system in place to learn when things went wrong.

Nightingale Group ltd. Trentham 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place 7 and 8 March 2018, and was unannounced. The inspection team consisted of four inspectors, two specialist nurse advisors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection, we reviewed the information we held about the service, including notifications. A notification is information about events that by law the registered persons should tell us about. We asked for feedback from the commissioners of people's care to find out their views on the quality of the service.

During the inspection, we spoke with eight people who used the service and 13 visitors. We also spoke with the nominated individual, registered manager, four unit managers, four nurses, two nurse assistants, eight staff and the activities coordinator.

We observed the delivery of care and support provided to people living at the location and their interactions with staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed the care records of 24 people and eight staff files, which included pre-employment checks and training records. We also looked at other records relating to the management of the service including complaint logs, accident reports, meeting notes, monthly audits, and medicine administration records.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 14 and 15 November 2015 we found the provider was not ensuring people were receiving safe care and treatment. We found a breach of Regulation 12 for safe care and treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting these regulations but further improvements were still needed.

People and their relatives told us they were supported to manage risks to their safety. One visitor told us, "The pressure mats have helped to keep [person's name] safe". Staff could describe risks to people and the actions they took to keep people safe. We saw assessments had been carried out and plans put in place to guide staff when supporting people. Staff were following the plans for people to prevent breaks in their skin ensuring they were repositioned in line with their care plan. Some people were at risk due to behaviours that challenged which may put them or others at risk. Staff followed the plans in place for people and where people needed continual monitoring this was done in the least restrictive way.

However we found some risk assessments were not consistently followed by staff. For example, people with a percutaneous endoscopic gastrostomy (PEG) had plans in place to support them to manage risks. A PEG is a medical procedure in which a tube is passed into the person's stomach to provide a way of feeding the person when they are unable to eat and drink orally. We saw staff had guidance in place to monitor the catheter site and the carry out procedures which prevent problems and infection. However we found there was some inconsistency in how these plans were followed. One person had not had the required checks carried out on multiple occasions, we saw this person had experienced some infections and required treatment from their doctor, although we were not able to link this specifically to the dates and times when the checks had not been carried out. We spoke to the nurses about this and they confirmed they would increase checks to ensure the plans were followed. People had plans in place to support them with their mobility. However these were not consistently followed. For example, we observed one person be supported to stand and walk with assistance from staff. The person was struggling and was very unsteady on their feet. We looked at the care plan and found although the person was assessed as being able to walk, the plan stated staff should use a wheelchair if the person struggled. We saw the person had recently had a fall and the plan had not been updated following this. We spoke to the unit manager about this and they reviewed the care plan immediately and made a referral to an occupational therapist for further assessment. In another example, we found actions had been taken when the risks to one person for malnutrition had increased due to weight loss, the advice of the dietician was being followed to help the person reduce their weight. A target weight had been set but this was not reflected in the person's risk assessment and plan, this meant when the person dropped below the target weight action was not immediately taken. We spoke to the unit manager about this and they took immediate action to seek advice from the dietician on day two of the inspection. This meant further improvements were needed to ensure risk assessments were followed and updated when things changed.

Nurses could describe how medicines which were prescribed on an 'as required' basis should be given, however the protocols in place for these sometimes lacked detail. For example, one person had been prescribed an 'as required' sleeping tablet; there was no protocol in place to say when this should be given.

We spoke to the nurse about this and they explained the person could ask for the table when they wanted it, but it had never been administered. We saw other examples of protocols in place for people that were detailed and we saw records which showed nurses had administered the medicine in line with the protocols. We saw where people required their medicine given in food or drinks without their knowledge their capacity had been assessed and decisions to do this had been made in their best interests. However some of the guidance for how to administer the medicine safely lacked detail. Pharmacists had not consistently been involved in providing guidance for staff on how to disguise medicines safely. Some medicines cannot be mixed with certain food types so it is important to get details about each medicine and how to mix it safely from a pharmacist. There were examples of plans in place which had involved the pharmacist and clear guidance on how to administer the medicines covertly was in place. We spoke to the nursing staff about the issues we found and they made arrangements to review the guidance and update it with clear advice from the relevant parties. This showed that there were inconsistencies in the guidance for nurses on how to safely administer some medicines.

