Prestwick Care Limited

Hadrian House

Inspection report

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Date of inspection visit:
11 May 2016
17 May 2016

Date of publication:
06 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 11 and 17 May 2016 and was unannounced. A previous inspection undertaken in July 2014 found the home to be fully compliant with legal requirements.

Hadrian House is located in North Tyneside and is registered to accommodate up to 50 older people, some of whom are living with dementia. Accommodation is provided over three floors with the second floor having some adaptation to support people living with dementia. The home was full at the time of the inspection.

The home had a registered manager who had been registered with the Care Quality Commission since January 2016. 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.

Staff were aware of the need to safeguard people from potential abuse and had a good understanding of safeguarding issues. They had received training in relation to this area and were able to describe the action they would take if they had any concerns. There had been 12 recent safeguarding alerts at the home; the majority noting low level concerns. The home had worked with key agencies around these safeguarding events.

Risk assessments were in place both in relation to the wider operation of the home and linked to the individual needs of people using the service. Regular checks were made on fire and safety systems to ensure they worked effectively. Equipment was checked to ensure it was safe to use. Window restrictors were initially found to be noncompliant with the guidance issued by the Health and Safety Executive, but were fully rectified before the inspection had concluded.

People told us they did not have to wait long for support and help and said they felt there were enough staff at the home. The manager told us she had recently introduced a range of new shift patterns to ensure that maximum staffing was available at key times, such as when people were getting up or going to bed. Suitable recruitment and vetting procedures were in place for new staff.

We found some issues with the safe and effective management of medicines at the home. There were gaps in the recording of medicines and some people receiving "as required" medicines did not always have appropriate care plans. The recording of topical medicines (creams and lotions) was not robust, with records not detailed or incomplete. This meant we could not be certain these medicines had always been given correctly.

Staff told us they had access to a range of training and updating. Records showed that a system was in place to monitor training at the home and ensure it was up to date. Additional training was available to further

enhance staff skills. Staff told us, and records confirmed regular supervision and annual appraisals took place.

People told us meals at the home were good and they enjoyed them. Alternatives to the planned menu were available. There was good access to a range of drinks. Staff supported people with their meals appropriately and in a dignified manner. Kitchen staff demonstrated knowledge of people's individual dietary requirements. People's weight was monitored and there were regular reviews of people's nutritional needs.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005 (MCA). These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom. Where necessary applications had been made to restrict people's freedom under the MCA. Staff understood the concept of acting in people's best interests and the need to ensure people made decisions about their care. Records showed people had provided their consent or that best interests decision had been made. The provider had notified the CQC about the outcome of DoLS applications as they are legally obliged to do so.

People and their relatives told us they were happy with the care provided. We observed staff treated people patiently, properly and with good humour. Staff were able to demonstrate an understanding of people's particular needs. People's health and wellbeing was monitored, with ready access to general practitioners and other health professionals. Staff were able to explain how they maintained people's dignity during the provision of personal care and demonstrated supporting people with dignity and respect throughout the inspection.

Care plans reflected people's individual needs and were reviewed to reflect changes in people's care, although reviews were often limited in their detail. Care plans also reflected advice from visiting professionals such as the behaviour analysis and intervention team (BAIT). A range of activities were offered for people to participate in, including one to one time. People said they enjoyed the activities and could choose whether to participate or not.

There had been six formal complaints within the previous 12 months. These had been dealt with appropriately. Information about how to raise a complaint was available around the home. People said they knew how to make a complaint and they would speak with the manager if they had any concerns.

A range of checks were carried out by the manager and the provider's Head of Compliance and Head of Clinical Governance. The home had a range of champions to help support best practice in key areas.

Staff told us the manager was supportive and approachable. Comments suggested they were happy working at the home. Regular staff meetings took place and workers said they were able to raise issues for discussion.

With the exception of some medicine records, other documents and records at the home were well maintained and kept securely. The home had made links with a number of other organisations in the local community.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to Safe care and treatment. You can see what action we told the provider to take at the back of the full version of the report.

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

Not all aspects of the service were safe.

There were some gaps on records related to the safe management of medicines. Records regarding topical medicines were not robust.

People and their relatives told us they felt their family members were safe living at the home and staff had undertaken training in safeguarding vulnerable adults.

