Four Seasons Homes No.4 Limited

North Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 10 June 2016 and was announced. The purpose of this inspection was to follow up on the compliance actions identified at the last inspection on the 13 April 2016. The service was initially inspected and placed in special measures on the 11 and 16 November 2015. This meant we had significant concerns about the service and judged it to be providing inadequate care for people using the service. As well as identifying a number of breaches of regulation, we also placed a condition on the services registration. This meant they were not able to admit anyone else to the service until we were satisfied they were able to provide a safe service which could effectively meet people's needs. We have communicated with the Local Authority who have followed up on individual safeguarding concerns and have been instrumental in supporting the service to improve.

We have since the inspection of November 2015, met with the provider several times and received updated action plans. We inspected in April 2016, as the provider said they were confident that they had made considerable improvements. Our findings following this inspection indicated that there were still concerns. This inspection was undertaken on the 10 June 2016 and had advised the provider of this date a day in advance, as we felt it essential that the manager and Regional manager should be present so we could establish what changes had been made. We found that the service had improved and there were no longer breaches of regulation

The service is registered for up to 65 people who might have a nursing need and, or living with dementia. On the day of our most recent inspection there were 34 people using the service.

Following our inspection in November 2015, the registered manager resigned and a temporary manager has been in post since then. They have recently applied to be registered as manager with the CQC and were successful.

'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.'

During our inspection on the 10 June 2016 we found: People's needs were assessed and staffed accordingly. There were enough staff to deliver effective care and continuity was being maintained. However high staff vacancies could potentially threaten the stability of the service.

Medicines were usually administered as prescribed but we identified a number of gaps on the medication recording sheet and a number of occasions where people did not get their medicines as prescribed. We have made a recommendation around more effective medicine auditing.

Risks were mostly managed well but we identified a number of issues around records and these not always

reflecting current practice. Risks associated with long term conditions and poor health status were not always clearly documented or records showing how these were being monitored.

Staff had a good understanding of how to report concerns and safeguard people in their care as far as reasonably possible.

Staff recruitment was robust at the last inspection so was not inspected again.

Staff were being supported through a robust programme of training, support and direct observation. New staff were being supported through a detailed induction and where possible staff were encouraged to undertake additional qualifications in care. There was a notable shift in culture and practice but some of these changes would take a while to become embedded.

People were supported to eat and drink according to their preferences. There were systems in place to monitor what people were eating and drinking but this could be strengthened by clearer records and a clear concise evaluation. We have made a recommendation about this.

People's health care needs were documented but we did identify some gaps which again we attribute to the homes record system and clinical oversight. Some improvement is still required.

Staff were complying with the Mental Capacity Act 2015 but were confident in staffs practices and records underpinning capacity and choice.

The staff demonstrated care and compassion and had a good understanding of people's needs. Care was centred around the individual and we saw good outcomes for people.

Complaints and feedback about the service were used to improve the service as required.

The home was responsive to people's needs and gave people the opportunity to participate in a range of activities which were appropriate to their needs and enhanced their sense of well- being.
Documentation had improved since our last inspection and records gave a good account of people's needs and actions staff should take to ensure people's health and well- being were maintained.

The home was being well managed and inclusive of the local community and family members. Staff felt well supported and the organisation of the service had improved.

Audits and quality assurance systems were in place to monitor the service delivery and take into account how the service was being provided. As a result of audits actions plans had been implemented. Further audits based primarily on observation by experienced quality assurance staff were being rolled out to try and capture the experiences of people who might not be able to tell staff about their feelings or complete a questionnaire.

Although the service had come along way further improvements are required to achieve a good rating

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 mostly safe.

Risks were not always identified and therefore not effectively managed.

There were enough staff to meet people's needs in a timely way but staffing vacancies remain a threat to this.

There were systems in place to help ensure people received their medicines safety. However a number of minor errors had not been identified by the service.

Staff knew how to safeguard people in their care and report concerns.

Is the service effective?