We found medicines were stored safely. We saw medicines which required refrigeration were stored safely and checks were being carried out on the temperature of the refrigerators and the medicines rooms. We found some people received prescription medicines which were controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled medicines or controlled drugs. We saw the controlled drug registers were completed and the stocks indicated in the register were correct. The nurse told us, "We check controlled drugs when handing keys over to the next shift and then both nurses sign to say have done so". However, we found there were some instances where these checks had not been carried out. We saw however this had been identified in the audits and action had been taken to address this. We found stock medicines were in date and liquids were dated when opened. This is good practice as liquid medicines often have a short shelf life. There were appropriate systems in place for the safe disposal of medicines. This demonstrated that medicines were stored and disposed of safely.

People were supported to receive their medicine as prescribed. One visitor said, "Yes [person's name] has support with medicines and there has not been any problems. The medicines are timed well and I would notice if my relative had not been taking the medicine properly". Nurses and nurse assistants told us there had been improvements in how medicine was administered. One nurse assistant told us, "It does help having two people doing the medicines. It doesn't make you feel under pressure". Medicines were administered by trained staff. We saw nurses washing their hands regularly during the process, they explained to people what they were about to do and obtained consent before administering medicine. The process was not rushed. They sat and waited until people had taken their medicine before leaving. We saw staff recorded on the medicine administration records (MAR) that people's medicines had been administered. At the front of the MAR chart was a current photograph of the person with allergy information and details of how they like to take their medicines included. Where medicines were not given the reason was recorded on the back of the MAR chart. People who had been prescribed topical medicines such as creams received them as directed. There were body maps in place to show where the creams were to be applied and directions for staff on how often the creams were to be applied. We saw where people required transdermal patches applied to their body; a body map was in place to ensure this was applied in line with the manufacturer's instructions. This demonstrated people received their medicines as prescribed.

People and relatives said the home was safe. One person said, "I feel very safe, very well looked after". A visitor told us they felt their relative was safe and gave the example of how well staff understood the fire procedures and how they could describe how their relative would be supported to evacuate in the event of a fire. We found staff had received training in how to recognise abuse and could describe the procedures for reporting this. Where incidents had been reported these had been raised with the appropriate agencies for investigation. This showed the registered manager was aware of their responsibilities for protecting people

from the risk of harm.

People and their relatives had mixed views about whether there was enough staff provided. One person told us, "Staff do not respond quickly enough to the buzzer when I need help to visit the toilet. I often resort to shouting loudly". A visitor told us, "Staffing now appears to be ok". Whilst another visitor said, "Staff help comes within five minutes of pressing the buzzer. I feel that the staff to person ratio is quite good". Visitors also told us there were less agency staff in use. One visitor said, "Reliance on agency staff has reduced, which is welcome". Another visitor commented, "There appears to be less Agency staff and those who are used tend to be regulars who know people better". Staff told us they felt there were enough staff to meet people's needs. They said there had been improvements over recent months and they felt as though people were supported effectively. The registered manager told us they had a system to allocate staffing to different units on a daily basis. This enabled them to deploy staff where they were needed to ensure there were enough staff to meet people's needs. We saw where people required one to one support from staff due to their needs this was in place. We found people did not have to wait for their care and support. For example, call bells were answered promptly and there were staff available to support people when they needed it. There was a system in place to identify the level of dependency people had and this was used to determine how many staff were needed. This was reviewed daily where required and adjustments made. The provider had an allocations manager responsible for this each day. This meant people were supported by sufficient staff to meet their needs.

People were supported by safely recruited staff. Staff told us they had undertaken an interview and provided two references and a check was carried out to ensure they were safe to work with people through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions. We saw records which supported what we were told.

People were supported in a clean and well maintained environment. Staff had attended infection control training. Staff could describe how they worked to prevent the spread of infection. We observed staff wearing protective clothing and using hand gels to minimise the risk of infection spreading. There was a nursing support worker identified as a lead for infection control. They told us they carried out audits on a monthly basis on each of the units. They told us, "It is really good to see that things are improving month on month and my role is making a difference". We saw there were cleaning schedules in place to ensure areas in the home were maintained. We saw regular checks were made and actions taken where issues had been identified. People could therefore be confident that practices in place would reduce the risk of cross infection.