Risk assessments had been undertaken in relation to people's individual needs and the wider environment of the home. Staff recruitment was effective and people told us there were enough staff to support them. The home was clean and tidy.

Is the service effective?

Good

The service was effective.

There was evidence applications had been made to the local authority safeguarding adults team to in relation to the Deprivation of Liberty Safeguards (DoLS). Staff understood about supporting people to make decisions and best interest processes were used where people lacked capacity to make decisions.

Staff told us, and records confirmed a range of training had been provided. Regular supervision and annual appraisals were undertaken. People's wellbeing was effectively monitored with access to a range of health and social care professionals.

A variety of food and drink was available at the home and specialist diets were supported. People told us they were happy with the meals provided. Areas of the home had been adapted and decorated to support people living with dementia.

Is the service caring?

Good

The service was caring.

Relationships between people and staff were friendly and compassionate.

People and their relatives told us they were happy with the care they received and felt they were well supported by staff. They said they had been involved in determining the care they received. Relatives said they were kept up to date on any issues or changes.

We observed staff supporting people with dignity and respect in a range of care situations. People were supported to maintain their independence. Relatives spoke highly about the end of life care provided at the home.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs had been undertaken and care plans largely reflected these individual needs. Plans were reviewed and updated as people's requirements changed and incorporated advice and guidance from health professionals. Some care review details could be repetitive.

There were activities for people to participate in. People said they enjoyed the activities. Staff sat chatting to people throughout the day. People told us they could make choices about how they spent their days or the care they received.

The provider had a complaints policy in place and people were aware of how to raise any complaints or concerns. Recent formal complaints had been investigated and action taken where necessary.

Is the service well-led?

Good

The service was well led.

Staff were positive about the support they received from the manager and felt that good ideas were being introduced. Relatives said the manager was approachable.

A range of checks and audits were undertaken on the quality of the care at the home. Regular meetings took place to support staff and develop care.

With the exception of medicines, records were up to date and maintained effectively. The home had made positive links with a number of outside organisations.

Hadrian House

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. Prior to the inspection we had also received information raising concerns about care delivered at the home. We used this inspection to follow up on these concerns.

This inspection took place on 11 and 17 May 2016 and was unannounced.

The inspection team consisted of an adult social care inspector and an Expert by experience (EXE). An ExE is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to our inspection, we reviewed the information we held about the home, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local clinical commissioning group. We used the information they provided to help plan the inspection.

We spoke with 12 people who used the service to obtain their views on the care and support they received. We also spoke with five relatives who were visiting the home on the day of our inspection. We talked with the Head of Compliance, the registered manager, Head of Clinical Governance, two nurses, 12 care workers, an activities coordinator, a member of the laundry staff, the maintenance worker and a member of the kitchen staff.

We observed care and support being delivered in communal areas, including lounges and dining rooms, looked in the kitchen areas, the laundry, treatment rooms, bath/shower rooms and toilet areas. We checked people's individual accommodation. We reviewed a range of documents and records including; four care records for people who used the service, 13 medicine administration records; four records of people

employed at the home, duty rotas, complaints records, accidents and incident records, minutes of meetings, a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

We looked at how medicines were managed and administered at the home. We found an unmarked basket of medicines in a cupboard with opened boxes of tablets for two different people stored in it. We asked the nurse on duty why the medicines were stored in this way. The nurse told us that the tablets belonged to a people who were no longer at the home. She stated she was unsure why they medicines had been left in this way and said they should have been disposed of.

We looked at medicine administration records (MARs) for people living at the home. We saw that each person had a front sheet with a photograph and important information regarding their health and any allergies to medicines. There were some gaps in MAR sheets where medicines had not been signed for to say they had been given. One person was prescribed the medicine Digoxin, which is used to help regulate people's heart rate. The medicine requires that people's pulses are checked prior to the administration of the medicine and previous MARs had been marked with "Pulse" to indicate that the item should be recorded. We found some gaps on the MARs where no pulse had been recorded. This meant we could not be certain that the person's pulse had been checked on these occasions. A nurse confirmed that such pulse recordings should be taken at each administration of the medicine.

