Care Quality Commission

Russell Court Limited

Russell Court Nursing Home

Inspection report

Russell Square
Longfield
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Date of inspection visit: 17, 18 and 23 February 2015
Date of publication: 10/08/2015

Ratings

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

Overall summary

This inspection was unannounced and took place over three days on 17, 18 and 23 February 2015.

Russell Court Nursing Home provides accommodation, nursing and personal care for up to 41 people. There were 38 people living at the service at the time of our inspection**.** Some people were unable to move independently, whilst others needed support due to illness or other age related conditions. Some people were living with dementia. End of life care was provided. Most people were able to express themselves verbally, whilst others used body language to communicate.

The property is purpose built with flat access and adaptations suitable for people with restricted mobility. Each person had their own bedroom with en-suite facilities. Accommodation is over two floors accessed by a passenger lift. There is an enclosed patio to the rear and to the front a small garden and parking bay. There is road side parking. Russell Court Nursing Home is located a short distance from the centre of Longfield, which has rail and bus transport links.

When we last inspected the service on 13 December 2013, we found that the service was meeting the Health and Social Care Act (Regulated Activities) Regulations 2010.

Summary of findings

At this inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Safe medicine procedures were not always followed and could put people at risk. Changes needed to be made to stock control to make sure people had the medicines they required available to them. The room temperature at which medicines were stored was not checked, which meant there was risk that they could become ineffective.

All areas of the service were clean and tidy. Nurses and care staff had a good understanding about how to prevent the spread of infection. There was written guidance about this for staff, which the manager was in the process of updating. We saw that some items in the laundry were not washed in the best way to prevent cross-infection. A nurse took action about this. We have recommended that laundry procedures prevent the risk of infections spreading.

There were enough staff on duty to meet people's needs in an unrushed manner. Staff told us they had enough time to carry out their duties. People had mixed views about how long it took staff to respond to their staff call alarms. The manager had previously increased the number of staff in the evenings following suggestions from people. The provider told us that they were going to provide another nurse in the evenings.

People told us they felt safe. Staff were trained in how to protect people from abuse and harm. There was information for staff guidance about what to do if abuse was suspected and how to report this. People were protected from harm, risks to their safety were assessed and managed appropriately. There were safe staff recruitment procedures, which included carrying out legally required checks on every applicant to make sure they were suitable to work with the people who lived at the service. Checks were carried out in the building on equipment and facilities to make sure that people were safe.

Staff had the appropriate skills, knowledge and experience to meet people's needs. People and their relatives told us the staff provided a good quality of care. Staff communicated well with people. Staff were trained to meet people's needs and supported in their roles by the management team. Staff asked for people's permission before they carried out any care tasks or nursing procedures. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. The manager was in the process of updating Deprivation of Liberty Safeguards applications, such as for some people who needed to use bed rails to protect them from harm.

People told us they enjoyed the food. People told us they had a choice of food and the chef would always make something especially for them, if they did not like any of the options on the menu. People could eat their meals where they chose to. Staff assisted people to eat where necessary and respected people's pace. The food and fluid that people consumed and their weight was monitored by staff, who took appropriate action if necessary, to reduce the risk to people's health.

People were supported to manage their health care needs. Nursing staff carried out regular health checks on people. People had access to a GP, chiropodist and dentist. People were referred to specialists and supported to attend hospital appointments when necessary.

People told us they liked their bedrooms and the home environment. The property was purpose built with flat access and adaptations suitable for people with restricted mobility. People were provided with equipment according to their individual needs, such as wheelchairs, electric wheelchairs or mobility aids. The building was well maintained and decorated.

People were treated with respect, kindness and compassion. People told us they were happy and felt cared for. Staff promoted people's independence and encouraged people to do as much as possible for

Summary of findings

themselves. Staff were patient and took time to explain to people what they were doing, such as when assisting people to eat or using a hoist. Staff demonstrated respect for people's dignity. Staff were careful to protect people's privacy, for example by making sure that doors were closed when personal care was given.

Specialist care was provided for people who were nearing the end of their lives. People were referred to a local hospice palliative team for additional support.

Staff were aware of the importance of maintaining confidentiality and discretion. People's information was treated confidentially and personal records were stored securely.

People said they received care and assistance when they needed it and they had a choice about how they preferred to receive it. People were involved in the assessment and planning of their care, needs and preferences. Care plans were reviewed regularly to make sure they were up to date.

People could spend their time how they chose to. Some people preferred to stay in their bedroom, whist others liked to join in organised activities, such as singing, quizzes and cooking. People who were not able to leave their room told us that staff came to see them often.

The manager investigated and responded to people's complaints and concerns. All the people we spoke with felt able to raise any concerns with staff or the management team.

People spoke positively about the way the service was run. They told us the manager and staff were approachable. Relatives told us they felt that the home was well run and could speak to the manager at any time if they had any questions or concerns. The organisation had a clear vision and values. Staff understood their roles and responsibilities and the staff and management structure ensured clear lines of accountability.

There were systems in place to review the quality of various aspects of the service regularly. Action was taken where any shortfalls were identified. Six monthly 'customer satisfaction surveys' and 'resident' and relatives' meetings gave people the opportunity to comment on the quality of the service. People were listened to and their views were taken into account in the way the service was run.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Safe medicine procedures were not consistently followed by staff.