Requires Improvement

The service is mostly effective.

People's health care needs were not always documented accurately or actions recorded which could result in people not getting the care they need.

People were supported to eat and drink enough but the monitoring of this could be improved.

Staff skills and competencies were being developed through improved training, support, supervision and direct observations of practice.

Staff had a good understanding of how to support people with their choices and knew how to support people lawfully where they might be unable to consent to care and treatment.

Is the service caring?

Good

The service is caring.

People are sufficiently stimulated and supported by caring staff who help to promote people's well- being, dignity and independence.

People are consulted about their care needs and these are promoted as far as possible

Is the service responsive?

Good

The service is responsive.

The staff provide opportunities for people to help maintain their physical and mental health and take part in a number of activities in the home and the wider community. They do so involving family members.

People's needs were well documented and showed what support people needed and how risks to people's safety were mitigated and how people's health was promoted.

Is the service well-led?

Good

The service was well led.

There was a strong management presence which staff were confident with.

There were good quality assurance systems in place to assess and measure the effectiveness of the care being provided.

The work force were being supported to ensure they were sufficiently skilled to provide effective care.

The staff were working hard to engage the local community and raise their profile.

North Court Care Home

Detailed findings

Background to this inspection

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

The inspection was announced giving less than 48 hours. This was because we inspected the service specifically to consider whether we might be in a position to lift the current restriction on the homes registration. We required the manager to be present for this inspection.

The inspection was carried out by an inspector and a specialist advisor who was a qualified nurse with many years of professional experience.

As part of this inspection we considered the information we already held about this service including their recent application to lift the condition, recent inspection reports, notifications which are important events the service are required to tell us about. We have also had communication with relatives.

During our inspection we spoke with nine people, ten staff, three visitors and case tracked six people where risks had been identified during this and previous inspections. We looked at a number of records, carried out some observations of care and requested some additional information.

Requires Improvement

Is the service safe?

Our findings

We last inspected this service on the 13 April 2016 and found a number of areas where the service was not complying with regulation. Where there were no concerns identified at the last inspection we have not looked at those areas again at this inspection. We had concerns at the last inspection about infection control, safe administration of medication, staffing, safeguarding and managing risk. We had no concerns about staff recruitment.

We previously had concerns about staffing levels and found at this inspection in June 2016, this had improved. Staffing rotas showed that shifts were covered as required and in line with people's assessed needs.

Staff recruitment was ongoing and there was a high vacancy rate for staff including 180 hours vacant per week for nurses and 180 hours for care staff. The manager told us the organisation had a recruitment specialist and every effort was being made to recruit additional staff particularly trained nurses. The provider continued looking at ways to recruit and retain nurses in the midst of fierce completion. The home were no longer using agency staff to cover care shifts but were reliant on agency nurses to deliver effective care. The same agency nurses were used to ensure continuity of care. The manager said a number of staff appointments had been made recently. However we felt the level of nursing vacancies was having an impact of the quality of nursing care provided. We identified some poor practice during this inspection which had not been identified by the management team or the trained nurses such as errors of recording.

Staff told us there were enough staff and staffing levels were being maintained. Staff said weekends were no different and they had the same numbers of staff. They said there were no agency staff just trained agency nurses. They said using more permanent staff meant people got continuity of care. Another staff member told us they previously were unable to give the care people needed because of staff shortages. They said things had improved and the shifts were more organised with good engagement, good support and the right staffing levels. We observed staff working cohesively and we saw that people received timely care. Staff told us they had time to meet people's needs in a way of the person's choosing. They told us they had time to sit with people and provide recreational activities.

At the last inspection in April 2016, we did not complete a full audit of infection control procedures but identified a number of areas and practices where infection control was poor such as communal areas which were dirty and sticky, waste materials not being disposed of properly and dirty cups and plates being left out. We told the provider to take action to improve in this area. At this inspection we found all areas of the home to be clean and odour free. Sufficient staff were employed to ensure the cleanliness of the home and staff were observed taking appropriate actions to minimise the spread of infection. A relative told us, "The home is much cleaner now."