Some people were prescribed "as required" medicines. "As required" medicines are those given only when needed, such as for pain relief. Some people had care plans for these medicines, describing when they could be given and how frequently they could be administered. Others did not have specific care plans for all the "as required" medicines they were prescribed. One person had a care plan for an "as required" medicine they were not currently prescribed. This medicine had also been included on a list of medicines that could be given covertly. Covert medicines are given to a person disguised in food or drink, because they may otherwise refuse them. This meant information regarding "as required" medicines was not always up to date meaning people may be given the wrong dose or number of tablets or medicines.

Some people were prescribed topical medicines. Topical medicines are items such as creams and lotions that are applied to the skin. A nurse told us that these medicines were administered by care staff and recorded in people's daily records. We looked in daily records and saw there was a body map detailing the type of medicine and where it should be applied on people's bodies. However, records showing when creams where applied were not complete. Records did not detail each individual cream or lotion or were not signed and dated to say they had been applied. This meant we could not be certain that people had received these medicines correctly and that each individual cream had been applied as prescribed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

Clinical rooms, where medicines were stored were clean and tidy and medicine trolleys were also well maintained. Appropriate systems were in place to ensure that new medicines were checked as they arrived and disposed of when no longer required. A number of people were prescribed controlled medicines. Controlled medicines are required to be stored in line with certain legal requirements. We saw that these

medicines were kept appropriately and that regular checks were undertaken to ensure stocks were correct. The home had also participated in a programme to review and reduce the number and range of medicines people took.

People told us that they felt save living at the home. One person told us, "I feel safe here." A relative told us, "I really believe that my (relative) is well looked after and I have seen nothing that make me think she might not be safe." Another relative commented, "At my (relative's) old home I felt I had to go in. Here, I come just because I want to see my (relative)."

The provider had a safeguarding policy. Any potential safeguarding incidents were logged, with the date the incident occurred, the person concerned and the type of incident; such as a missed dose of medication. There had been 12 safeguarding incidents logged in the last 12 months. Where additional action was required then this was also noted; such as the need for additional training or supervision or a review by a pharmacist. Staff told us, and records confirmed that they had undertaken training on protecting vulnerable adults. They told us they would immediately raise any concerns with a member of the nursing staff or the manager. There was information about how to report any concerns or safeguarding matters throughout the home. This meant systems were in place to protect people from potential abuse and action was taken when any concerns were noted or raised.

Risk assessments were in place, both for the general running of the home and as part of people's care records. Regular checks were made by the home's maintenance worker on fire safety equipment, waters systems and other equipment throughout the home. There were also Control of Substances Hazardous to Health (COSHH) risk assessments for cleaning solutions and similar items used throughout the home. We noted that on the first day of the inspection window restrictors in place at the home did not fully comply with Health and Safety Executive guidance regarding care homes. We spoke to the manager about this. We noted that on the second day of inspection all the restrictors had been updated to comply with the issued guidance. People's care records contained individual risk assessments related to their health and well-being, such as risks associated with moving and handling, falls, visits out from the home and nutritional intake. People also had Personal Emergency Evacuation Plans (PEEP) detailing the level of support or assistance they would require in the event of a fire or other emergency at the home. This meant appropriate systems were in place to identify and minimise risk within the service.

Accidents and incidents were recorded and reviewed by the manager. A daily log of any falls was maintained noting the name of the person and the date of the fall or incident. Falls were reviewed in relation to individuals, to determine if an individual was having an increased number of falls, and also by time, to ascertain if there was a higher risk at certain times of the day. Where necessary remedial action had been taken and people's care plans had been reviewed. This meant systems were in place to manage and limit the risks associated with falls and other incidents.

The manager told us there were around 60 staff in total employed at the home. The home had a dependency tool in place to help determine the level of staff required to support people. The tool examined each of the three floors separately to determine the levels of need for each area of the home. Dependency levels were reassessed each month. People told us they felt there were enough staff to support them or their relatives. Staff told us that more staff would be helpful and that weekends could be busy, especially if some staff called in sick. During our inspection we noted there to be a number of staff available on each floor and that people did not have to wait long periods for care. The manager told us that she had recently revised shifts to try and ensure that there were maximum staff available at busy times. She had instigated an 8.00am – 2.00pm shift to ensure there were additional staff in the morning to support people getting up and having breakfast. She had also instigated a twilight shift, 6.00pm – 10.00pm, to support people going to bed. This

meant that systems were in place to ensure there were effective levels of staff to deliver care to people in a timely manner.