The provider had taken reasonable steps to protect people from abuse.

The service operated safe recruitment procedures.

There were enough staff to meet people's needs.

Risks to people's safety and welfare were assessed and managed effectively.

Is the service effective?

Good

The service was effective.

Staff were provided with training, including induction and essential training. All staff received regular supervision and appraisal.

Staff understood the importance of obtaining consent form people. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests.

People were supported to manage their health care needs. People were referred to healthcare professionals promptly when needed.

People were supported to be able to eat and drink sufficient amounts to meet their needs and people were provided with a choice of suitable and nutritious food and drink.

Is the service caring?

Good

The service was caring.

Staff treated people with respect, kindness and compassion. People's privacy and dignity was protected. Staff communicated effectively with people and responded to their needs promptly.

People or their representatives were involved as far as possible in planning their care.

Explanations were given by staff to people about their day to day routine and activities. Staff promoted people's independence and encouraged people to do as much for themselves as possible.

Specialist care was provided for people who were nearing the end of their lives.

Staff were aware of the importance of maintaining confidentiality and discretion.

Summary of findings

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved to the home to make sure the service was suitable for them.

People received personalised care or treatment when they needed it from staff who knew them well. Their individual care plans provided the information staff needed to do this.

People were provided with activities they could choose from and on-to-one activities were provided for people individually if they were not able or chose not to leave their bedrooms.

People's concerns and complaints were listened to, investigated and responded to.

Is the service well-led?

Good

The service was well-led

There was an open and positive culture which focussed on people. The manager welcomed people's and staff suggestions for improvement.

The provider had a clear set of vision and values.

The service sought feedback from people and their representatives about the quality of the service. Action was taken to address any suggestions or shortfalls.

Staff, people and their visitors were provided with forums where they could share their views and concerns and be involved in developing the service.

There was a system of quality assurance in place. The acting manager carried out audits to identify where improvements to the service could be made.

Russell Court Nursing 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 inspection took place on 17, 18 and 23 February 2015 and was unannounced.

In addition to the inspector, the inspection team included one pharmacy inspector and one specialist nurse advisor. They advised us on the management of medicines and aspects of nursing care. The team also included an expert by experience, who is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience who took part in this inspection had specific knowledge of older people who needed nursing care.

This inspection was carried out in response to concerns that had been raised with us.

Before the visit we examined previous inspection reports and information and notifications we had received about the service. A notification is information about important events which the provider is required to tell us about by law.

We spoke with nine people who lived at Russell Court Nursing Home, five relatives and 10 members of staff, including nurses and care staff, one administrator, one chef, one maintenance person and one member of staff employed for domestic duties. We spoke with the provider and the registered manager. We also spoke with a hospice nurse who was visiting people at the service.

We spent time making observations of the practices and care provided within the service. Some people were not able to tell us about their experience of living at the service due to dementia. To help us to understand the experiences people had, we used our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allowed us to spend time watching what was going on in the service and helped us to record how people spent their time, the type of support they were given and whether they had positive experiences.

During our visit we looked at records. These included 11 people's personal records, care plans and risk assessments, three staff files and a sample of other records, including staffing rotas, training records, audits, health and safety checks, medicine records, satisfaction surveys, meeting minutes and policies and procedures.

At our last inspection of 13 December 2013 no concerns were found.

Requires improvement

Is the service safe?

Our findings

People and their relatives told us they felt the service provided a safe environment. People said "I feel totally safe" and "I feel safe and happy...the carers like me and they look after me". Although people made positive comments about how safe they felt we found improvements were required to provide consistently safe care.

The management of medicines in the home was inconsistent. Some areas of the management of medicines required improvement. For example, records of people's medicines, including when they were given, were not all clear or accurate. There were 16 gaps in the medication administration records (MAR) over a two week period. Because of this, it was not clear whether staff had forgotten to sign the MAR or whether some people had not been given their medicines or food supplements on time. Staff had signed as having given two people their medicines when they had not received these, as the doses remained in the packet. Staff had not recorded the specific dose of medicine that they had given to three people. Because of this, there was a risk that these three people could be given too much or too little of these medicines. One person's change in dose was not confirmed in writing by the G.P. Another person was given a medicine on two consecutive days, that was prescribed to be administered every two days. Staff had not checked properly whether there was enough medicine available for three people. Because of this, there was a risk that people may not receive their medicines as prescribed.

Some people were prescribed medicines 'to be taken when required'. For one person, this was to be taken if they had a seizure and for another, when they became agitated. There was no written guidance for staff about when it was appropriate to give people these medicines.

The room temperature in which medicines were stored was not checked. Because of this, there was a risk that medicines were not kept fit for use. The expiry date for one medicine was in 2013. Although this had not been given to anyone since then, there was a risk that it could, as it had not been disposed of appropriately.

People were not always protected against the risks associated with the unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of the shortfalls in the management of medicines and was in the process of taking steps to improve procedures and reduce the risk for people. For example, a new system had recently been arranged with a local pharmacy to deliver the medicines that people needed in pre-packed containers.