The registered manager had systems in place to learn when things went wrong. For example, where incidents and accidents occurred these were discussed the following morning at a meeting which was attended by all heads of units and departments. The registered manager received documentation about the incident and these were entered into a system to allow the manager to check and monitor the outcomes following the incident to ensure the correct actions had been taken and agencies had been informed. There was a post incident check list completed which assigned actions to specific staff members and these were checked and feedback received during the daily meetings of department heads.

Good

Is the service effective?

Our findings

At our last inspection on 14 and 15 November 2016 we found the provider was not meeting the regulations for seeking consent to care and treatment. We found a breach of Regulation 11, for consent, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting these regulations and they had made the required improvements.

People's needs were assessed and they had a care plan in place. One person told us, "I came from Hospital here with all the paperwork which included medicines and I spent time with the staff to help compile my care plan". Staff told us people had assessments undertaken to identify their needs and specific care plans were put in place to meet people's needs. One staff member said, "We try to get as much information from the people as possible, if not, we try to get it from their relatives or closest friend". Staff could describe people's needs and the support they needed to meet them; we found this was well documented in peoples care plans. We found where required specialist advice had been sought to assess people's needs and develop plans. For example a number of people had been assessed by the speech and language therapy team (SALT). People had copies of their SALT assessments on their care plans and staff followed the guidelines to ensure their dietary requirements were met safely. We saw people had specific plans in place to support them with health conditions. For example, there were seizure recovery plans were in place for people living with epilepsy and those living with diabetes had their blood sugars monitored when required. We saw care plans were reviewed regularly and people and their relatives were involved in the reviews. The registered manager told us they undertook a review process each day selecting people through conversations during their daily meeting to become resident of the day. This process enabled a review of people's needs and care plans. We found care plans were reviewed and updated regularly. This meant people's needs were assessed and plans were in place to meet them.

People and visitors told us they felt staff were mostly well trained. One visitor said, "The staff seem to have the right skills and know how to support people". Staff told us they had an induction and carried out shadowing. One staff member said, "We've had a few new starters and we've buddied them up with regular members of staff. The care coordinator and the senior carer supervise them". We found records which showed people had an induction and this was monitored by the registered manager. We saw staff evaluated their training and there were clinical supervision work books completed every two months to check competency of staff for areas such as pressure care and catheter care. Staff told us that they received regular training and received reminders when their training was due. One staff member said, "We get emails all the time to remind us when our e-learning is due". All the staff we spoke with told us they had regular supervision and they were able to discuss any training needs during supervision or any concerns. One staff member said, "The care coordinator asks us if we have any problems, we talk about everything and there is a form completed. We observed staff were using the skills they had to provide care and support, for example, with support at meal times and the application of the Mental Capacity Act (MCA). This showed staff had the skills to support people effectively.

People and visitors told us the food was good and there were plenty of meals and drinks available and they could choose what they wanted to eat. One person said, "The food tastes nice". Another person told us, "The

food is good for lunch I am having potatoes, mince gravy with cake and custard or cream for dessert, at breakfast I like to have Earl Grey tea". The person went on to explain they preferred to have their meals served on a small adjustable table as their mobility was limited. A visitor told us, "[Person's name] loves toast and jam in the morning and porridge too and they can have that". Another visitor told us, "My relative didn't want breakfast this morning when they got up, but later about 11.30 they had a bacon sandwich". Another visitor told us, "I do food testing for the home, I am a guinea pig. My relative has pureed food in moulds, which makes it look like normal consistency food". Staff told us there was a menu and people had a selection of meals they could choose. They could also order food which was not on the day's menu. A visitor confirmed this. They told us, "The chef made a special menu for what my relative can eat and can't and they stick to it. The menu is in their bedroom and also out in the kitchen. The chef did it with us as my relative doesn't eat what other people eat". We observed staff understood people's preferences for meals and drinks. We saw people were offered a choice and alternatives were found for people that had changed their mind about the meal they wanted. We did however observe one person asking staff for something to eat mid-way through the morning, staff told them it wasn't long until lunchtime and did not offer the person a snack. We spoke to the registered manager about this and they said they would look into it as snacks were readily available, which we had seen throughout the inspection. We saw peoples dietary needs were assessed and appropriate plans were put in place, we observed staff following these plans and providing appropriate support. For example, we saw one person was at risk of malnutrition and they were receiving regular supplements and their weight was monitored. This demonstrated people were appropriately supported to eat and drink sufficient amounts to promote their health.

