

Four Seasons Homes No.4 Limited

# Kingfisher House Care Home

## Inspection report

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## Ratings

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

# Summary of findings

## Overall summary

This unannounced inspection took place on 30 January 2018. At the last inspection on 23 and 24 January 2017 there were five breaches of regulations that we have followed up. Three breaches related directly to the care of people. These were that risks were not fully mitigated because of poor assessment, planning and evaluation of risks; records did not always provide an accurate, contemporaneous record and not everyone received the support or adequate monitoring of their dietary needs. We have seen improvements in many areas. This included the other two breaches relating to staffing and management systems known as governance.

Following the last inspection we asked the provider to complete an action plan to show what they would do and by when to improve the service. We also met with the provider to confirm that all our key questions would improve to at least good.

Kingfisher House 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.

Kingfisher House site is purpose built and can accommodate up to 91 people in total. At the time of our visit there were 70 people living at the service. In Kingfisher House, downstairs is for people with personal care needs, commonly known as 'residential care' and upstairs is for people requiring nursing care. Next door and part of the registration is Spiller. This is purpose built accommodation for people living with dementia. Again this is split into two units with personal care downstairs and nursing care upstairs. There were 26 people in Spiller on the day of our visit and it can accommodate up to 29 people. Everyone can have access to outside space as there are gardens surrounding the accommodation.

The registered manager was present throughout the inspection visit. 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.

The registered manager was very responsive to feedback given and wanted to improve the service for people where ever they could. We received confirmation of actions taken following our inspection visit.

These included the change from domestic showers to health care standard showers so that hot water could be continuously delivered at the correct temperature and not present a risk of scalding. The installation of the domestic showers had been commissioned by the provider and the usage had not been reviewed. This had placed people at potential risk. People had confidence in the management team and found the service to be well led. The management was approachable to people and staff spoke highly of them. There was a desire to drive improvement from monitoring service delivered and acting when matters needed addressing.

People at the service could expect a comfortable, clean and appropriate environment in which to live. People were very complimentary about the catering and food provided. People had access to appropriate healthcare to keep them well. There was a variety and range of activities for people to become involved with should they choose to do so. Relatives and friends could visit people whenever they desired. There were pleasant seating areas both inside and in the gardens.

People's care records were well kept and the assessments and plans provided staff with clear information on how best to support people. Information about people's history, likes and dislikes enabled staff to provide personalised care. Care plans had small details such as how people liked their tea served. Risk assessments were known by staff and followed to keep everyone safe. People were consulted and involved with their care. Plans were kept under regular review. Staff understood about choice and enabling people to make decisions for themselves where possible, but also how to support people where they lacked capacity.

Staff were well supported through provision of training to complete their roles effectively and given guidance, support and supervision with appraisals in place.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was safe.

People received safe support with their medicines.

Staff understood their responsibilities to safeguard people from abuse and were confident about reporting their concerns.

There were sufficient numbers of staff employed to meet people's needs.

The home was clean and people were protected by the prevention and control of infection.

People had risk assessments in place to guide staff in providing safe support.

Good 

### Is the service effective?

The service was effective.

The design and layout of the building met the needs of people who lived here. Adaptations such as health care standard showers had improved.

People's rights were protected in line with the Mental Capacity Act and DoLS.

Staff were well trained and received supervision to monitor their performance and development needs.

People were supported nutritionally in accordance with their needs.

People received support from community health professionals when necessary. Service staff worked well with other agencies.

Good 

### Is the service caring?

The service was caring.

Good 

Staff were kind and caring in their approach and relatives were positive about the care people received.

People and their relatives were involved in decisions about their care.

People were treated with respect.

### **Is the service responsive?**

The service was responsive.

Care plans were person centred and covered a range of people's needs.

People had access to a range of activities suited to their needs.

There was a complaints procedure in place and people felt confident about raising concerns.

People could expect a comfortable, dignified and pain free death.

**Good** ●

### **Is the service well-led?**

The service was not consistently well led.

The service was well led by a management team who were open, inclusive and empowering. The service was keen to continuously learn and improve.

People were consulted and involved in the running of the service.