Staff personnel files indicated an appropriate recruitment procedure had been followed. We saw evidence of an application being made, interviews undertaken, references being requested and followed up and Disclosure and Barring Service (DBS) checks being made. DBS checks ensure staff working at the home had not been subject to any actions that would bar them from working with vulnerable people. Registration of the nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC). Staff records all contained an indication that a comprehensive induction process had been followed. New staff were also subject to regular probationary reviews during the first six months of employment. This verified the provider had appropriate staff recruitment and vetting processes in place.

The home was clean and tidy with no malodours present. Housekeeping staff were busy cleaning throughout both days of the inspection and people told us the home was always kept clean. Bathrooms and shower rooms were clean and tidy, although we noted they were often used for storage of chairs and hoists during the day. The laundry area of the home was exceptionally clean with a clear flow through system to ensure that dirty clothing did not mingle with clean clothes, thus preventing contamination. The home's kitchen was also clean and tidy. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited.

Good

Is the service effective?

Our findings

Relatives we spoke with felt that staff were skilled in supporting people who lived at the home. Staff told us they had undertaken a range of training including areas such as moving and handling, safeguarding, health and safety and fire safety. They told us that if they wanted additional training then this could be requested from the manager. The manager told us the home could access central training resources and personnel from the provider.

On the first day of the inspection a refresher training event was taking place at the home. The manager told us that staff had come in specifically to attend the event, with sessions run in both the morning and afternoon to ensure as many staff as possible could attend. Staff personnel files contained certificates and details of previous training. Nurse personnel files contained a note of when competencies in particular areas had last been checked; such as supporting people with percutaneous endoscopic gastrostomy (PEG) feeding tubes and administration of medicines.

The manager showed us the system for recording and monitoring training at the home. She said that they were currently transferring training records onto a new electronic system, which was not fully up and running. She told us the system had not yet been fully programmed with the individual intervals that training required refreshing, so was currently only picking up training as requiring updating yearly. The system highlighted the dates when staff had last undertaken training and used a traffic light system to identify when training was in need of renewing or past a date when refresher training was due. Before we undertook the inspection we had received information regarding a lack of training around moving and handling at the home. We spent time observing moving and handling practices at the home and saw they were carried out effectively. The majority of staff had undertaken moving and handling training in the last three years. Staff who had not completed recent moving and handling training were non-care staff, such as housekeeping or kitchen staff.

Staff told us, and records confirmed that there were regular supervision sessions taking place at the home. Staff were also subject to an annual appraisal, which included a six monthly intermediate review. The regional manager showed us the provider's published programme for conducting appraisals. They explained that staff would complete a personal review and rating and this would then be discussed and reviewed with their manager or supervisor. We saw reviews were detailed and contained actions for future development and training. This meant appropriate systems were in place to maintain and develop people's skills and knowledge.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw documentation related to DoLS was contained within people's care records and that the manager kept an oversight document to track applications and expiry dates.

Where people had capacity to make their own decision about the care they received then this was documented. Where people did not have capacity to make their own decisions then staff had followed the MCA and best interests decisions were noted. This included where people were supported to be safe through the use of bedrails. We noted that in some reviews consideration of alternative options, to ensure the least restrictive option was utilised, were not always well documented. We spoke with the manager about this and she said this would be reviewed and updated. There was evidence of appropriate processes being followed where people had DNACPR (Do No Attempt Cardiopulmonary Resuscitation) notifications in place. Staff understood about supporting people to make personal choices where ever possible. This meant appropriate action had been taken by the home to ensure proper and legal processes were followed in relation the MCA and DoLS.

People were supported to maintain good health and wellbeing whilst living at the home. There was evidence in people's care records which showed they were supported and encouraged to attend outpatient or hospital appointments. Where necessary people had been visited and assessed by health professionals, such as occupational therapists or speech and language therapists. During our inspection we noted a number of professionals visiting the home to undertake examinations or assessments of people living there. This meant people's health and wellbeing was supported by the home.