We found systems were in place to keep staff up to date about people's needs. There were handover meetings when shifts changed and information about any changes were passed to staff coming on duty. We saw there were meetings daily where staff in charge of each unit and the departments within the organisation came together to discuss people's care, any incidents or accidents for example. We found the provider operated a system called resident of the day. This meant on the same day every month, a particular person's care plan was reviewed; and relatives knew when this took place and could be a part of the process. We saw other professionals were routinely involved in people's care and updates were made to people's plans based on their advice. This showed systems were in place to ensure people received consistent care.

People and visitors told us there was access to a range of health professionals when required. One person said, "A doctor comes in from the local practice twice a week". Another person said, "It's very good here, the chiropodist comes every couple of months as does the optician". A visitor told us, "The doctor comes every week but if urgent care was needed a doctor would be called in". They added, "[Person's name] is PEG fed and is weighed regularly and the dietician kept a close watch to ensure they are getting enough nutrition". We saw records which showed peoples were referred promptly to other health professionals when needed. For example, people had regular visits from doctors, dieticians, SALT team and community psychiatric nurses and where required plans were updated to follow the professional advice. We did find one person had been sent a letter for some screening tests, we found this had not been followed up. We spoke to the nurse about this and they followed this up straight away.

People and their relatives told us the home was clean and comfortable and met their needs. Some units would benefit from improved signage to assist those with dementia to find their way around the units. We saw each of the units each had adapted toilets and bathrooms for people to access with different equipment in to support people effectively. We found there was specific equipment in place for some people such as sensor mats to alert staff to people's movement. We found some people had specialist seating to help keep them safe. There were outside areas which were accessible for people and had specialist floor coverings to reduce the likelihood of an injury if people were to fall. There was a sensory room which we

found some people accessed as this provided stimulation and a place to relax. This showed people were supported in an environment which met their needs.

People were asked for their consent before they received care and support. Staff understood the principles of the Mental Capacity Act (MCA) and could describe how they sought consent. One staff member said, "Some people have some capacity but can't make complex decisions. They have no insight as to why they have to live here". Staff were able to demonstrate their understanding of seeking consent from people they supported through discussions and our observations. For example consent was sought when people were offered their medicines and personal care support.

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 that could not give their consent or make decisions about their care and support a mental capacity assessment had been undertaken. We found documented discussions about decisions made in people's best interests. For example, one person was unable to consent to their medicines, a best interest discussion had taken place and the doctor, pharmacist and relatives had been involved in agreeing the medicine should be given to the person in food and drinks without their knowledge.

People can only be deprived of their liberty so that they can 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). Where people had restrictions in place to ensure they received the appropriate care and treatment applications had been made to the authorising body for a DoLS. We found one person was having their walking aid removed by staff, this restricted their movement around the home. Staff told us this was because the person was at risk of falls if they walked without staff and would not always ask for assistance. We spoke to the unit manager about whether they had considered less restrictive options such as chair sensors to alert staff if they moved. The unit manager told us they would review the persons DoLS to consider this. Staff demonstrated knowledge of the care requirements for people with authorised DoLS and could describe how they needed to support people in the least restrictive way. We saw one person had a DoLS in place and required continual supervision, the advice for staff was to allow the person space and monitor them from a distance, for example staying outside their room when they went for a lie down. Staff were observed following the care plan for this person during the inspection which demonstrated people were supported in line with the MCA.

Good

Is the service caring?

Our findings

At our last inspection on 14 and 15 November 2016 we found the provider was providing a caring service at this inspection we found the provider continued to provide a caring service.