There were systems in place to assess quality and safety. However, the provider had not identified the matter of the showers being unsuitable.

**Requires Improvement** ●

# Kingfisher House 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.

This was a routine unannounced inspection. It took place on 30 January 2018 to gather the required evidence.

The inspection was carried out by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had used this type of service previously as a relative.

Prior to the inspection we reviewed all information available to us. This included a Provider Information Return (PIR). A PIR is a form completed by the registered manager to evidence how they are providing and care and any improvements they plan to make. We also reviewed notifications. Notifications are information about specific events that the provider is required to send us by law.

We spoke with 16 people using the service and nine relatives. We also carried out a Short Observational Framework Inspection (SOFI) observation. This is a structured observation that helps us understand the experiences of people who aren't able to speak with us. We spoke with 10 members of staff as well as the registered manager and deputy. We spoke with two health and social care professionals. We reviewed care records for nine people using the service and looked at other records relating to the running of the home such as quality assurance records, recruitment and medicines records.

## Our findings

On our previous inspection on 23 and 24 January 2017 we found a breach of Regulation 12 known as Safe Care and Treatment, we said that risks were not fully mitigated because of poor assessment, planning and evaluation of risks. We were pleased to find that risk management to people had been addressed and improved.

Risk assessments were in place and were designed to minimise the risk to people in their day to day lives so that they could keep their independence as much as possible. For example the risk of being hurt if they fell, we saw there was guidance for staff on what support people required to reduce the risk involved without restricting their independence. One person was unsteady on their feet and was at risk of falling. They had a walking frame to give them extra support, but they sometimes forgot to use it. To enable the person to walk independently without restricting them, their mobility care plan asked staff to remind the person to use their frame if they noticed them walking without it. One staff member explained that one person's clothing was a potential trip hazard and therefore, with the person's consent, they had tried different types of trousers.

Risks involved with people developing pressure areas were also explained and guidelines in protecting people in that area was available to staff. This included not leaving people to lie in the same position for too long and helping people to reposition at regular intervals. A relative told us, "I do feel all right when I leave. I don't worry about my relative. They follow the guidance of turning [them] every two hours."

Records showed that this guidance was followed. One person had been admitted to the service with severe pressure ulcers. Risk assessments and care plans had been developed that detailed what support the person needed to keep them free from pain and what treatment they needed for the ulcers to heal. The pressure areas had healed and the staff were following the risk assessments to protect them from further harm. One person told us that staff had explained why they had to keep turning them in bed.

There were also policies and procedures in place to manage risks to the service involving untoward events or emergencies. Each person had an individual personal emergency evacuation plan (PEEP) in place so that staff and emergency workers knew what support they needed in times of emergency. When we spoke to staff they were clear that risk assessments were in place and where to find them. One staff member told us, "The PEEP for each person should be in their room, and also moving and handling procedures for the person." We found that some hot water temperatures were above the recommended limits and could cause potential scalding. Before we left the premises the maintenance staff had adjusted all wash hand basins and bathing facilities as they had thermostatic mixing valves. The reason these were not suitably adjusted was a

combination of new valves and a new staff member being instructed in their usage. These were safe when we left the premises.

We read through the minutes of a recent health and safety meeting and found that actions were taken to ensure staff were trained and processes in place to keep people safe. Where there were incidents identified action had been taken. An example being that on occasion staff had, despite their training, been seen to use the hoist once their own. These staff were supported to understand the safety implications through supervision and further training and observations. This showed us further examples of the registered manager ensuring lessons are learnt and improvements made.

On our previous inspection on 23 and 24 January 2017 we found a breach of Regulation 18 on staffing. We had said that the service did not have sufficient numbers of suitably qualified or competent staff who were sufficiently deployed across the service. At this inspection we found that matters had improved.

Most people were positive about their experiences of staffing levels. One person said, "They [staff] are always there if I need them." Another person said, "The [staff] are good people, they know what I need doing... they know what they are doing." One person said, "Yes it's true they do sometimes have difficulty getting to me, but they only have one pair of hands. I have had to wait half an hour for them to get to me."