Some areas of the management of medicines were managed appropriately. For example, medicines were ordered monthly and when people's needs changed, as prescribed by a doctor. Medicines were received into the home and disposed of safely and those that people had declined to take, were returned to the pharmacy. Medicines and oxygen were stored securely and hygienically. Medicines that required refrigeration were stored at the correct temperature and kept fit for use. Staff wrote the date of opening on liquid medicines and eye drops to make sure that they were not used beyond their expiry date. Medicines that required additional procedures for storage, administration and disposal were managed appropriately.

Nursing staff gave people their medicines and provided assistance for people to take these when necessary. Most people were given their medicines as prescribed and intended by their doctor. The home maintained a small stock of "homely remedies". These were medicines that were not prescribed for any one individual and used for day to day minor ailments, such as headaches and colds. There was guidance available for staff about when to give these to people. People were protected as staff knew about any allergies they had to medicines. The risk of people receiving medicines meant for someone else was reduced. This was because people's photographs were attached to their records and the containers in which their medicines were stored.

People lived in an environment which was cleaned regularly. People told us that their bedrooms were kept clean and tidy. One person said "My bedroom, the ensuite and my wardrobe are all kept very clean". Communal areas, bedrooms, bathrooms and toilets were clean and free from malodour. Cleaning schedules were carried out daily and weekly and a rotational deep clean was undertaken monthly. Hazardous waste was removed using an approved contractor.

Requires improvement

Is the service safe?

The nurses and care staff had a thorough understanding of infection control practice and took measures to ensure that the service was clean and free from the risk of infection. They demonstrated this by wearing protective clothing, such as gloves and aprons when assisting people with their personal hygiene. One member of staff told us "There are always enough aprons and gloves available to use". Staff used correct hand washing techniques and hand sanitizers were available throughout the service. People who needed assistance to move had personal sliding sheets and slings for hoisting. As these were not shared, the risk of cross-infection from equipment was reduced. Information was available for staff guidance about what to do in the event of an outbreak of infection.

Staff were trained in how to reduce the risk from the spread of infection. The registered manager was the infection control lead, to whom staff went to for advice. The service had a copy of the Department of Health's code of practice on the prevention and control of infections and related guidance. The registered manager was in the process of reviewing and updating the infection control policy and procedure to make sure it reflected current guidance.

The laundry room was clean and tidy. Laundry staff were knowledgeable about how to protect people from infection. However, although washed at a high temperature, one washing machine load, with both soiled and non-soiled items together, was observed. The nurse on duty was aware that this was not best practice in reducing the risks of cross-infection and addressed the situation immediately.

We recommend that the service makes sure all laundry procedures follow best practice in relation to preventing the spread of infection.

There were enough staff on duty to ensure people's safety in the early hours of the morning, during the day and in the evening. We observed staff met people's needs and spent time with people in a relaxed and unrushed manner. People told us that staff provided the care they needed and looked after them well. Most staff, senior staff and the registered manager told us that they felt there were enough staff on duty to meet people's needs and to spend time with them.

Most people told us that they did not have to wait long for staff to arrive when they used their staff call alarm. One person said that they never had to wait for a response, that staff were pleasant and helpful and "Do not make me feel like a nuisance". However, another person told us they had to wait anything "between five to 15 minutes". Two relatives said that when people were in the large lounge they sometimes had to wait "A long time for staff to come" and got annoyed or upset.

There was one nurse on duty in the afternoons and evenings. A nurse and an agency nurse told us that this was sufficient. The nurse told us that sometimes they were interrupted in assisting people with their medicines by other duties, such as phone calls or visits from health care professionals or relatives. They said "This is not a large problem and only happens at teatime. It happens occasionally and not very often". Another nurse told us that assisting people with their evening medicines finished late and did not always leave them enough time for other duties before assisting people with their night time medicines.

The provider told us they were making arrangements to increase the number of nurses on duty in the afternoons and evenings to provide additional staff. The registered manager told us that they worked out how many staff should be on duty from people's needs and deployed staff around the service accordingly. The registered manager said that they did not use a formal analysis tool to make sure the number of staff on duty met people's needs.

We recommend that the provider seeks and follows best practice guidance to ensure that there are adequate staff deployed in the service to meet people's needs at all times.

The registered manager told us it had been difficult to recruit nurses. They did say that when they used agency staff they tried to use staff who had worked there before and knew people for consistent care whilst they recruited new staff. The service employed staff for administration and reception, domestic duties, laundry, maintenance, catering, hairdressing and organising activities for people.

The service operated safe recruitment procedures. Applicants attended an interview and provided references. Legally required checks were carried out before they started work, such as for identification and disclosure and barring. All staff were subject to a probation period before they became permanent members of staff and to disciplinary procedures if they behaved outside their code of conduct. This ensured people could be confident that

Requires improvement

Is the service safe?

staff were of good character and fit to carry out their duties. All nurses' registration (PIN) numbers were checked annually to ensure that the nurse was on the active register of the Nursing and Midwifery Council (NMC).

People told us that they felt safe. They knew how to raise concerns if they needed to, felt confident that they would be listened to and that action would be taken. Two visitors told us they had raised concerns with the registered manager and the issues were resolved. Staff had a good understanding about how to safeguard people. They knew how to protect people and described the various types of abuse to look out for and how to report this. Staff told us "I will make sure that any suspected case of abuse is reported" and "I feel safe to practice here...the manager is good and goes to any length to protect people from abuse". There was information for staff guidance about what to do if abuse was suspected and how to report this. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team and the police. Staff had received training in how to protect people from abuse.