People and their relatives told us they enjoyed the food at the home and that it was of a good quality. Comments from people included, "The food here is lovely and it has got better since we have the new chef"; "I like the food. I get enough choice and I can always ask for something else" and "I like the food and there is plenty of choice; and although I don't have a good appetite I enjoy what I have." Relatives told us, "There is plenty of food choice and the staff allow plenty of time when helping people to eat" and "My (relative) needs assistance to eat and I have never seen them rushed with their food."

We spent time observing how people were supported over meal times and saw this was done appropriately and with dignity and respect. Where people required additional equipment to support them with their meals and drinks, such as plate guards, this was available. Where people required specialist diets these were provided. Pureed or soft diets were well presented with each element of the meal individually presented on the plate. A choice of two meals was offered at each sitting and a range of sweet choices were also available, including fresh fruit. Hot and cold drinks were available throughout the meal.

Each person also had a dietary preference sheet to identify their likes and dislikes, as well and any special requirements. Where there were concerns about people's food or fluid intake then a record was kept to monitor their consumption. We saw these were up to date. People's weight was regularly monitored and action taken if there were concerns. The manager also told us the home had worked with the local Clinical Commissioning Group around the introduction of a computer application that helped monitor people's daily fluid intake. This meant people were supported to sustain an adequate dietary and fluid intake whilst living at the home.

The home overall was well presented. Some redecoration was ongoing at the time of the inspection. The middle floor of the home was designated as offering support for people with dementia. We noted that the environment was well suited to this group. Flooring was of a single colour vinyl and wall coverings did not

contain any bold patterns to distract or confuse people. Toilet and bathroom areas were pictorially identified and toilet seats were of a contrasting colour to make them easier to see. There were large windows at the end of corridors to provide an interesting aspect for people to look out on and spend time watching what was going on. There were also posters on display and a range of hats and other items that people could pick up or wear. Some people had dolls which they enjoyed holding. Doll therapy is documented as being potentially useful to people living with dementia. There was access to a range of sheltered patio areas on the ground floor, which we saw people using, and a balcony area on the top floor. This meant the environment of the home supported people to live their daily lives.

Good

Is the service caring?

Our findings

People and their relatives told us that staff at the home were caring and supportive. Comments from people included, "Everyone is kind; they'll do anything for you"; "The carers are lovely; they all are. They do anything you ask" and "Staff are always very kind to me." Relatives told us, "The care is fine as far as I can see. I visit twice daily and have never seen anything that would cause me concern" and "I know that my (relative) will be looked after properly in a kind and respectful way. I have seen this with my own eyes."

We spent time observing the interaction between people and the staff. We saw there appeared to be good relationships and staff treated people with kindness and consideration. Staff spoke to people in a kind and sympathetic manner and also engaged in jokes with people. We observed two care workers entered one person's room to help get them up in the morning. They knocked on the door before they went in, greeted the person by name and asked, "How are you today?" The door was closed during the delivery of personal care but we witnessed a great deal of laughter emanating from the room whist the person was supported and the individual came out of the room smiling broadly. We also noted care staff sat with people talking to them and holding their hands. One person became distressed and staff immediately moved to reassure and comfort them.

Staff told us that no one at the home had any particular religious or cultural needs, but said they felt it was important to get to know people as individuals in order to provide good care. One care worker told us, "It's important to take time finding out what people prefer; get to know what people like and get to know them well."

People and their relatives told us they were involved in developing their or their relative's care packages. There was evidence in care plans that people's preferences had been sought prior to them coming to live at the home. One relative commented, "They always contact me and let me know any changes. They let us know if a GP is needed." Information about a range of issues was displayed around the home, including forthcoming events, minutes of recent meetings, changes in care or processes at the home and contact details for outside support groups. Information was also available about accessing formal advocacy services, although staff told us that most people living at the home were supported by their relatives.

We saw posters on display advertising a "residents' and relatives'" meeting. Copies of previous minutes were also available. We noted that the meetings were not always well attended. We spoke to the manager about this and how she was looking to improve engagement with people and their relatives. She told us she had an open door policy and that anyone could come and speak with her if they needed to. She said she had tried running a "surgery", one afternoon a week, but this had not proved successful, as relatives just spoke to her when they were visiting. She said she was also looking at linking meetings with events at the home or coffee mornings. She told us that Admiral Nurses, from a national dementia support organisation, were looking to develop a relatives' support group at the home and she hoped this would further improve opportunity for communication. This meant action was taken to involve people and relatives in the delivery of care at the home.