We noted that call bells were answered quickly and staff were not rushing, they spent time in people's bedrooms passing the time of day after they had supported them with their personal care. A relative told us, "I am confident that [relative] is fine here. I get help for [relative] if I ask. One day I pulled out the alarm plug from the wall and they [staff] came in immediately." Staff were visible and able to respond to people when needed. The registered manager had a method of working out staffing levels based upon several factors including dependency and numbers of people resident. We examined four weeks rosters and found that staffing levels were maintained. We looked at the agency usage and saw that the same regular nurses and care staff were booked. We spoke with a nurse who regularly worked shifts from an agency. They told us that they had received a thorough induction to Kingfisher House and had their competency checked through training provided by the agency.

Staff told us that they had the training and support they needed to carry out their role effectively. Records evidenced that staff received appropriate supervision and appraisal. These sessions were focused around developing the skills and knowledge of the staff team. In these sessions staff were offered the opportunity to request training and discuss career progression.

We saw that there was a policy and procedure in place for the safe recruitment of staff. The files showed that this procedure had been followed including disclosure and barring service checks on staff. This meant that the service checked upon staff's suitability to work with the people who used the service.

Staff told us that they had training in regards to safeguarding and whistle blowing. Those staff we spoke with were able to tell us what action they would take if they suspected any of the people they supported had been abused. They were able to give us examples of the different forms of abuse and who they would report it to. One staff member gave us an example of the action they had taken when they thought someone had been abused in a previous position. Another staff member said, "I've had the [safeguarding] training and wouldn't think twice if I saw anything out of place... [the management] are always reminding us to listen to people and report anything at all."

People told us they felt safe, one person told us, "I do feel safe, I think of the [staff] here as friends." Another said, "They [the staff] make sure I'm safe, they told me to tell them if I have any worries." Posters displayed

within the service gave information to people about who they could talk if they believed they had been harmed. Whistle blowing procedures were also well displayed for staff. Whistleblowing is the term used when a worker passes on information concerning wrongdoing.

We were able to follow up the statutory notifications we had received in relation to safeguarding matters. We found that appropriate referrals had been made and investigations had been completed. The registered manager worked well with the local authority safeguarding department. We could see that, where necessary, the registered manager had followed their duty of candour. They were able to demonstrate that lessons had been learnt and development opportunities had been put in place. An example was where an item of jewellery had gone missing. Processes were now in place to photograph valuable items to ensure a record of them. A different example related to money being received within the service. Procedures had been revised to make sure there was a double signature when money was received by staff. In addition a limit was now in place on how much money the service would hold for people. These actions would lessen the likelihood of similar events happening.

Medicines were safely managed. One person told us, "I get my pills when I need them; I'm glad [the staff] take care of that for me." Another said, "They [staff] are kind, they make sure I take my tablets and tell me what they are for if I forget."

Staff had undergone regular medicine training with their competencies checked. Training records showed that 100% of staff had completed both the foundation and advanced medicines training. Storage was secure, temperatures checked and stock balances were well managed. Medicines that needed additional storage measures were found to be safe and accounted for. Records were comprehensive and well kept. Body maps were used to monitor the administration of medicines prescribed to be administered in patches. Staff were able to tell us about medicines and their side effects and those medicines that were time critical to keep people well. Staff were observed administering medicines appropriately and told us they were confident that people received medicines as they were intended. There were regular and effective auditing systems in place. Actions were taken to improve and provide medicines safety.

There were systems in place to protect people with the prevention and control of infection. The premises were visibly clean and tidy. We saw cleaning taking place during our visit. We were told that rooms were cleaned every morning. We saw an example of 'before-and-after', with a room being visibly cleaner on our return visit. Staff had access to protective equipment such as gloves and aprons. There were sufficient housekeeping staff on duty during our inspection to undertake the cleaning tasks set for the day. Records showed that 99% of staff had completed their training in infection control. There were systems in place to prevent the potential of Legionella in the water systems. We did a spot check on six mattresses and found these to be clean.