At the last inspection in April 2016, we identified a breach in relation to the safe administration on medicines. We noted that some creams were out of date; there was a lack of robust information about people's medicines and their preferences on how to take it. Medication protocols were not robust. During

our inspection in June 2016, we observed medicines being administered to people and this was done safely and in a way which was appropriate to people's needs. Medicines prescribed when necessary such as pain relief were offered to people and the nurse ensured people were comfortable.

People's care plans contained a comprehensive list of people's medications and their side effects within the section "Drug Therapies and Medication Needs. " Professional notes showed people's medication was regularly reviewed to ensure it remained appropriate to need. Abbey pain scales were used as an assessment tool to establish how much pain a person might be experiencing and how they might express this where they might not be able to verbalise this.

At the last inspection we found a number of creams undated or past their best date. In our inspection in June 2016, we found creams which had been opened included the opening date and name of the individual. This was good practice and ensured creams were given to the right person and could then be changed monthly.

We looked at medication records and saw a number of gaps in recording between the 26 to the 29 May for a number of people without any explanation. The nurse was not able to explain these discrepancies. However when checked we saw that the medicines had been administered but staff had forgotten to sign. We also saw from recent incidents records that one person had missed their medication and another had not had their pain patch for one day as required and another did not have the medicines they required as they were out of stock.

We looked at people's Diabetic Monitoring forms and found gaps in recording. The reasons for this were explained to us but without a nurse being present we would not have been aware and the information about this person could not easily be found as it was recorded in different places. This was a concern to us as the nurse coming on to the next shift might not always be aware of the recent history of the person who had needed medical intervention. Handover records were kept on each person but we would expect all the required information to be on the persons file. For this person there was no 6pm recording of their blood sugar or a record of insulin being given or withheld. The person had not missed medication but had been admitted to hospital but this was not clear from their records. This was poor practice to have medication unsigned for and no explanation on the back of the form. This omission occurred ten days ago and there was no evidence this had been identified by the service. The home were not able to provide us with a recent medication audit and this requires tightening up.

We recommended that daily audits on medication records should be implemented to pick up recording errors soon after they occur so this can be acted on as quickly as possible

We looked at other records including a signature of which nurse was holding the medication keys and who they handed them to. However this did not accurately reflect which nurse was holding the key and we found other records such as "Duration of Medication round ". There were no records for 28-5-16 and no night signatures for 29th, 31st May, 2nd and 7th June. An unclear system for these records might make it difficult for an agency staff or new nurse who would not easily know what to complete.

During our inspection in April 2016, we identified a continued breach of regulation 12 which refers to safe care and treatment. We found records were ambiguous and we could not always see if risks were fully mitigated as risk assessments were not always in place. We had concerns around the monitoring of people's health care needs, pressure care/mattress setting, skin tears and the effective management of pressure care. We had concerns about a person at risk of chocking because their documentation was unclear and staff did not know what their current needs were. We also identified concerns about a person's use of oxygen as there

was no guidance for staff on its usage.

Improvements were identified during our inspection in June 2016. Risk assessment workshops have been implemented and attended by a number of staff and the manager. New company risk assessments have been implemented and there has been an audit on equipment specifically wheelchairs and foot plates.

At our inspection in June 2016, we looked at the same people's records we looked at last time and additional people. We found some improvements had been made. Care plans had been altered to reflect people's needs. We saw there were records in place including a Moving and Handling Risk Assessment for each person which had a clear description of any equipment used to support a person with transfers. Folders in people's rooms had clear written guidance for Moving and Handling .There was a Personal Emergency Evacuation Plan (PEEP) which was up to date and clear. We observed that a laminated copy of this plan had been placed in the folder in This was good practice as it is very clear to the carers and others what people's requirements were in case of emergency.