People and their relatives told us they felt the staff were kind and caring. We asked people and relatives to tell us if the staff supported them in a caring way. One person said, "Yes, staff are very caring". Another person told us, "I'm treated very well, I enjoy it here you get used to it. They are very nice people and I get on well with them". A visitor told us, "The staff love my relative, they speak with them in a nice way and they always listen to them and me". Another visitor told us, "The staff know my relative well and they have a good relationship and they do listen to me and make me feel valued". Whilst another visitor told us, "The staff are very friendly, they have a laugh and a joke with my relative and are very caring". Staff told us they had good relationships with people and demonstrated they were caring in their approach. One staff member said, "I like to sit and have a chat with [person's name]. They like a cup of tea and a cup of coffee". Another staff member said, "I love it here. I wish I'd done this years ago. It's rewarding caring for them and making them smile. You know you've helped somebody when you go home". Staff demonstrated a good knowledge of people and were observed being caring in their interactions. For example, we observed one person have support to eat their meal in bed, staff positioned the person safely, sat with them and described the meal, checking on the temperature and if they liked what they had been given. We saw staff gently coaxing the person to eat stroking their hand to keep the persons attention and giving time for the person to finish each mouthful. The staff member supported the person to wash their hands and face after their meal and gave the person a drink. We observed kind and caring interventions between staff and people who were under 1:1 levels of observation. However, we did see some interactions with agency staff which showed they were not as knowledgeable about people and did not demonstrate a caring approach. For example, we saw agency staff did not engage in conversation with people, in particular one person was being supported with their meal and the agency worker did not engage in conversation others were observed not responding when people spoke to them. These issues are further addressed in well led. Permanent staff were kind in their approach, for example one staff member we spoke with, told us, "I hold one hand and reassure the person that everything's alright and we're all here to help them. The hand holding seems to help". We observed the staff member doing this several times during the inspection and saw the persons care records documented the person responds very well if their hand is held and reassurance given when they become anxious. This showed people were supported by caring staff.

People and their relatives told us they were involved in making decisions about their care and support. One person told us, "I can choose to have my meals in my room, staff support with fetching me any shopping I want and help me to shower when I want to". A visitor told us, "Staff always ask if my relative wants to get up in the morning and they respect their wishes when they choose to stay in their room". Another visitor described their involvement in their relatives care plan. They told us they were fully involved in their relatives care and monitored how their loved one was being supported when they visited daily. They told us when their relative first came in they had requested a change to their care to increase the frequency of checks during the night and this had been put in place. We saw people and where appropriate their relatives were involved in their care. We found people could make choices for themselves and staff supported them with

this. For example, people chose when to get up, what meals to have and where and how to spend their time. We found people were given information in a way in which they could understand. There were picture menus to assist people with making choices about their meals. We found individual needs had been assessed and plans were in place to aid communication. For example, one person did not speak English as their first language. We found staff that spoke the persons language had spent time teaching them some phrases and had made cards for other staff to use when communicating with the person. We found people were supported to be as independent as possible, for example one person used a self-propelled wheelchair to access the outside court yard on several occasions during the inspection. We saw another person had a kettle available to them in their bedroom to enable them to make a drink when they wanted to. One of the unit managers told us staff supported people to be as independent as possible. The unit manager said, "We let [person's name] make themselves a drink in the kitchen, whilst we are watching. It's for their independence. We don't want them to lose that". This demonstrated people were supported to communicate effectively, make choices for themselves and maintain their independence.

People and their relatives told us staff were respectful and protected peoples dignity and privacy. One person said, "I am independent and staff do respect my privacy". "A visitor told us, "If I want to go home, the staff come and carry on walking with [person's name] until they are settled". Another visitor told us, "[Person's name] has one to one care but staff leave us to enjoy each other's company when I come to visit." Whilst another visitor told us, "[Person's name] is bedbound with limited communication, staff always treat them with respect". Staff could describe how they supported people to maintain their privacy and gave examples such as closing doors, covering people when they had personal care and respecting their choices. Staff were observed and heard to be discreet when people needed assistance. They reassured people who were anxious and distressed and responded promptly, calmly and sensitively. We observed people were allowed to go to their bedrooms to have a rest whenever they wanted to. We found visitors could come at any time and when people were visited by friends and relatives their privacy was respected. This showed people were treated with respect and their dignity and privacy were maintained.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 14 and 15 November 2016 we found the provider was not meeting the regulations for person centred care. We found a breach of Regulation 9, for person centred care, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the provider was meeting these regulations but further improvements were needed.