People told us that staff treated them as an individual and that they did not feel discriminated against. Staff were trained in how to value people's diversity. Staff knew how to treat people equally whilst respecting their individual preferences and choices.

People were assessed individually to identify risks to their safety, such as from falls, restricted mobility, behaviour that challenged and skin integrity. This was recorded in people's care plans, together with guidance for staff about how to reduce the risk for people and protect them from harm. Staff followed the guidance in care plans for each person. Risk assessments were kept and updated and reviewed regularly. In this way, any change in the risk to people could be identified, and staff could change the way they supported people to make sure they continued to be protected from harm.

Eight people had been assessed as being at risk of developing pressure ulcers. Staff followed guidance in people's care plans to prevent pressure ulcers from developing. People were assisted by staff to move regularly and prescribed creams were applied. People were provided with specialist equipment, such as beds, mattresses and cushions. Care staff knew how to prevent pressure ulcers from developing and the importance of reporting any change in skin integrity to the nurse on duty. The nurse on duty was knowledgeable and skilled in the prevention and management of pressure ulcers.

There was a system in place to manage accidents and incidents. These were recorded by staff and brought to the attention of the registered manager. The registered manager analysed the records to check whether common triggers could be identified, so that any lessons could be learnt and minimise further risks. For example, people who were at risk of falling from bed were risk assessed and provided with bed rails, which protected them from harm.

The premises were well decorated and maintained. The provider ensured that the premises were maintained safely and securely. Appropriate windows restrictors were in place to ensure people's access to windows was safe. Radiators were boxed in to protect people's skin from the heat.

Safety checks were carried out at regular intervals on all equipment and installations to protect people from the risk of harm. For example, for hoists, specialist beds and wheelchairs. People's portable electrical appliances were checked for their safety. Action was taken to protect people from the risk of scalding and Legionella, including regular water temperature checks. Food safety checks were carried out. The local authority had carried out an environmental health inspection in December 2014.

Fire safety systems were in place and each person had a personal emergency evacuation plan to make sure staff knew how to evacuate them safely in the event of a fire. There were regular checks of emergency exits, fire doors, the fire alarm, emergency lights and firefighting equipment. Fire escape routes and fire exits were clearly labelled and displayed.

Staff assisted some people in their rooms with equipment, such as hoists. When staff had finished assisting one person, they then moved the equipment into the corridor before assisting the next person. Two hoists and one weighing scale were in one corridor before being moved by staff. The corridor was wide and had adequate space for people to pass. However, the corridor was a fire exit route and, in an emergency, the equipment could cause a potential hazard. The nurse on duty told us that equipment was not stored in the corridor, and that they would address the amount of time it was left there, between being used to assist people.

Good

Is the service effective?

Our findings

People said "I feel very confident with the staff" and "…I am fine and staff are good" and "Staff are very nice and know my needs". One relative told us "Staff seem to be well trained and able to provide care".

People told us they enjoyed the food. They said "....the food is good...all homemade food, no frozen food, everything is fresh" and "The food is nice especially the soup and sandwiches…" and

"I like the treats of cake and biscuits which I never had at home".

People told us "The care here is the best and the staff are very kind" and "I needed new glasses, so they came, and now I'm waiting for my glasses to arrive".

Staff had the appropriate skills, knowledge and experience to meet people's needs. People and their relatives told us the staff provided a good quality of care. Staff used their understanding of each person to communicate with them in a way that helped them to understand and respond appropriately. For example, one person did not communicate verbally but had their own individual signs.

There was a programme of staff training which made sure that staff knew how to carry out their roles competently and to meet people's needs. The registered manager explained that this was organised on an annual basis. They told us that any updates needed in staff training would be completed within the year. Staff told us they were provided with the training they needed. They said "I've done training in dementia, fire, moving and handling and coming up in May I've got stroke awareness" and "We update our training every year" and "The manager is very proactive and knowledgeable and organises training that suits staff training needs. For instance I am going for three training [courses]; wound care, Parkinson's disease and nutrition".

Essential training for staff included how to move people with restricted mobility, how to prevent the spread of infection and how to safeguard people. There were seven first aiders and five fire marshals. Other training provided included how to value people's equality and diversity and how to promote people's continence. Some staff had completed courses to meet the more specialist needs of people, such as diabetes, dementia, and end of life care. Planned training for March and April 2015 included catheter care and resuscitation. Senior staff and nurses were trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The registered manager told us that care staff would complete this training within the year. Staff were trained for their specific roles. For example, all kitchen staff were trained in how to prepare food safely, the head chef in nutrition, domestic staff in how to use hazardous chemicals safely and the administrator in record keeping.

Nursing staff confirmed that they were supported in their professional development. This was confirmed in staff files together with assessments for their skills on an on-going basis. 19 out of 29 care staff had obtained relevant qualifications, such as a diploma in health and social care or a national vocational qualification (NVQ).

All new staff were provided with induction training. This included shadowing experienced staff for their first few shifts to enable them to get to know people and observe how to provide the care and treatment people needed in the way people wanted their care to be delivered. One agency nurse on duty at night had not worked at the service before. They told us they had received a thorough induction at the service before they started their duty.