Staff understood about the need to maintain confidentiality and we saw evidence that staff had been reminded about the need to act cautiously when accessing social media. People and relatives also told us that staff respected their privacy. One relative told us, "They respected my (relative's) right to confidentiality when she did not want us to know something. This is good." Staff were also able to describe how they would support people's dignity during the delivery of personal care. We saw that this was put into practice during the inspection with people being supported discretely, with door closed when personal care was supported. One person's care plan around supporting their dignity included instructions that if staff entered the room when the person was busy, they were to apologise and leave the room immediately. People's independence was also supported. People were able to stroll around the home as they wished and access the outside spaces. One relative told us that they had insisted that their relations end of life care was undertaken at the home because they felt that care at the home was good. They told us, "I would recommend this place to anyone. They are superb."

Good

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to their needs. Comments included, "I can have food in in my room if I like"; "The carers come quickly when I use my buzzer" and "I've got no worries. If I need the doctor then they will get the doctor." We observed there were no times when call bells rang for long periods. Staff also responded when staff called them. One care worker told us, after responding to a person calling out a particular name, "It's not me they are calling. I have the same name as their granddaughter. But if they call out and I'm in earshot I always respond. I think it helps."

We looked at care records for people who used the service. We saw that people's needs had been assessed prior to them coming into the home. Care plans and risk assessments had been developed in line with people's assessed needs, with care plans for cognitive and emotional needs, communication, mobility, nutritional needs and specific areas such a catheter care. People's level of need for each of these areas had been assessed on a monthly basis. Whilst there was a description of the type of care that would indicated a low, medium or high care need, we could not see how the various levels of care had been arrived at, or clear indications why a care need had changed from being a medium to a high need level.

Most care plans contained good detail about the type of support people required and how care and nursing staff should support each individual. Some care plans were more corporate in nature, with care plans in separate care records using almost identical wording. There were also short term plans in place, if, for example, a person had developed a chest infection or other short term condition. Care records were reviewed monthly, although the written reviews tended to be very similar, with phrases such as, "(Person) continues to be disorientated to time and place" or "care plan remains appropriate." We spoke with the regional manager and compliance manager about these matters they agreed that care plans should be individualised and told us that staff had been instructed about completing monthly reviews in an individual and appropriate manner.

Care plans incorporated advice and information from professionals. We saw plans had been updated following assessments or visits from speech and language therapist (SALT), the behaviour analysis and intervention team (BAIT) or general practitioners. We saw in one person's plan the BAIT had made a number of suggestions about how to support a person when they became distressed or anxious and these had been incorporated into the person's care plan around their potentially challenging behaviour. This meant that people's care plans were based on their identified needs, were reviewed regularly and took account of advice from outside professionals.

Staff we spoke with had a good understanding of people's individual needs. They were able to talk about people's particular likes or dislikes and also their family and backgrounds.

The manager told us there were two activities coordinators working at the home, although one was on leave at the time of the inspection. The coordinator told us that activities were decided by the people themselves. They told us they would sometimes take small groups into a designated activities area that was set out with a range of objects or activities. They said they took the lead from what people were attracted to. They said

they also undertook individual sessions with people who either did not like, or were unable to participate in, group based activities. These activities depended on the individual's interests or needs. We saw a group activity underway during the inspection and also noted some people having their nails buffed and painted on an individual basis. On the first day of the inspection several people participated in the home's "Wednesday Walk", which was a weekly event. The manager said this had been instigated to allow people to get out into the community, but also to provide an activity that both people and relatives could participate in, if they wished. People confirmed that activities occurred at the home and that they could choose to participate if they wished. The home had also supported the placement of some occupational therapy students and they had provided some short term one to one activities for certain individuals. This meant people were supported to engage in meaningful activities.

People and their relatives told us they were able to make choices. We saw staff actively supported people in making choices. For example, at lunch time, staff did not simply ask people which dish they preferred; they presented both meals on a plate and asked them which they preferred. People were asked if they wished to join in activities and whether they wanted to move to the dining room for lunch. Some people chose to have their meals in the lounge area, and this was accommodated. This meant people were supported to make choices.