We noted on the ground floor there were bedrail assessments and risk assessments which had been regularly reviewed. However on the first floor we saw a person had a bed rail consent form but no bed rail risk assessment so it was not clear if the person had been assessed and if bedrails were suitable for use. We saw an example of a recent bed rail audit which had been completed so not sure why this had been missed.

We identified a number of concerns in relation to risk. Two people had acquired pressure sores at the service. There was clear documentation in place for both. However for one person the care plan did not reflect how staff were treating the person's pressure area. Their records were not up to date and there was not up to date information about the wound, its size or up to date photograph. There was a risk that the person would not get consistent treatment.

In addition, we identified a person whose bed-sheet did not fully cover the mattress and could have caused additional pressure to their already poor skin and the mattress beneath was stained. The person had a pillow under their legs whilst on a pressure relieving mattress. The nurse said this was the person's choice however there was no mention of this in their care plan and putting a pillow between the mattress and the legs means that the pressure relieving effect of their mattress was lost and the legs will have no therapeutic movement to aid blood circulation. The nurse was advised of this.

Mattress settings were still not being recorded in people's care plan in line with a person's weight and needs. Mattress setting differed without a clear justification as to why and how it was most appropriate to people's needs. The nurse was unable to find information about the product to assure us, they were confident about the use of mattress settings and what they should be. This is poor practice throughout the home, the types of mattress's being used should be recorded in the care plan and the correct settings for each resident should also be documented. They cannot be monitored or audited if this information is not known.

At the last inspection, we had identified a person at risk of choking and who had actually struggled with the food presented to them. The person has capacity to choose and liked food not advised. They have been assessed by the Speech and language team and been given appropriate advice. However although their care plan has been updated in terms of this person's needs, wishes and risks, we found the room information contained information which was still incorrect. This was unsafe as carers may use this for guidance. With a person at high risk of choking this folder with their care plan should be reviewed and contain accurate information. We noted another person's care plans gave a very detailed insight in to the person's needs and a high risk of chocking. However this information had not been transferred to their care folder in their room and when we asked staff supporting this person they did not identify them at high risk of

choking.

We saw people's weights were being monitored and people had been referred to the dietician in some instances and prescribed dietary supplements. However we found one person on the nursing unit had lost weight and this was recorded. However when the care plan in relation to nutrition was reviewed there was no reference to the fact the person had lost weight or if interventions were adequate. In contrast, we reviewed people's weights on the ground floor and found for one person they were on weekly weights and having a fortified diet and milkshakes.
The chart has been completed with weekly weights and it is easy to see that their weights were stable. The record had space for comments and monitoring. We felt this was good practice as it is a clear visual guide to a person's weight and the frequency of monitoring that is being carried out. It then contains space to comment and change the regime if necessary.

One person was clearly able to express their needs and wishes but there was no plan in place to try and help support their continence with a regular toileting programme. There were no details about the size or type of incontinence pads required. The manager told us that referrals had been made to the continence service and the home were in the process of reviewing people's continence needs and providing staff training on continence products and how to use them.

At the last inspection in April 2016, we felt all staff spoken with had a good understanding of raising safeguarding concerns and knew how and who to whistle blow if they felt their concerns were not being addressed. Staff had received training and safeguarding was a regular agenda item as part of staff supervision and team meetings. Staff told us during our inspection in May 2016 that things had definitely improved and the manager was not afraid to tackle poor practice to which some staff had acknowledged had occurred in the past. Staff felt the care provided to people had significantly improved and felt both people and staff were a lot happier.

The manager told us there had not been any recent safeguarding concerns other than one, which we were aware of. This was not substantiated.

Requires Improvement

Is the service effective?

Our findings

At the last inspection In April 2016, we identified a continued breach around safe care and treatment and could not always see how people's health care needs were met. We had concerns about continence and bowel management and the monitoring of what people were eating and drinking. At our most recent inspection In June 2016 some improvements had been identified. We found staff were knowledgeable and familiar with people's needs. Care plans had been updated and contained very detailed information. We saw the home had updated some of their documentation including introducing a "Clinical Hotspot Indicator ", which stated primary high risk areas/information staff should be aware of such as if a do not attempt cardiopulmonary resuscitation, (DNACPR,) if there was a risk of choking and other medical treatment/intervention.