Staff told us they felt well supported in their roles. Staff told us they had regular supervision sessions with their line manager where they were able to discuss their work. They said "I find supervision helpful and supportive. Also we're a small team and we talk about things all the time" and "The manager is very supportive but makes sure that things are done the way they are supposed to be done". Most staff had received an appraisal within the last year. A few staff had not had an appraisal within the last year due to absence from work.

Staff told us they understood the importance of obtaining consent from people before care or treatment was provided. Staff asked permission before they carried out any care tasks or nursing procedures. Care plans and risk assessments were signed by the person concerned, their relative or their representative, as agreement to their care planning and the assistance they received from staff. This included consent to their care and treatment, medicines and where necessary, the use bed rails. People were assessed to identify whether they needed bedrails to protect them from harm by falling from bed. These assessments were recorded in people's care plans.

Good

Is the service effective?

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. The registered manager had sought advice from the local authority, as they were in the process of updating DoLS applications, such as for some people who needed to use bed rails to protect them from harm. There was a policy and procedure about DoLS available for staff guidance. Where people lacked the mental capacity to make decisions the service was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in the person's best interests. Most people had a lasting power of attorney who could make decisions on their behalf. The registered manager and senior nurse demonstrated a good understanding of the process to follow when people did not have the mental capacity to make certain decisions.

People told us they liked the meals at the service. People told us they had a choice of food and the chef would always make something especially for them, if they did not like any of the options on the menu. They said "I like the food, but if I don't like something they've got, then they always give me something else that I do like. The chef comes round every day to ask what you want…" We observed the chef asking people in the lounge what they wanted to eat. People told us that their meals were hot when they received them. One person said "The food is always hot when you get it". One person told us "There is always enough to eat".

People could eat their meals where they chose to. One person told us "I like to eat in my room…" Other people enjoyed eating their meals together at lunchtime in the dining room. All people in the dining room used wheelchairs and there was enough space for everyone to be seated comfortably. Staff asked people where they would like to sit. Staff assisted people to eat where necessary and respected people's pace by not rushing them. Staff spoke with people throughout the meal, offered help when it was needed and checked that they were happy with their meal or whether they needed more to eat or drink.

The food and fluid that people had and their weight was monitored and recorded regularly. From this staff were able to tell if a person was getting enough to eat and drink or had lost or gained a significant amount of weight. Staff took appropriate action to reduce the risk to people's health. This included referral to health care professionals, such as a GP or dietician. A dietician was visiting people during the inspection. Staff were knowledgeable about how to support people with weight loss and at nutritional risk. People's care plans contained individual guidance for staff to follow. One nurse told us "Normally when a resident loses weight we will inform the GP and refer to a dietician....then follow the instructions given on how to manage the resident's weight".

Staff knew about people's dietary preferences and restrictions. The needs of 12 people who had specific dietary needs were provided for. This included the provision of food that was pureed, soft, fortified or diabetic. The chef brought fortified milk to one person's room. There was a friendly rapport, which enabled and encouraged the person to drink it. Drinks were provided for people that were within their reach.

People were supported to manage their health care needs. Nursing staff carried out health checks on people where necessary, such as for blood sugar levels and blood pressure and these were recorded in people's care plans. Care plans contained information about people's health needs and medical conditions along with guidance for staff. Visitors told us that their relative received medical care when they needed it. Staff told us that a GP came to the service once a week, and visited people who needed to see them. People had regular appointments with health professionals such as chiropodists, dentists and opticians.

People were referred to specialist health care professionals to meet their more specific needs. For example, one person was referred to a psychologist because of their behaviour that challenged. Staff were knowledgeable about specialist guidelines and able to meet their needs in practice. The service had sought specialist support for people from a speech and language therapist because of a person's difficulty in swallowing, the psychiatric team and a physiotherapist. Specialists regularly supported people at the service with dementia care, wound care and end of life care.

Good

Is the service effective?

People were supported with hospital appointments and admissions. If people need to go to hospital for treatment, staff took relevant information with them. This made sure that health care professionals know about people's needs and medicines.

People told us they liked their bedrooms and the home environment. They said "I have a lovely room on the first floor" and there is a "nice view from my room". The property was purpose built with flat access and adaptations suitable for people with restricted mobility. Each person had their own bedroom with en-suite facilities. There was a large lounge, a smaller quiet room and a dining room for people to use. The lounge could be accessed from the quiet room and the corridor and contained an area for watching TV and two other sitting areas. Accommodation was over two floors accessed by a passenger lift. Corridors, communal rooms and bedrooms were a suitable size to accommodate people who used wheelchairs and for the use of equipment, such as hoists to assist people. There was an enclosed patio to the rear of the building and to the front a small garden, both of which were accessible for people using wheelchairs. People were provided with equipment according to their individual needs, such as wheelchairs, electric wheelchairs or mobility aids.

There was an effective system in place for on-going repairs. Staff told us that handrails in the corridors were in the process of being repainted, bedrooms were decorated for a new person moving in and the refurbishment of bathrooms was planned. Items for maintenance and repair were entered in a log book by staff and dated when completed.

Good

Is the service caring?