The provider had a complaints policy in the place and information about how to raise a concern or complaint was available throughout the home. The manager maintained a complaints log which showed there had been seven formal complaints in the previous 12 months. Records showed that complaints had been investigated, a formal response provided and, where necessary, action taken to change the operation of the home. For example, one complainant had raised concerns about some odours in parts of the home. The response indicated that deep cleaning of the areas had taken place. All the relatives that we spoke with told us they were aware of how to complain. One relative told us, "I would speak to the nurse in charge or go to the manager. If I was not satisfied with the result I would go to head office." Another relative told us, "The manager is very approachable and listens and acts on any concern we may have." People we spoke with told us they would also initially raise any concerns with the senior staff at the home. This meant the provider had a process in place to deal with any concerns and acted appropriately when complaints were raised.

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed she had been formally registered with the Commission since January 2016. The registered manager and Head of Compliance were at the home on the first day of our inspection and assisted us throughout the day. The Head of Compliance and Head of Clinical Governance supported us on the second day.

Staff told us they felt supported by the new manager and that she had introduced some good ideas, including developing flexible shifts to provide more cover at key times of the day. Comments from staff included, "The manager is absolutely spot on. She is approachable, friendly and listens"; "I feel I can approach her. I think that she is nice" and "The manager is very good and tells us she appreciates what we do. We often get a 'thank you'."

Staff told us they were generally happy working in the service. They said there were occasional tensions, but that in the majority of cases staff worked as a team. Comments from staff included, "All staff work together well, we are a good team. We work on different floors from time to time which means we all know each other. We have to work as a team, all of us, to make sure that all the residents are happy and cared for" and "I really like it here. It's a lovely home and the staff are lovely."

Staff told us, and records showed there were regular staff meetings at the home. They said that they were encouraged to participate in the meetings and could raise any concerns of ideas. They said the manager would listen if they did raise any items.

The manager told us that a range of audits and quality checks were undertaken at the home. We saw evidence of a range of checks including the use of a monthly nutritional audit tool, which ensured action was taken to monitor people's weight and dietary intake; audits on the effectiveness of pressure care; audits on the operations of the kitchen and medication audits. The provider's head of compliance also carried out an overall quality audit which checked on areas such as the presentation of the home, the management of falls and accidents and staff recruitment. Where necessary an action plan was produced to ensure and matters were addressed.

The manager conducted a range of meetings to ensure there was effective oversight of the home. We saw there were regular meetings with care staff and team leaders. There were also meetings to review people nutritional needs at the home, which involved both care or nursing staff and kitchen personnel. This meeting checked on people's nutritional needs and ensured information was shared with all key departments. Wider meetings also took place, including regional administrative meetings and a recently instigated meeting between leads for tissue viability at various homes in the area. The manager told us she had recently reviewed staff interests at the home and this had led to a range of champions being appointed to lead on the development of key areas. We saw there were champions for health and safety, end of life, falls and infection control. The manager told us the lead would ensure that appropriate systems were in place for these areas and also ensure that training was up to date. This meant there were systems in place to monitor and review the operation of the home. Staff were involved in this process.

There were also handover meetings when shifts changed each morning and each evening. We sat in on one of these meetings. We saw that each floor at the home was reviewed in turn with key information passed on to incoming staff. Any concerns were noted and any issues, such as the need for a GP appointment or checking the results from a blood test, were followed up. Information passed across in these meetings was of good quality and allowed staff to ensure care was maintained across the shifts.

The manager told us that she wanted all the staff to feel involved in the care and support of people and to have an understanding of them as individuals. She said that to promote this she had introduced the Friday "Three o'clock stop." She said this was a time for all staff at the home to stop what they were doing and sit and have a drink and a chat with people, to help build relationships and a sense of community. We saw this event was advertised throughout the home.

With the exception of those related to the use of medicines and topical medicines we found records at the home were well maintained, contained good detail and were readily available.

The manager told us the home worked in partnership with a number of other organisations, in addition to the work they had participated in with the CCG and the medicines reduction programme. She told us they worked with the local college to try and stimulate interest in young people working in care. The home was also going to offer placements for student nurses in the near future. This meant the home was looking to establish partnerships with other organisations.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Appropriate system were not in place to ensure that medicines were managed effectively and safely. Regulation 12 (1)(2)(g)