Personalised care and support was not always delivered in line with peoples plans by some of the agency staff. For example, one person had a plan in place which said staff should provide time for the person to sit with them and talk, watch TV and listen to relaxing music; however we found there was no evidence this was followed for this person on a regular basis. We observed the agency staff did not always did not always interact or engage in meaningful conversations. We observed three people that required one to one support not being spoken with or engaged by the agency staff supporting them. For example, one person needed to have one to one support; their care plan said this should be used as an opportunity for the person to have meaningful companionship rather than the person just being watched by staff. However during the inspection we found this person spent most of their time sleeping and when awake sat passively watching and talking to themselves, the agency staff member providing the one to one support was observed not interacting with the person, just sitting at the side of the person in silence. This meant the person did not receive the personalised care set out in their plan.

People and their relatives had mixed views about whether people had access to social interaction and meaningful activities during the day. One person said, "I enjoy reading it keeps my brain active". The person showed us the various local and national newspapers that were provided daily for them to read. Another person told us, "I really enjoy going to the small wild life centre next to the home to feed the parrot, I get satisfaction from seeing them well looked after". This person was observed being taken out in the afternoon to visit the parrot. Another person told us they had been on an outing to a local restaurant but would like to see more opportunities to go out. A visitor told us, "[Person's name] does not take part in anything. I have seen some activities take place, but not every day. There could be more which would be useful, something to stimulate people". Whilst another visitor told us, they had spoken to the activities coordinator to discuss outings to see a local football team which their relative would really enjoy and they were able to ensure they could listen to the commentary of football matches on a radio. Staff told us they thought activities provision could be improved. They said there were things going on but it often meant taking people to another unit, which was not always practical. This meant some people did not get to take part in things on offer. We spoke to the activities coordinator and they told us they were supported by two part time assistants and they aimed to ensure everyone had access to one to one time throughout the course of a week to follow their interests. They said they spoke to people and relatives to find out what type of things people liked to do. We observed some people were engaged in activities at some points throughout the day but this was limited. We saw people were sat for long periods only engaging with staff when care and support was delivered. We saw the animals from the rescue centre were brought in to see people. We found people were engaged by this and were seen smiling and enjoying their time with the animals, however this was a short lived experience and those people were then left to sit without interaction. This showed people had access to social interactions but improvements were needed to make this more consistently available.

People and their relatives told us they felt staff understood their needs and preferences and provided appropriate support. One person told us, "Staff know me well and know how I like to have things done". A visitor told us, "The staff really understand [person's name] needs and preferences well". Another visitor told us, how staff were working with other health professionals to arrange a customised wheelchair to improve their relatives quality of life. They explained this would reduce the number of transfers required and enable the person to go out more frequently. Staff told us how they found out about people's needs and documented things in the care plan. We saw people had an all about me document in their care plan which gave staff detailed information about their preferences. Staff were able to describe peoples preferences for us and could tell us about how they supported people in a person centred way. One staff member told us, "I sit with people and their families when I put a plan in place and we go through each section together and any changes are also discussed". Another staff member told us, "[Person's name] is very religious and they like you to be able to say a prayer with them before they go to bed".

We found people had their preferences followed. For example, we saw staff were able to use their knowledge of peoples preferences for meals to support them when choosing what they wanted to eat. One staff member told us about a person that liked to spend their time with the animals on site and that it was important for them to have their handbag with them. We saw this was documented in the persons care plan and staff followed this throughout the inspection. We found where people had specific dress requirements relating to their culture these were documented in the care plan and followed by staff. We found assessments and care plans explored how people expressed their sexuality, however the plans we saw did not document discussions about peoples sexual identity or preferences, the focus was on peoples appearance. We spoke to the registered manager and nominated individual about how people's needs in relation to their sexuality could be explored. This showed peoples individual preferences were explored with them and used to provide personalised care.