We asked one relative about their family member's health care needs. They told us, "The staff are more attentive to [my relative], they are better than they were. They phone me regularly if mum needs a GP visit or feels unwell, before they didn't tell me if she had seen a GP."

We did however identify some concerns which we have asked the service to address. We were not always able to find a continuous record of care delivery as information was being recorded in a number of different places and there were separate records being used by the nursing and care staff. For example one person's records referred to the next of kin being informed about the person's eye but it was not clear to us what had been wrong with the person's eye. Daily notes had been written by the nurse in one set of records and by care staff in another set of records showing the person had a bruised eye, one record stated how this was treated but there was no evidence to suggest how the person received the bruised eye or if there had been any investigation. It was very difficult to establish how needs were being monitored and met when two separate daily record booklets were being completed. If a Registered Nurse deals with a person and writes advice concerning the persons care, the care staff do not have access to this information. This is poor practice as it does not give a current and ongoing record of a person's care. In addition we noted that the recording of bowel motions on the nursing floor might also be recorded in different places with no clear oversight or monitoring of this which could result in action to alleviate constipation delayed.

At the last inspection in April 2016, we identified some poor practice and a breach around people's nutritional needs. At this inspection we carried out observations of the lunch time experience which were positive for people. Records and observations showed people were regularly being offered snacks in between meals and finger foods and the quality of the meal time experience was improving. A nutritional support assistant had been appointed to encourage and promote people's eating and drinking and to assist with this when staff were busy. Our only concerns were records did not always show a clear evaluation of what people were eating and drinking and if it was enough for their needs. Records were recorded in different places which did not help us see continuity of care. For example one person's daily notes viewed after lunch said they had eaten and drank well. Their record showed they had some porridge, (no quantity) recorded and 50mls of tea which is not very much. However another separate record showed they had a homemade milkshake.
We recommend that records around the management of people food and intake is standardised so there is

no difference between each floor. The use of shaded plates would help determine how much people had eaten and staff to be reminded to include totals of fluids taken which could be assessed against individually agreed fluid targets. A continuous record would give a clearer picture of the persons care.

We saw that dining room audits had recently been completed to assess the quality of people's experience and if their dietary needs were being met. The audit awarded the highest star rating possible. The audit was internal and did not record what people thought about the food or provide evidence that people's experiences were asked for.

We noted that people's records contained information about a person's capacity to make decisions about their care and welfare and where they were unable to make decisions the home had documented how they had made decisions in their best interest and who had been consulted. Staff were observed offering people meaningful and appropriate choices and had received training on the Mental Capacity Act 2005 and the Deprivation of Liberties so knew how to support people lawfully.

At the last inspection in April 2016, we were concerned about the ongoing support, development and training of new and existing staff and identified a breach in this area. At this inspection in June 2016, we saw improvements in this area. The home manager was investing in CHAPS which was a scheme which supported care staff to obtain additional skills to enable them to undertake tasks which might have previously been carried out by a nurse, such as taking blood, and administering medicines. They would then be able to assist the nurse but not replace the need for nursing staff. At the last inspection, we found the nurse working downstairs was an agency staff member and the staff member leading the nursing floor had undertaken enhanced training but was not working under direct supervision of the nurse. We were not confident of their skills level. Since then we found additional staff have been enrolled on this programme and were being supported through a programme of additional training. Staff champions had been identified which were staff with specific interests and skills who took a lead on a key area of practice. For example nutrition lead and dementia care lead. Some care staff were champions and were supported by a qualified nurse.

Staff we spoke with told us, they had undertaken a lot of training in recent months and felt they had the skills necessary to deliver effective care. One staff told us, "There's more support now and much more training: end of life, dementia care, promoting continence, and clinical skills. Another member of staff told us the training had improved and they were doing additional training so they could support the nurses. They said they had done medicines training, taking blood, and updating records. They said, "There is training almost every day."

