Care Quality Commission

Church Farm at Rusticus Limited

Church Farm at Rusticus

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 27 November 2018 and returned, with the provider's knowledge, on 3 December 2018. Church Farm at Rusticus Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service was formed in three parts. The first two provided permanent residential and/or nursing care for older people. The third part, referred to in this report as 'Hawthorn House', provides short term assessment beds. These are for people who have left hospital and have their longer-term health needs assessed to determine whether they should return home, or move to permanent residential care.

Church Farm at Rusticus accommodates up to 76 people in one building. At the time of our inspection there were 46 people living at the home. This is the service's first inspection under its current registration since it commenced in September 2017.

A registered manager was in place but not present during the inspection. 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. The registered manager was on long-term leave and the home was managed by an interim manager until their return.

People received their medicines safely; however, medicines were not always stored appropriately. Records used to record how medicines were stored were not always fully completed. There were enough staff to support people; however, we did note an occasion when staff were slow to respond to an alarm that was activated in a person's bedroom. Nursing staff at Hawthorn House required more staff to support them; recruitment for this was in process. Some relatives raised concerns about the variable quality of the agency staff. Risk assessments were in place to reduce the risk people's safety. Checks of pressure relieving equipment had not always been carried out. The home was clean and tidy and staff understood how to reduce the risk of the spread of infection. Accidents and incidents were regularly reviewed, assessed and investigated by the interim manager and reviewed with the Head of Operations.

People's physical and mental health and social needs were assessed and met in line with current legislation and best practice guidelines. Staff were well trained and felt supported to carry out their role effectively. People were supported to follow a healthy and balanced diet. Referrals to dieticians had been made when weight loss was identified; however, for one person more action was needed to address these concerns. People had access to external health and social care agencies. The home environment was well maintained and was undergoing extensive renovation work to ensure it offered all people with a physical disability or living with dementia the best possible life. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People found staff to be kind and caring and felt they were treated with respect and dignity. People's privacy was respected and people were involved with making decisions about their care. People's cultural and religious needs had been discussed with them and acted on where needed. Advocacy services were made available for people if they required them. Supporting people living with dementia was a key aim of the provider. They had taken steps to provide people, the local community and relatives with information about dementia to enable them to understand the disease. People's records were handled in line with data protection regulations.

People's care records were person centred and they received care from staff in line with their personal preferences. There was sometimes a delay in forming detailed care planning and risk assessments at Hawthorn House. Care records were largely up to date but a small number viewed at Hawthorn House did not always reflect people's current needs. People were treated fairly, without discrimination and systems were in place to support people who had communication needs. Records showed complaints had been dealt with appropriately. People were supported to make decisions about how they wished to be cared for at the end of their life.
However, not all records at Hawthorn House were fully completed.

The interim manager and Head of Operations were aware of the issues raised during this inspection and had already acted to address them. Quality assurances processes were in place to assist the interim manager with identifying any areas for improvement. People, staff and relatives liked the interim manager and found her to be approachable. People told us they would recommend this service to others. Staff felt valued and enjoyed their role. People, relatives and staff were encouraged to give their views about how the home could be improved and developed. The views were then acted on. The provider had extensive plans in place to renovate the home and to provide all people with high quality care.

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.

People received their medicines safely; however, there were issues with the way medicines were stored and records completed. There were enough staff to support people; however, we noted some staff at times required additional help. Recruitment for this was in process. Some relatives raised concerns about the variable quality of the agency staff. The risks to people's safety had been assessed. Checks of pressure relieving equipment had not always been carried out. The home was clean and tidy. Accidents and incidents were investigated and acted on.

Is the service effective?

Good

The service was effective.

People received effective support with their health needs. Staff were well trained and their competency was assessed. People were supported to follow a balanced and healthy diet. People had access to external health and social care agencies. Decisions were made with or for people in line with appropriate legislation. The home environment was well maintained and was undergoing extensive renovation work.

Is the service caring?

Good

The service was caring.

Staff were caring, treated people with dignity and respect and listened to what they had to say. People's diverse needs were respected. People were encouraged to lead as independent a life as possible. There were no restrictions on people's friends or relatives visiting them. People's records were handled appropriately and in line with the General Data Protection Regulation.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Some people's care records were not always formed in a timely manner. A small number of people's care records did not reflect their current needs. People raised concerns about the activities provided. People were supported to make decisions about their end of life care, but records were not always fully completed. People were cared for in line with their personal preferences. Efforts had been made to ensure information was provided for people in a way they could understand. Records showed complaints had been dealt with appropriately.

Is the service well-led?

Good

The service was well led.

The management team were aware of some of the issues raised during this inspection and had acted. People, relatives and staff were encouraged to give their views about how the home could be improved and developed. Quality assurance processes were in place. Staff felt valued and enjoyed their role.

Care Quality Commission

Church Farm at Rusticus

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 27 November 2018 and was unannounced. We returned on 3 December 2018 and the provider was aware when we would return. The inspection team consisted of one inspector, a nurse specialist advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On this occasion, we had not asked the provider to send us a provider Information return (PIR). A PIR is a form that asks the provider to give some key information about the service. This includes what the service does well and improvements they plan to make. However, we offered the provider the opportunity to share information they felt was relevant.