## Our findings

The design and decoration of the premises met people's needs. All areas of the premises were suitable for people who used wheelchairs and the environment was suitable for people living with dementia. However the adaptation was not always suitable. This was particularly relevant in the case relating to showers. Ordinary domestic showers had been installed and the temperatures they reached could not be regulated and kept safe. We would expect the provider to have installed 'healthcare standard' showers which are designed to prevent unsafe hot water temperatures under all conditions. Following our site visit the registered manager confirmed that the purchase order for the work to proceed had been authorised. The service was waiting for the date for the engineers to come and fit the equipment. Therefore, going forward people will be protected by the adaptations in place. The manager had lessened the risk to people until the work was completed by ensuring staff accompanied people to shower and had placed warning signs on the shower.

On our previous inspection on 23 and 24 January 2017 we found a breach of Regulation 14 that related to nutrition and hydration. We said that not everyone received the support or adequate monitoring of their dietary needs and food/fluid intake. On this inspection we found that matters had improved. Staff understood the importance of keeping records. Especially if there was a clinical need to do so. One staff member told us, "For people on food or fluid charts this should be documented and noted at handover if under target." Staff were observed assisting people to eat in a careful and considerate manner. Talking with them and ensuring food was presented at a speed that suited them. Other people were able to eat independently. People confirmed that they were enjoying the food which looked and smelled appetising.

People were positive about their experiences relating to food provided and the catering. One person said, "The food is absolutely excellent - beautiful in fact and I look forward to every meal. They ask me what I want the day before and I choose. I can change my mind if I want." People told us that they enjoyed their meals; they had two choices for dinner and were able to ask for an alternative if they did not want what was on the menu. One person told us, "The food is well okay, I enjoy my meals." Another person said, "I can ask for something different if I don't like what's on offer, I have seconds if I fancy it."

We were told by staff that snacks were available 24 hours a day. Freshly made up sandwiches were left by the chef for people at night along with fortified yoghurts. A staff member explained, "If people are not happy with the food at a mealtime the chef will try to do something that they would like such as a jacket potato." A person gave a good example of this and told us, "Breakfast is lovely. Today I had porridge, egg and bacon. I never go hungry. I asked for a different thing at lunch because I wasn't too hungry so they made me egg and

chips with a banana to finish."

The home had responded to specialist feedback given to them in regard to people's dietary needs and had taken action to meet them. For example, by introducing food that was fortified with cream and extra calories to enable people to maintain a healthy weight. Staff were knowledgeable about supporting people to eat healthily and meeting their individually assessed dietary needs. We saw in different parts of the service where people were not able to eat their meal unaided they were offered support to eat. We saw evidence that specialist cutlery, plates and cups were available to make it easier for people to stay independent while they were eating. In a care plan there was reference to ordering 'lite cutlery' for one person who had trouble holding regular cutlery. Meaning that people could continue to make maintain their independence and helped to ensure that people got the food they needed to stay well.

The building was well suited to the needs of people. There was access to safe well maintained gardens where people could access nature and fresh air safely. Outdoor chairs and tables were provided. For security reasons and people's safety, there was a buzzer system to let people in and out of the premises. Lounge areas were homely and comfortable. Seating in lounges were arranged in a small sitting room style giving a cosy feel.

All the people that we spoke with said that staff were well trained and able to meet the needs of people. Staff told us that they had the training and support they needed to carry out their role effectively. The registered manager had a computerised training matrix that allowed them to monitor any training updates that were needed. Current compliance of all staff training stood at 96%. This showed us that staff had all relevant up to date training in place. There was an effective and well-structured induction for new care staff. A senior member of staff was present on the day of our visit and able to tell us and demonstrate that the induction for new staff was thorough and at the pace of the staff member being inducted. The registered manager had sent us information in the form of a PIR. It told us that not only does the provider have internal training arranged by the provider but that they access external courses too. The service had 90 staff attend dementia framework training. This was a program that ran for a year giving staff both face to face training and e learning. This ensured that the service was accredited as a dementia home. We looked at the training of nurses and found that they received regular clinical updates to ensure that they remained registered with the Nursing and Midwifery Council (NMC)

Records demonstrated that staff received appropriate supervision and appraisal. These sessions were focused around developing the skills and knowledge of the staff team. One staff member said, "Yes I receive regular supervisions. I have it every 3 to 4 months by one of the nurses. We also have annual appraisals in place." In these sessions staff were offered the opportunity to request training and discuss career progression. Staff spoke of good staff morale and how they all worked as a team. Nurses had clinical supervision and were able to discuss practice issues within a group for shared learning.