Assessment of staff's competence was completed for a number of key areas of practice including the safe administration of medicines. The manager was an approved train the trainer and delivered a lot of training in house. At recent clinical skills days, questionnaires were issued to try and identify where staff felt their training gaps were so this could be addressed. Key policies have been reissued and staff asked to familiarise themselves with them.

Training was planned around the specific needs of people particularly around dementia care and training around promoting continence and good oral hygiene. End of life care and syringe driver training to control pain symptoms was being undertaken by the nurses.

The manager told us all staff supervisions were up to date, annual appraisals had been completed and they were doing direct observations of staff practice to ensure staff had a sufficient understanding of their

training and able to put it into practice. We saw copies of direct observation which were sometimes role specific and other times task specific. They were used to assess the person's skill in a particular area and to identify if any additional training or resources were required. We saw supervisions had been planned in advance to ensure these took place in a specific time frame and all supervision/appraisal were up to date.

New staff had been signed up to the care certificate a nationally recognised induction programme which they could then use to advance to further recognised awards, certificates and diplomas in care . We saw examples of staff induction and staff told us what was covered and how they were supported until they felt confident to work independently of other staff.

Good

Is the service caring?

Our findings

At the last inspection, we identified caring practices and rated this section as good. We continue to see this in place in terms of staff practice and how people were being supported.

During our inspection in June 2016, we carried out observations in both units, over lunch, across the day and during activities. We saw people were in a state of well -being and relaxed, responding well to the staff. In the unit for people living with dementia, we saw good family involvement and support from volunteers. People were not left unattended and we saw staff promoting people's food and fluid intake. We also saw staff engaging people in various activities.
We spoke with family members, one of whom told us a recent trip to Felixstowe had been very successful and staff had supported their relative and their immediate family members. They told us that since being at this service their [relative] had improved and was no longer withdrawn. We spoke with the person who told us they were happy living at North court. They praised the staff who supported them saying how kind everyone was. They said they wanted to go out again and had really enjoyed the trip and the activities.

People were complimentary about the service. One person said I like it here, the staff are very good and there seems more to do, like today. "We asked staff about the home and one staff member said, "There's more activities, more laughter, more games and more spontaneity. "

We saw a person seeking affection and attention from staff. Staff were very positive and reflected on positive experiences the person had. A relative told us staff spontaneously showed affection to their family members where appropriate and they really appreciated it. We saw staff skilfully intervening and ensuring people were alright and as engaged as they wished to be. We were told one person, helped out in the newly created sweet shop. Staff told us they had completed recent training in dementia in which they experienced how it might feel to have a cognitive impairment and dependent on others for their support. One staff member described how they had been blindfolded and fed cold porridge by another carer and how this had made them feel. They said they would be more mindful when assisting people with their meals to ensure food was tasty and nutritious and at a temperature comfortable for people.

During the day, staff dressed up in their best attire served people and their relative's tea and cakes in the newly opened tea room/café/sweet shop. People enjoyed tea from bone china cups and staff asked people to share their memories about the queen and her 90th birthday celebrations. As people recalled their memories staff listened and validated people's memories and feelings.

One person when asked about the tea party told us, "I had a lovely time and I won the competition about the queen, as I have met her several times at Sandringham." They told us "I had the loveliest piece of cake, it was just how my mother used to make it, really light. "

Throughout the rest of the home we saw improvements had been made including a painted street completed by volunteers and improvements to the fully accessible garden which people were said to enjoy on a regular basis.

Around the home there were sensory objects for people to engage with and gentle music was playing in the morning and films were put on for the afternoon.

We observed staff knocking on people's doors before entering their rooms and offering people meaningful choices. At lunch time we observed staff supporting people with their meal in a timely, respectful way. People were given a choice of food, and people were able to change their mind. We observed good communication between staff and people using the service. We observed staff giving people swift attention and trying to establish what people wanted so they could immediately help them.