Our findings

People said they were happy and both they and their relatives described the staff as caring and friendly. People told us "Staff are all very caring, helpful people" and "I get on well with staff, they are always friendly" and "The staff are very nice. They are always gentle with me". One person who was not able to leave their room due to restricted mobility told us "Staff come and see me a lot. They always come in to have a chat". Staff were considerate and listened to people. One person said they felt cold and a member of staff immediately went to fetch a warmer garment for them.

We observed staff treating people with kindness and compassion. Staff supported people in a calm and relaxed manner. They did not rush people, they went at the person's pace and kept up conversations whenever they were providing care and support.

People's diverse needs were accommodated. People's individual care was planned and regularly reviewed to make sure their needs were understood by staff. Each person had an individual care plan, which was updated if people's needs or preferences changed. Personal records included people's life history, likes and dislikes and preferred daily routines. People were supported with their preferences in their day-to-day lives. They had choice about when to get up and go to bed, what to wear, what to eat, where to go in the service and what to do.

People and their relatives told us they had been involved in planning how they wanted their care to be delivered. Relatives said they felt involved and had been consulted about their family member's likes and dislikes, and personal history. They said that the staff communicated well with them. Care plans were signed by the person concerned or their representative. People or their representatives were involved in their care as much as they were able or wanted to be. People told us that staff discussed their care plans with them. One person said "I've got this bit of my care plan here about my personal history and things I like, which they've asked me to fill in because they want to know". People can talk to nursing staff about their medicines, any concerns they may have and to discuss their purpose.

Staff promoted people's independence and encouraged people to do as much as possible for themselves. Whilst most people needed assistance with their mobility, some people were able to move around the service independently using either a mobility aid or an electric wheelchair. The service used an independent advocate where necessary, to represent people's views if they had no other representative.

There was friendly interaction between people and staff responded positively and warmly to people. Staff called people by their preferred names. Some people who had difficulties with verbal communication needed time to express themselves. Staff responded to these needs appropriately and spent the time that was needed with people. Staff were patient and took time to explain to people what they were doing, such as when assisting people to eat or using equipment to help them to move. They did this in a way that people understood. People told us "Staff talk to me" and "They put themselves out most of the time" and "Staff use my name, talk to me and tell me what is happening". One member of staff assisted a person with equipment into a wheelchair. The member of staff spoke to the person by name, was careful to check the equipment was comfortable for them, explained what was happening all the time and checked that the person was comfortable and secure. One person became distressed and unable to eat their meal. A member of staff knelt down beside them and spoke with them quietly and soothingly. The person then relaxed and settled and was able to continue to eat their meal.

Staff demonstrated respect for people's dignity. They were discreet in their conversations with one another and with people who were in communal areas of the home. We observed staff initiating conversations with people in a friendly, sociable manner and not just in relation to what they had to do for them. They gave people time to answer questions and respected their decisions. People told us "…Staff take care with me and are respectful" and "Staff always ask me what I want to wear. I can wear the clothes I like". A hairdresser visited the service three mornings per week. The hairdresser assisted people in a way to make having their hair washed a relaxing and pleasurable experience. People told us their hair was washed gently by hand and they had a choice of using a hairdryer or not.

Staff were careful to protect people's privacy, for example by making sure that doors were closed when personal care was given. Any treatments people needed were carried out in private. Staff knocked on people's bedroom doors, announced themselves and waited before entering. People

Good

Is the service caring?

told us “Staff always knock on my door” and “Staff never come in without knocking first, they always knock. They always ask first before they do anything, like ‘Is it alright if I help you to wash now?’”. People were able to spend private time in their bedrooms when they chose to throughout the day.

Specialist care was provided for people who were nearing the end of their lives. People were referred to a local hospice palliative care team for support. Two visitors told us they had been involved in developing the end of life care plan for their relative. Practical action was taken to make people as comfortable and pain free as possible. Anticipatory medicines and prescriptions were stored, so that they were available when people needed them and were reviewed regularly. A nurse from the local hospice visited people at the home regularly and provided guidance for staff. The hospice nurse told us that the home was proactive in supporting people who were nearing the end of their life and had good systems in place to do this. Some people had advanced care plans or ‘Do Not Attempt Resuscitation’ (DNAR) forms in place. The latter had been completed correctly and signed by an appropriate health care professional.

Staff were aware of the importance of maintaining confidentiality and discretion. People’s information was treated confidentially and personal records were stored securely. Personal information was printed on the containers in which people’s medicines were stored. People’s confidentiality was protected as once these were used and immersed in water, the information dissolves, and they can be discarded.

Good

Is the service responsive?

Our findings

People told us they could choose to eat in the dining room or in their bedrooms. One person told us "I like the food. They always ask me what I want to eat".

Staff communicated effectively with people, responded appropriately to their requests and offered people choices. For example, about what they wanted to eat and drink and where they wanted to have their meals.

People said they received care and assistance when they needed it and they had a choice about how they preferred to receive it. For example, people told us they decided what time they would like to be assisted by staff in the mornings, with their personal hygiene and to get up. People told us "I wake up naturally at about 6am and need help to go to the toilet. I ring for the carers and they come. If I want a wash they'll do it, they're very good. I've never been woken up to have a wash" and "It's my choice whether I get up or stay in bed. Today I got up and watched some TV, but then it suited me to go back to bed again".