We reviewed other information we held about the home, which included notifications they had sent us. A notification is information about important events, which the provider is required to send us by law. We also contacted county council commissioners of adult social care services and Healthwatch and asked them for their views of the service provided.

During the inspection, we spoke with 13 people who used the service and five relatives and asked them for their views on the quality of the service provided. We also spoke with two members of the care staff, a nurse, a domestic assistant, the part-time kitchen manager, the interim manager, the Head of Operations and a representative of the provider.

We looked at all or parts of the records relating to eight people who used the service as well as three staff recruitment records. We looked at other information related to the running of and the quality of the service. This included quality assurance audits, training information for support staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

After the inspection we asked the provider to forward us additional documentation and they did so within the required timeframe.

Requires Improvement

Is the service safe?

Our findings

The processes to ensure the safe management of people's medicines were not always effective. We observed staff members administering medicines to people. When doing so, staff did so patiently and waited with them to ensure they took them. However, we saw a staff member had left a medicines trolley unlocked on one occasion when the member of staff was administering medicines in a separate room. During the time the staff member was away from the trolley we could open it and to carry out checks on other medicines within the trolley before they returned. This meant, if we had not been present, people could have accessed medicines not prescribed for them, which could place them at risk of harm. We did note that when we observed other members of staff administering medicines, the trollies were locked.

The room where medicines were stored was locked. The temperature of this room and the refrigerator used to store medicines were not always recorded daily. It is important to check these temperatures daily to ensure medicines are not stored at temperatures that could impact their effectiveness. However, we did note when checks had been completed the temperatures were within acceptable limits. Controlled drugs were stored safely; however, daily stock checks were not always completed as per the provider's medicines policy. This could cause a delay in identifying any discrepancies of the numbers of these medicines.

People's medicines administration records contained their photograph to aid identification, people's allergies and how they liked to take their medicines supported staff to administer people's medicines safely. Patch application records were kept to record the site of application of medicinal skin patches to ensure the site of application was rotated as per the manufacturers safety instructions. However, we found these records were not always completed. This could lead to unsafe administration.

Protocols were in place for staff to consider when administering medicines that were to be given 'as required.' These protocols are important to ensure people received their medicines consistently and in line with their assessed needs.

People told us they felt there were sufficient staff in place in support them. One person said, "The staff come (when they press their call bell) definitely, I'm very well cared for." Another person said, "I feel safe, the staff are fine. They do come, sometimes you have to wait but if they're not busy you get quite good help quickly." Relatives gave mixed feedback about the numbers of staff available to support their family members. One relative said, "There's usually someone in here. They look after him very well I've no concerns." However, another relative said, "They have regulars who are always here, but they have lots of agency staff who hang around and do nothing. Sometimes when [my family member] wants to go to the loo, they may have to wait a long time, there should be more staff."

We observed sufficient numbers of staff were in place to monitor the communal areas. However, we did note that when we inadvertently activated a person's sensor mat it took staff ten minutes to respond. On this occasion the person had not left their bed; however, staff would have been unaware of this when the sensor was activated. This could have placed the person at risk. On occasions, staff were slow to respond to some call bells on Hawthorn House. We also observed a nurse was regularly interrupted during tasks, such as

administering medicines by the requirement to respond to other issues. The Head of Operations told us they acknowledged that nursing staff required more support to enable them to carry out their nursing roles effectively and plans were in place for an additional senior member of staff to work alongside them. Additionally, the number of nurses working at night had also recently increased to offer additional support.

The provider had assessed the staffing requirements and acted to increase staff numbers where needed. However, the additional demand for staff, had resulted in an increased use of agency staff until permanent staff could be recruited. The Head of Operations told us they used the same agency and asked for staff who were familiar with the home to ensure people received consistent care. However, we received some comments from permanent staff, people using the service and their relatives about the variable quality of agency staff. A person using the service said, "I am worried about staffing levels and the use of agency staff." In relation to one aspect of their care, they said, "I have to tell them how to do it. They don't always listen or understand." Some relatives felt some of the agency staff did not understand people's needs. The interim manager told us they were aware of these concerns. They told us they had informed the agency of staff who they did not want to return to the service which they hoped would see an improvement in the quality of care people received from agency staff.

Robust recruitment processes were followed to ensure that people were protected from unsuitable staff. Before staff started working at the service, a check had been carried out through the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. We also saw that proof of identity and appropriate references had been sought prior to staff commencing work. This meant that the provider had taken appropriate steps to ensure people were protected from staff who may not be safe to support them

People told us they felt safe living at the home and that staff supported them in a way that made them feel safe. One person said, "I feel safe with staff they treat me alright. If you need them they come." Relatives agreed that their family members were safe. One relative said, "[My family member] is safe here, the staff are lovely."