People and their relatives understood how to make a complaint and felt confident their concerns would be addressed. One relative told us they had raised concerns with the registered manager and felt these had been addressed. We saw the provider had a system in place for investigating and responding to complaints. Complaints were logged on to a system and the registered manager investigated them. The registered manager said, "There is a complaint process in place. I use whatever means of communication that suits the person who has complained". We saw records of complaints which had been acknowledged once received, which apologised and outlined how an investigation would be carried out. We saw people were kept up to date on progress and outcomes were shared, with an offer of a formal feedback meeting to discuss how the actions taken would prevent the situation from reoccurring. We saw how information about complaints was communicated to staff internally and staff signed to say they had seen the communication. This showed the registered manager had a system in place to respond to and learn from complaints.

People were able to plan for their end of life care. We saw people had advanced plans in place which stated how they would prefer to be supported at end of life and this had involved the person and their relatives. Staff told us they had received training in end of life car and, records supported this. We observed a staff member reviewing one person's end of life care plan with a relative. It was carried out in the sensitive manner and the family provided information relating to the person's choice of a burial or cremation, and whether they wanted the last rights to be administered and details of the funeral directors to be used. The staff member involved told us, "We're just going through the end of life plan. We're talking to relatives about it. Some relatives have not thought about it. We try to encourage them to have things in place. We tell them it takes the burden off them if and when it happens". We saw plans which supported what we were told.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection we found the provider did not have effective governance systems in place. There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance. At this inspection we found improvement had been made and the provider was meeting the regulation; however there was still more work to do to ensure the changes made were sustainable.

We found the checks carried out on the conduct of staff had not identified the concerns we found with agency staff. We found not all agency staff knew people well; they were not always following the personalised plans which were in place and did not always provide support in a caring way. The systems in place to check on staff did not appear to extend to the suitability of the agency staff and this meant people were sometimes receiving care which was not responsive to their needs from agency staff that did not always provide caring support.

The checks and audits in place to monitor the quality of peoples care were not consistent in identifying concerns. For example, checks were in place to ensure medicines were stored safely, and stocks were checked however these were not consistently followed by staff. For example, the temperatures of refrigerators and medicines rooms should have been checked daily, these had not consistently been checked by staff. We found the registered manager had completed an audit and identified this and had plans in place to ensure staff carried out these checks. We found some guidance for how to safely administer medicines was not detailed. The medicines audit process had not identified these concerns at the time of the inspection, however the unit manager confirmed this would be checked during a medicines audit and they took immediate action to update the plans.

We found checks were completed at the end of each shift to identify if people had received the care they needed and escalate any concerns. The unit manager told us the staff completed people's daily charts and these were checked by senior staff on duty. All concerns were then discussed in the handover meeting and adjustments made or actions taken. However we found these checks were not consistently carried out. For example, we found some food and fluid charts had not been checked and signed by senior staff on duty, staff were aware that the records should be checked and told us they recognised documentation needed to be improved. The audits carried out by the registered manager and the unit managers had also identified this concern and staff were being reminded to document and escalate any concerns. In another example we found checks which were in place for one person's PEG site had not consistently been completed, and this had not been identified by the audit process at the time of the inspection, however the unit manager said this would have been picked up in the unit audits. This showed further improvements were required to the checks in place to ensure people had the care they needed.

The registered manager told us that they had a system in place called resident of the day to check peoples care plans were accurate and up to date. They told us the process highlights which resident care needs to be reviewed that day, and those who are involved in their care are engaged in the process. This is used to make changes as required and the whole of the persons care plan is reviewed. We found where reviews had taken place, relevant people had been involved and aspects of the persons care plan had been reviewed. However

the process had not identified the concerns we found with the information in some peoples plans. For example, one person's mobility needs had not been reviewed following a recent fall. In another example a person's care plan had not been updated with the advice from a dietician and this had meant their advice on escalating concerns about weight loss had not been followed. This meant the checks were not consistently effective in ensuring care plans were up to date.

We saw unit managers undertook checks on all aspects of peoples care. For example, daily records, equipment, and care plans. We saw these were not consistently effective in identifying areas for improvement for example with medicines. However, the registered manager and nominated individual also undertook additional audits to check on the service. These audits had identified some of the concerns we found during the inspection. For example, with medicines and record keeping, and we could see actions were planned to make improvements. The audits looked at a number of aspects of quality, for example, medicines, infection control, health and safety and care plans. This meant some of the audit processes required further improvement.