Staff had guidance about which people were likely to want assistance early in the morning. Staff on duty in the early morning told us that they did not disturb people who were still asleep or who did not want assistance at this time. They told us "If residents are sleeping, we let them sleep and we don't get them up…from 4.30am buzzers go off, if residents are awake and need company or something like a drink or a bedpan. We wash residents if they need it and "Some residents like an evening wash. We have a list of people who usually like to be washed before 7am, but we don't do this if they are still asleep". People told us they could choose whether they wanted to be woken early to take their medicines or take them at breakfast time. Staff call bell alarms were within people's reach and staff carried pagers which alerted them when people required their response.

Staff knew people well and were able to describe the kind of support each person needed and how they preferred to be supported. For example, staff knew who liked to get up early and who liked to be left to have a lie in. Staff were enthusiastic about their roles and committed to ensuring that each person's needs were met.

People told us they could chose when they wanted to go to bed, when they wanted to have a bath or shower, what they wanted to wear and whether they wanted to spend time in their bedrooms or with other people.

People were involved in the assessment of their needs and preferences. People who were considering moving into the home were visited by a member of the management team who carried out a pre-admission assessment to determine if the service was able to meet their individual needs. The staff were made aware of these assessments to make sure they knew about people's particular needs and wishes as soon as they moved into the service. From the pre-admission assessment, a detailed care plan was developed after people moved in, about how to meet their long-term needs. The management team consulted with health and social care professionals who had been involved in people's care and treatment, as part of their assessment process and care plan where appropriate.

Care plans identified where care and support was required for specific issues such as, assistance to move, wound care, falls, cognitive ability, medicines and personal hygiene. Care plans provided guidance for staff about people's preferences and how they wanted their care to be delivered. For example, What they liked and disliked, how they preferred to spend their time, what they liked to do and how they preferred to socialise and communicate. One person told us "Staff do ask me how I would like my care".

People's individual assessments and care plans were reviewed monthly and updated when people's needs had changed. Visitor's spoke of the care provided being changed, to meet the changing and increasing needs of their relative.

Staff discussed each person when they handed over to the next shift, highlighting any changes or concerns. Because of this, staff knew about changes in people's needs and could respond appropriately to meet them. For example, changes in people's medicines, illness, skin integrity and fluid intake and a hospital appointment. During the meeting staff were told about the start of food and fluid monitoring for one person, as they had not been eating well recently. Another person was very anxious. Staff knew how to reassure them and that an appointment with a psychologist was booked. In response to this person's behaviour that challenged, staff had arranged on-going support for them from appropriate health care professionals and medical procedures.

Good

Is the service responsive?

People were actively encouraged to bring belongings from their previous home, such as furniture, ornaments, pictures and photographs. People's bedrooms reflected their personality, preference and taste. Each bedroom had one wall covered with wallpaper different from all the other rooms to provide some individuality. People told us "I like my room with all my things and I like my wallpaper" and "I bought my table from home, because I liked it and I can do jigsaws on it" and "the service is friendly and homely".

One person told us "I can't go out of my room but I'm quite happy. I like playing cards and Sudoku, doing crosswords, reading and watching TV. My family visit me. They can come whenever they want to. My relative phones from abroad. I've got a mobile phone, which staff remind me to keep within reach in case they phone, although sometimes I forget. I see staff quite a lot. We have a chat and a laugh. I know them well…and they know my family well". Another person said "I don't go downstairs as I don't like to mix with people, I like staying in my room. My relative takes me out. The activities lady comes to visit me in my room". One relative told us "My relative seldom does group activities as they are profoundly deaf. But people see her in her room all the time. The recreation lady goes in and other staff and they get on well". One member of staff told us "One-to-one activities with people are good, they go round to see residents in their rooms and spend time with them, reading or looking at pictures or whatever they want".

There were group activities, in which people could participate, if they chose to do so. Staff told us "They played bingo today with residents, which they enjoy" and "On Tuesday they've got music for health. Also a lady comes in with a dog that does tricks. At Christmas time we went to two pantos. There is an activities lady who comes in a few days a week, who does activities in the dining room and visits residents in their rooms". We observed people in the lounge enjoyed listening to music and singing. Group activities were planned for a week in advance. This week they included cooking, playing cards, keep fit and celebrating the Chinese new year. Some books, games, jigsaws and CDs were available for people to use in the quiet room. People watched a TV in the lounge. The noticeboard displayed photographs of people enjoying various events and activities. Staff told us that the garden was used in the summer months. Last summer the service held a sports day, barbeque and coffee morning.

People said they were happy living at the service and had no concerns. People told us "There is not one thing I want to complain about" and "The best thing is I have no complaints". One relative told us "The place is first class. There are no faults or problems". People and their relatives felt able to raise any concerns with staff or the management team and told us the manager was approachable. They knew how to make a complaint if they needed to, felt confident that they would be listened to and that the complaint would be addressed. Two visitors told us they had previously raised concerns with the manager that their relative was not drinking enough fluid. They said were very satisfied with the response from the manager and the outcome that staff checked more often that their relative is drinking adequately. We observed staff encouraging this person to drink. People could complain formally or through an anonymous suggestion box available in a communal area. Complaints were recorded in a complaints log. These had been investigated thoroughly and, where not anonymous, the complainants had received responses.