People's care records showed that their day to day health needs were being met and that they had access to healthcare professionals according to their specific needs. The home had regular contact with GP surgeries that provided support and assisted staff in the delivery of people's healthcare. People were supported to attend hospital and have access to other healthcare professionals. One person told us that, "They [staff] get me a doctor if I need one, they [the staff] make sure of that." People were able to attend hospital appointments and had their needs reassessed following a hospital stay.

During our visit the Chiroprapist was visiting. They had been coming to the service for the last 13 years. They gave positive feedback about the service on offer to people. We overheard staff asking people if they wanted their feet done and respecting their decisions.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People using the service had their capacity to make decisions and consent to their care assessed appropriately under the MCA. DoLS applications had been made to the local authority and authorised where appropriate. The registered manager monitored these carefully and had a tracker in place to ensure they knew where applications were and if they needed to be reviewed or where circumstances had changed and needed to be chased up. During our visit we met a representative of the local authority who was visiting to review a DoLS application. They gave positive feedback and said the registered manager made appropriate referrals. This demonstrated to us that other organisations were consulted to enable the best outcomes for people using the service.

Staff demonstrated they understood the MCA and DoLS and how this applied to the people they supported. Staff were able to tell us who and why people were subject to DoLS. Care plans recorded where other people had lasting power of attorney (LPA) and staff understood what this meant. People who had been appointed LPA for care and welfare had been consulted and signed consent to form for care support in the care plan. Care plans had good evidence based best interest decisions documented with appropriate people consulted. Important decisions such as not to resuscitate and covert medicines were appropriately managed and recorded, stating who had made decisions and why it was in the persons best interest. People's care records showed that consent had been sought by the service to take photographs and to support the people they worked with, where able people had signed the consent form. We observed that staff knew people well, and this allowed them to support people to make decisions regardless of their method of communication. An example of this was at lunch time when the two meal options were plated up and people were shown each one and enabled to decide for themselves based upon what they saw and smelt. This showed us that the care staff had good practice knowledge of how to promote real choice.

## Our findings

People felt that staff treated them well and that they were kind and caring. One person said, "The girls [staff] are kind." Another person said, "I feel comfortable here, I can tell [the staff] anything. They are so friendly and listen well."

When staff spoke with people they were open and friendly, we saw there was an atmosphere of light-heartedness and laughs. Staff entered people's rooms with a bright greeting and people responded in the same way. We heard a staff member compliment a person on their newly styled hair that was appreciated. There was obviously a strong level of familiarity and friendship. One person felt so strongly that they told us, "The ones [staff] I see regularly are kind to me. In fact they love me and I love them. Well they tell me they love me. It gives me such a lift when they say that and it cheers me up."

We observed that people's dignity and privacy was respected. Staff knocked on people's doors and waited for a response before entering. We overheard a member of staff seek permission before they moved a person in their wheelchair. One person said to us, "They treat me with great respect and I feel they care about me and they know what's good for me. I am content with all of that." We spent time in communal areas and observed a calm and relaxed atmosphere. Staff responded to people in a friendly and supportive manner in a way which maintained their dignity. Staff told us that they tried to support people to maintain their independence as much as possible and assessed the level of support people needed all the time.

People were involved about making decisions relating to their care and support. One person said, "I can manage to go to bed on my own and they will help me up at a suitable time in the morning." Relatives said that they felt involved in care and decisions and they were made to feel at home. People could have visitors whenever they wanted and there were no restrictions in place. We saw records of people's care reviews and it was evident that family members had been involved and able to express their opinions about the care their relative received.