At the time of our most recent inspection in June 2016 there was no one receiving end of life care. However there was good documentation in place regarding people's wishes should they be at the end of their life and what they would like to happen in terms of staying at the home, admission to hospital, possible treatment options and pain relief. The manager told us they were working closely with the hospice and trying hard to raise the standards of its end of life care, in order to be a centre of excellence.

We saw evidence of consultation with people using the service about their care needs and preferences of care. People were involved in their care reviews and family were asked to participate as much as they wished. Families were supporting staff in developing the life stories for people.

Good

Is the service responsive?

Our findings

At the last inspection in April 2016, we found that although improvements were being made staff were not always responsive or sufficiently familiar with people's needs. We also found some care plans contained information which did not reflect people's current needs and had very little information about the person and how they would like their care to be delivered. We made a compliance action. At this inspection in June 2016, we continued to see improvements. The care provided to people was carried out in a relaxed, positive way. People were well presented and staff ensured people were warm, comfortable and had their pressure areas protected. Staff were on hand to promote drinks and snacks and staff were visible to ensure people's safety.

There was a plan of activities and these were undertaken by all staff in an environment conducive to people's needs. We observed people to be content and staff interacted with people regularly enhancing their sense of well-being. Staffs understanding of supporting people with dementia had improved with recent training for staff. Life story work was being developed to try and help staff understand people's needs better and link their previous experiences with their current behaviours.

On the day of our inspection there was a tea party, we observed people joining in, others listened to music and in the afternoon staff engaged people in a creative activity which involved covering a table with cling film, putting liquid paint on it and then another layer of cling film which people were then encouraged to move the paint around on the table with their hands. The home was getting ready for a care home open day a national event and a summer party at the weekend. Staff said people enjoyed ice cream and tea in the garden. There was also very good engagement with the local community, friends of Bury, family and volunteers via the local colleges. External outings have taken place and were being planned. One trip had taken place to Felixstowe for 19 people and there were photographs of people participating.

The care plans we viewed were very detailed and contained information regarding every aspect of the persons care, how to promote their well- being and their safety. They were easy to read, well organised and up to date.

Staff told us about improvements in meeting people's needs and said there was now a personal care checklist which demonstrated when people had a bath/shower, nail care and so forth. Staff told us they had more time to ensure people received appropriate care and to understand why a person might initially be reluctant. Staff told us about dementia champions within the service who had received dementia training and had a greater insight into people's needs and stress reactions. We noted life stories and my preferences which told staff about people's preferred choice routines were not completed for everyone and where completed provided a very good insight into the person's needs.

During this inspection we were informed that work on care plans was still underway bringing all the information up to date, rewriting some sections to make them clearer and ensuring effective monitoring of people's needs were taking place. We could see the improvements but found the standard of record keeping poorer upstairs than down and felt there was insufficient clinical insight of the main risks to people. Some

areas requiring improvement included: The continence needs of people on the first floor were not personalised, there is no recording and assessment of the type or size of incontinence pads they require. To ensure skin integrity these should be individually assessed, a too small or less absorbent pad could lead to excessive leakage and skin breakdown due to exposure to urine or faeces. We spoke to the nurse about this and they told us they were in the process of reassessing people and had requested input from the Continence Service, however the Continence Service was normally only contracted to assess residential residents, not nursing residents, so they will not come into the home to assess all the people. The Nurse said they will be reviewing all the pads they have in store and then allocating appropriate pads where they are needed and then making sure each person receives the correct type and size they have been assessed for.

Weight records were kept but a change to a person weight was not always commented upon when care plans were being reviewed to show staff had considered what action if any needs to take place. We also found records of what people were eating and drinking were not of a consistently high standard. We noted that there were spaces to record snacks and drinks. However staff were not recording quantities of food taken and fluctuating fluid totals were not being acted upon. For example we saw one person whose regular pattern was to have days when they did not eat or drink much. However they did not have an individually agreed fluid protocol or what actions staff should take if a person had not drunk much over a number of consecutive days.