We saw checks were carried out on equipment to ensure this was working well. For example, spot checks were done on sensor mats in people's bedrooms to ensure they were in place and in working order. We saw suction machines were also checked daily to ensure they were clean and working correctly. However, we did find one person was using a wheelchair that required a repair. The checks in place had not identified this. We spoke to the unit manager about this and they took action to request a repair. The registered manager undertook a series of spot checks with staff. We saw one check had identified staff were entering the car park too fast in their vehicles; they were not observing the correct dress code and some staff had arrived late for their shift. We saw action had been taken and reminders had been sent to staff about these issues.

The registered manager told us they had spent time building confidence in the location with relatives who had experienced a lot of concerns previously. They told us they made sure they were accessible and relatives could contact them directly by using their mobile phone. They were able to share examples of feedback they had received from relatives which showed positive comments about how the service had developed. People and relatives told us they had opportunities to attend meetings and discuss their experience of the service. One visitor told us, "I have a monthly one to one meeting with the unit manager. I am given a date and time and kept well informed". The registered manager told us some residents are encouraged to be involved in the running of the service. They get involved in managing the main reception, maintenance, and housekeeping. They said risks are assessed to ensure that they are safe to carry out these tasks. We saw satisfaction surveys were carried out on an annual basis and these checked on the quality of care people had received for example food choices, menus and the experience of care. We saw the responses were analysed and changes were communicated back to people and their relatives.

The registered manager understood their responsibilities. We received information as required by law from the registered manager about incidents such as safeguarding concerns. We saw the rating from the last inspection was on display for people and visitors to see. The registered manager could explain how they met the duty of candour and how they worked to ensure transparency within the service.

People and their relatives understood the management structure. Most people knew who the unit manager was and many were familiar with the registered manager and nominated individual. We were told both the management team were all accessible and approachable. One person said, "The unit manager is very nice, they are approachable and they listen". A visitor told us their relative had been at the home a long time and they had previously raised a number of concerns. They told us that since the registered manager and nominated individual had been in post things had greatly improved. They told us both were always accessible and they felt they could go to them with any issues. Another relative told us, "The new

management are excellent, the registered manager is interested and involved and cares about people and the staff, they make things happen". They added that they felt much happier now and worried much less about their relatives care. This was a sentiment shared by everyone we spoke with.

Staff were positive about the current management arrangements and felt the registered manager and nominated individual were accessible and approachable. They could describe how things had improved since the last inspection. For example, one staff member said, "The atmosphere is better. We've got better staff, the morale is a lot higher, the unit is happier and everyone is working as a team and getting the training right. Communication is also a lot better. The new managers are nice and approachable. To me, there's just more stability". Staff told us they were well supported and there were arrangements in place for constant on call cover during out of hours periods. Staff told us they felt listened to and that the registered manager and nominated individual took action when they asked for changes. One staff member said, "I never felt I could go to management before the nominated individual listens to what we say, for example they have increased the staffing levels at night which is much better". A nurse told us, "It's the best job ever, the staff work really hard, they are the best group of staff that I have worked with since leaving the NHS". Staff told us they had regular opportunities to meet with their managers and they had supervision and team meetings. They told us they were supported to identify training needs. The nominated individual said they had put schemes in place to support staff. They told us about a discount for a local sports centre and Indian head massages that staff could access. They also told they had free fruit available for staff every Friday. Staff confirmed this with one staff member telling us, "The registered manager and nominated individual seem to be taking a lot of care of the staff now. We have fruit Fridays (where staff are given free fruits), yoga, Indian head massage and we've had discounts for the gym. It feels like they're caring for us as well". This meant staff felt supported and able to make suggestions for improvements to the management team.

We saw staff had access to regular updates to their training and received regular reminders from the management team when updates needed to be completed. We saw there were records in place which monitored the training staff required. We saw records which showed staff had checks on their competency.

We found collaborative working within the service was in place and this was helping to ensure people received good quality support. For example, the registered manger told us about clinical governance quarterly meetings which were planned and the monthly senior manager meetings. Any lessons learned from incidents, accidents or complaints were shared with others at a meeting which took place every morning to discuss any relevant information with staff from each area in the home. The meeting also allocated tasks to staff for action, this meant staff were kept informed of changes required and helped to ensure people received the care they needed.