## Our findings

On our previous inspection on 23 and 24 January 2017 we found a breach of Regulation 9 for Person centred care We said that records were not updated as and when people's needs changed and did not always provide an accurate, contemporaneous record. Staff were not using people's plan of care to help guide them in delivering effective, cohesive care. At this inspection we found a much improved situation. Care plans were clearly written and had been reviewed and updated to reflect people's changing needs and preferences. One staff member told us that in order to communicate with a person staff needed to read their care plan. Such useful information, "Promotes staff to read about their service users."

People told us they were happy with the standard of care they received. Care plans recorded information about the person's likes, dislikes and their care needs. In plans we saw a document entitled, 'Living - my choices'. This is a Four Seasons initiative across its care homes. It contained life story information, documented important relationships and past occupation. In one person's file we saw that illustrations and pictures were used to clearly show the person's main occupation. This was to evoke memories for people. People's religious beliefs were clearly noted. A staff member told us that the local vicar visited regularly and that a priest was arranged for those who wished them to visit.

Care plans were split into two with a working document that needed regular reference held in each person's bedroom. Care plans were detailed enough for staff to understand how to deliver care to people in a way that met their needs. The outcomes for people included supporting and encouraging independence in areas that they were able to be independent as in choosing their own clothes, what to eat and when to get up and go to bed. The document entitled 'My journal' recorded a person's daily life. This contained daily notes made by care staff. It was informative about the person's day. For example their involvement in activities, what they chatted about with care staff such as, 'had nails done, enjoyed bingo.' Comments from visitors were welcomed here too.

Care plans were very clear and informative about the care to be provided and the person's preferences when receiving this care. This meant that staff could get a good insight into the service user as a person and provide person-centred care. It was evident that there were regular reviews and updates so that care plans continued to reflect people's evolving needs. We fed back a concern relating to one person living with dementia and their distress at being at the service. This was quickly followed up by the registered manager and they confirmed that their dementia nurse specialist had visited and reviewed the person's needs and made appropriate changes to meet this person's complex needs.

We talked with people about how their care needs were met, they were positive and about the staff's supportive and caring attitudes. One person told us, "I like to keep myself to myself, but I'm not lonely [the staff] come in and out and make sure I get what I need." Another said, "I do spend a lot of time in my room, but will go down for my dinner and some of the shows."

Different activities and outings were planned and staff worked together in making sure people were provided with the opportunity of participating in activities to reduce the risks of boredom. There was a planned programme of activities displayed around the service. A member of staff told us how they liked to get the community involved with the monthly coffee mornings and also the Summer and Christmas fairs held at the home. We received differing views about the activities on offer. One person said, "I don't like to miss any activities and I'm a sociable person. This morning I did exercises and this afternoon it's dominoes. There's lots to do and then there's TV. Boredom doesn't enter my head." Another said, "I like the exercise classes. As I'm settling in I'm doing more, like the coffee meetings, the ice cream session and the talks. There's certainly things to do. I read and watch TV so I'm happy. I'm never bored."

One relative said that they would welcome more staff to provide activities on a one to one basis. Staff spoke about making cards with individuals in their bedrooms, but people fed back that there was less to do for those who remained in their bedrooms.

End of life care planning was in place for people. People's wishes and preferences were known and documented in people's plans. This included people's choice to be resuscitated and if they wished to receive medical interventions and if they wanted to go to hospital. People had documentation such as Do Not Attempt Cardio Pulmonary Resuscitation signed by GP. We saw records where people had made their own decision on this matter with a GP and relative present. Staff had received appropriate training. Nursing staff were aware of and able to administer pre-emptive medicines and use specialist techniques such as syringe drivers for pain, agitation and sickness. A syringe driver helps reduce symptoms by delivering a steady flow of injected medicine continuously under the skin.

A person had died the morning of our inspection. We were told that their family had been supported to stay with them through the night. Staff had kept them company and offered snacks and drinks to them. We saw that the person's wish to receive care at the end of their life in the service and not to be admitted to hospital, had been respected. Staff talked respectfully about the person as they made necessary arrangements after they had died. This demonstrated that people were supported to have a dignified death of their choosing.