The manager told us there had been no recent complaints since the last inspection and they continue to have an open culture in which concerns and complaints would be recorded and dealt with in line with the homes complaints policy. Information was accessible to staff and people using the service.

Good

Is the service well-led?

Our findings

At the last inspection in April 2016, we identified a continued breach around clinical governance and ineffective auditing and management.

At this inspection in June 2016, feedback about the home from staff and people using the service and visitors was very positive. The view was this home was improving and had continued to improve since the last inspection. One staff member told us, "A good manager makes a good home, they are very visible and work alongside us, There is lots of different activities for people, care has improved and there are more resources, more staff, equipment and basic toiletries." Another staff member told us, "Yes she is a good manager, very strong."

There was a clinical lead nurse who mostly covered the residential/dementia floor and a deputy manager who had been in post for about six months and had time supernumerary to help with the administration. The manager became the permanent manager of the home in January 2016 after the registered manager left. They have since been successful with their registration with the CQC. The senior team were all relatively new to post but had formed a close bond and worked well together as a team. The first floor, (nursing) had a registered nurse working on the day of our inspection and an assistant practitioner was leading the ground floor. Ideally the home would like a nurse on each floor with a clinical lead for each floor. The manager told us they had recruited to the post of clinical lead. The home was trying to support existing staff by developing their skills and knowledge whilst still trying to recruit additional staff. In addition senior roles had been strengthened through further training and support. One assistant practitioner told us they had completed a higher care qualification and told us more recently," I am doing extra training here and really enjoying it, I love working with people with dementia and we have made a lot of changes since I came, improved personal care and especially mouth care."

We felt at the moment there was an improved and strengthened management team but the nursing team was still developing and it was recognised that The use of CHAPS was not a substitute for Registered Nurses', as they do not have the knowledge; experience or skills to fully assess and review care. We felt they should be working alongside a Registered Nurse and the trained nurse should be acting as their mentor. It was the view of a specialist advisor that unless there was an effective assessment process for the people that were currently at the home, new admissions would not receive an embedded effective care needs assessment. The Manager does not have a clinical background and is not able to support the Deputy with the clinical assessment of people.

Following our inspection we met with the provider to discuss our concerns in relation to lifting the condition currently placed on the homes registration in regards to new admissions. We were given absolute assurances that any new admissions would be carefully planned and thorough assessments would be in place. New admissions would be carefully tracked to ensure the home was effectively meeting their needs.

We have growing confidence in the provider, as they have been open with us and have achieved a lot in a relatively short period of time. There is now a registered manager in post and organisationally a number of

teams are in place to support ongoing improvement and quality within the service. The home has shared their action plans with us which detailed what has been achieved and what is planned in terms of development of the workforce.

Audits were being completed and showed clear actions identified with timescales for anything requiring improvement. Trackers were in place showing what needed to be completed and by when. This included such things as: weight monitoring, bed rail audits, health and safety updates, staff performance issues, (sickness) and an analysis of any risk- accident, incident, fall or near miss. We saw a schedule of meetings including clinical meetings, staff meetings, relative/residents meetings and provider visits. Flash meetings were also being held daily at 11.00 am and involved all key staff to determine any immediate concerns within the home so these could be addressed promptly. In addition a new dementia care framework was being rolled out across the homes and was designed as a tool to capture the residents experience through observation, case tracking and feedback about individual's experience. Staff were all required to do a minimum amount of training and experience how it might feel to have an impairment and dependent on another person to have their care needs met.

Recent visits have taken place with members of Suffolk county council who are also monitoring the home and supporting the service to improve.

We saw a sample of audits which asked people, the staff and relatives for their feedback about different aspects of the service. A recent one tested staffs knowledge on health and safety. Another tracker looked at housekeeping and another looked at the resident's experience which was detailed and covered many aspects of care and included an audit of their records to ensure their needs were documented correctly.