Good

Is the service well-led?

Our findings

People said "The service is friendly and homely" and I would recommend it to anyone" and "I would not change anything". One member of staff told us "The residents are happy. We have good relationships with residents and there is a good rapport".

The provider had a clear set of vision and values. The statement of purpose for the service stated "We want everything we do in the home to be driven by the needs, abilities and aspirations of our residents, not by what staff, management or any other group would desire. We recognise how easily this focus can slip and we will remain vigilant to ensure that the facilities, resources, policies, activities and services of the home remain resident-led. We are committed to achieving our stated aims and objectives and we welcome the scrutiny of our residents and their representatives". The registered manager told us that they aimed to nurture an open and positive culture that focussed on people. Staff were aware of these aims and put them into practice.

The service had a welcoming atmosphere and staff were relaxed. People and their relatives were positive about the way the service was run. We observed people were comfortable with the management team and staff. People told us the registered manager and staff were approachable and the management team often chatted with them and asked them how things were.

Relatives told us they felt that the home was well run and they could speak to the manager at any time if they had any questions or concerns. They described how the service kept them informed about any developments in their relative's health. One told us "I would be quite happy to come in here as a resident". We observed one visitor discuss an issue concerning their relative with staff, who were supportive and helpful.

People and their relatives were asked for their views about how the service was run and the care they received. Customer satisfaction surveys were sent out to gain feedback about the quality of the service provided. Completed surveys were evaluated and the results were used to inform improvements for the development of the service. The most recent analysis for returned surveys contained mostly positive responses. Some suggestions had been made about the need for more variety in the menu, more activities and staffing numbers. The registered manager took action in response to these suggestions. They had addressed meal choices with the chef, employed an activities coordinator and additional care staff in the evenings.

'Resident' and relatives' meetings were also held, which enabled the manager to keep people and their families up to date with what was going on and gave people an opportunity to express their views, voice any concerns and ask questions.

The service had a clear, accountable management and staffing structure. We spoke with staff about their roles and responsibilities. They were able to describe these well and were clear about their responsibilities both to people and to the management team. They knew who they were accountable to.

Staff said they felt supported and motivated. They said there was a good atmosphere and staff worked well together. They told us "We work well as a team" and "The manager and senior staff are approachable". The registered manager ran an employee of the year award to recognise the quality of staff.

Staff meetings were held where information was shared about a variety of issues to improve the service provided for people. For example, at the last care staff meeting it was raised that some people were not able to have as many baths as they would like. A system was introduced to address this. At the last nurses meeting, discussion took place about how to improve the support for people who needed wound care and people approaching the end of their life. At the last meeting for domestic staff, a new checklist was introduced to make sure that no lime scale or dust was missed. A regular deep clean was also introduced.

Staff had access to the service's policies and procedures, which gave them guidance about a variety of issues, such as how to safeguard people from abuse and information about the Deprivation of Liberty Safeguards (DoLS). This ensured staff were aware of procedures to follow and of the standards of work expected from them to provide safe, effective, responsive care and support for people. At the time of this inspection, the registered manager was in the process of reviewing the infection control policy to make sure that it followed current best practice guidance.

The service had links with health care professionals to support people's needs, such as a GP, chiropodist, dentist

Good

Is the service well-led?

and optician. People were referred to specialist health care professionals when necessary, such as a psychologist, psychiatrist, speech and language therapist and physiotherapist. There were good links with a local hospice. The hospice nurse told us that the service was proactive in supporting people who were nearing the end of their life and had good systems in place.

There were systems in place to review the quality of various aspects of the service provided, such as risks from the environment and the spread of infection, people's care plans and care needs and equipment, including specialist mattresses and hoists. The management team carried out regular audits and improvements were made where any shortfalls were identified. For example, the latest wheelchair audit found a fault with a wheelchair. The registered manager took action to ensure that staff addressed this. The registered manager audited any incidents and accidents to identify any triggers or patterns in causes, so that appropriate action could be taken to minimise the risk of reoccurrence and harm to people.

The registered manager was aware of the shortfalls with the management of medicines and had taken steps to improve this. For example, a new system had recently been arranged with a local pharmacy to deliver the medicines that people needed in pre-packed containers, to make it easier for staff to administer.

The system for the management of medicines was audited regularly. Medication administration records (MAR) had been checked and where errors were found, these were addressed. A record of incidents with medicines was kept, which showed that action was taken to resolve the matters. For example, there were three incidents of pain relief patches, which staff forgot to change. A new procedure was introduced to remind staff. No further incidents of this nature were reported. A practical assessment of nurses' competency to administer medicines was undertaken. The GP has reviewed medicines for everyone living at the service. The registered manager told us that this was beneficial and aims for this to be repeated once a year.

The manager was registered with the Care Quality Commission (CQC). The service was registered appropriately for the type of care provided and the number of people accommodated. The registered manager notified the CQC of any significant events that affected people or the service. Records were labelled, dated and stored securely and confidentially in dedicated spaces.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines, corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. How the regulation was not being met: People who use services were not protected against the risks associated with the unsafe management of medicines.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.