The service routinely listened to people to improve the service on offer. Views of people were regularly sought both informally and formally on a regular basis. Examples of this were visible at different points within the service. An electronic device was available for people to leave their feedback and experiences. One person said, "I feel content here, without any worries." The registered manager had a robust complaints process in place that was accessible and all complaints were dealt with effectively. People were confident that if they did have any reason to raise a complaint it would be handled quickly and dealt with properly. A person living at the service said, "I haven't needed to complain, staff help me if I need to have a grumble."

A staff member told us how they tried to resolve concerns raised, "If it is something to do with the food, we will get chef to come and have a chat. Lost items of clothing we take them into laundry room to see if they can locate clothes." When a complaint had been received we could see that the matter had been dealt with, but also consideration was given to prevent similar matters happening again. For example, one complaint had been made by one family member but others did not necessarily agree. However, the matter was taken seriously, investigated and resolved. A member of staff personally apologised to a relative. Examples seen showed us that complaints received were viewed as positive and used to drive improvements. The

registered manager was clear how complaints sat with safeguarding matters and their duty of candour and the need to apologise when things had been found to have gone wrong.

### Our findings

On our previous inspection on 23 and 24 January 2017 we found a breach of Regulation 17 that related to Good governance. We said that systems were in place to measure the effectiveness and quality of the service provided but we found poor record keeping did not support this or show that people were getting the support they needed around their health and welfare. This exposed people to unnecessary risks. These matters had been addressed and we found improvements had been made.

There was a registered manager in place who was supported by a competent deputy manager. The management team worked well together and had ensured the steady improvements at the service. They had been supported by the systems and processes in place by Four Seasons and managers within the wider organisation. However, the provider Four Seasons, through their systems had not recognised the risk of using and installing domestic showers at this location. This lack of review and the high potential risk meant we have rated this section as requires improvement.

Staff were positive about the culture changes and the management style within the home. One staff member said they would describe them as, "Brilliant." Another staff member said that morale had improved and that staff regularly got together after pay day. Staff we spoke with said the management team were supportive and that the registered manager was easy to talk to them. They were able to approach them if they needed to talk with them and were confident that the registered manager would take action to deal with any concerns they raised.

People living at the service were on the whole positive about the management, some would have liked to have seen more of the registered manager, but they knew who she was. Others were more positive. One person said, "The manager is lovely. She is easy to talk to and listens to me. Everyone here is good." A different person said, "I don't know much about the management of the place. Things seem to run well." A relative told us, "[The registered manager] is wonderful. She bends over backwards to help." People were consulted and we found the minutes from recent resident meetings showed that people were informed and involved in matters relating to staff changes, and activities arranged, such as a tea dance that was being planned.

The service had good links with a host of health and social care professionals as they were on the border of two counties they related to both local authorities and knew how the systems worked. There were good working relationships with social workers, local hospitals and the local primary care providers such as the GP. Many professionals were consulted and involved with people's care support packages including more

specialist dementia advisers. This showed us that service staff worked openly with others but also that they were keen to seek advice if needed.

Systems were in place which continuously assessed and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents monitoring. The registered manager understood their duty of candour and we saw a recent letter of apology on one matter where they had set out what they would do differently in the future. The documentation showed that management took steps to learn from such events and put measures in place which meant they were less likely to happen again.

The registered manager continued to assess the quality of the service through a regular programme of audits. We saw that these were capable of identifying shortfalls which needed to be addressed. During the inspection visit the registered manager gave us a copy of their action plan. We had previously received updated action plans from our previous inspection. This was a gathering together of different audits and management visits where any improvements were recorded and monitored and followed up. The registered manager also had a system of trackers that monitored various pieces of work they were developing such a recruitment trackers and DoLS applications. This showed us that the registered manager had oversight of the service and its functions and so did the provider.

We noted that notifications to the Care Quality Commission were made when necessary in accordance with legislation. These were consistently of good quality and informative. This demonstrated the registered manager was aware of the responsibilities of their role. Internal systems of incident reporting were well managed. Training records showed that 100% of staff were trained in how to use the internal systems. We received a copy of this data and were able to see that the provider had oversight of all incidences within the service and was able to monitor directly any trends or areas of concern to action. The key element of this was that investigations were followed through with key findings noted. Lessons learnt were implemented to ensure continuous learning for service staff.