People were supported by staff who understood how to protect them from avoidable harm and to keep them safe. A safeguarding policy was in place and staff had received training in safeguarding adults. Staff could explain how they would act if they thought someone's safety was at risk. This included reporting incidents to the interim manager, the provider, or external agencies such as the CQC. The staff felt the interim manager would support them if they reported any concerns about abuse. People and relatives were provided with information about who to contact if they were concerned about abuse and this was displayed in the home. We noted the interim manager had the processes in place to investigate concerns and to report them to the appropriate agencies where needed.

Detailed risk assessments were in place that helped staff to identify and reduce the impact of any hazards that could affect people's safety. People were supported to lead their lives without unnecessary restrictions, but also had risk assessments in place where needed. This included people's ability to mobilise independently of staff, managing their medicines and eating and drinking.

We saw the risks of people developing pressure ulcers, falling and the use of bedrails had also been assessed. Pressure relieving mattresses, used to support people who may develop pressure ulcers due to limited mobility when in bed, were set appropriately for the weight of the people using them. Most pressure relieving mattresses were functioning correctly. However, we found one had deflated. A member of staff told us the mattress had been disconnected the previous night during a power failure and had not been reconnected afterwards. We noted routine checks on pressure relieving equipment were not currently

recorded, which meant discrepancies would be more difficult to identify. The interim manager told us checks were completed; however, they needed to be regularly recorded to reflect this.

After the inspection the provider informed us that they had resourced new technology which enabled pressure relieving equipment to be used without the need of a pump. This equipment is being trialled and if successful, this technology will be used across the home. This, the provider told us, will reduce the reliance on pumps and the risks associated with them.

There were procedures in place for evacuating people from the premises in the event of a fire or emergency. Each person had individualised plans in place to enable staff to support them safely. However, we did find for one person who had been at the home for four days prior to the inspection did not yet have this plan in place. This could put them at risk in an emergency.

Regular maintenance was undertaken at the home. Regular servicing of gas installations and fire prevention equipment had been carried out. This helped staff to support people in a safe environment. A fire risk assessment was in place and the interim manager understood how to ensure the risks associated with the home environment did not impact on people's safety.

The home was visibly clean and staff spoken with told us they had access to personal protective clothing and equipment (known as PPE). We also found that bathrooms contained liquid soap and disposable hand towels in addition to visible instructions about correct hand washing technique. We spoke with a member of the domestic staff who told us they had adequate time allocated for cleaning and laundry duties and were aware of the action they should take in the event of an outbreak of infection. This helped to reduce the risk of the spread of infection.

The provider ensured that processes were in place to act on and investigate any accidents or incidents that occurred at the home. Processes were also in place that helped staff to learn from mistakes and act to reduce the risk of incidents recurring. The provider took an active role in monitoring the service and alongside the Head of Operations, discussed any themes or trends and what action could be taken to address them. This meant people's on-going safety was reviewed to reduce the impact on them or others.

Good

Is the service effective?

Our findings

Staff had access to policies and national good practice guidance in the staff areas, which guided them on how to support people effectively. In addition, we noted recognised assessment tools were used to assess people's pressure areas, mobility and nutrition. Where people had health conditions that required the support of staff to help to manage them effectively, specific guidance was in place to support staff. The interim manager had also ensured that the protected characteristics of the Equality Act 2010 were implemented when care plans were formed.

People and their relatives told us they felt most staff understood and knew how to support them or their family members. People told us they felt staff were well trained and could recognise if they were ill and needed more help. We observed staff provide people with effective care and support. For example, we saw a staff member respond quickly to a person who complained of feeling unwell during lunchtime. The staff member acted quickly, carried out tests such as checking the person's blood pressure and temperature and stayed with the person until felt they better. This showed staff reacted quickly and effectively to people's changing health needs.

Records showed staff were well trained, received a detailed induction and an on-going supervision and development programme. A recruitment drive was currently in place to increase the numbers of permanent staff and to reduce the number of agency staff currently working at the home. All agency staff received the same corporate induction as permanent staff. The Head of Operations told us this was to ensure all staff, including agency staff, understood the expectation of working at a Church Farm home. Staff spoken with told us they felt well trained and felt supported to carry out their role effectively. Staff were encouraged to undertake professionally recognised qualifications such as diplomas (previously known as NVQs) in adult social care. This helped to improve staff knowledge and expertise when supporting people.

People told us they liked the food provided for them at the home. One person said, "There is quite good food, you're never short of something to eat." Another person said, "It is quite reasonable food, it's not like your mum's but you get a choice."

We observed the lunchtime meal being served in three of the dining areas. We observed at least one staff member sitting with people at each table helping some to eat and prompting others where needed. There was a relaxed atmosphere with staff and people chatting whilst people ate their meals. We did note one agency staff member did not engage positively and meaningfully with the person they were supporting. They did not engage in conversation with person and at one time pushed their drink towards them. This was not a positive experience for the person. We raised this with the interim manager who told us they would address this with the agency staff member. Apart from this example, we noted the lunchtime experience for people was a positive one.

Staff completed nutritional screening for all people using the service and when people had difficulties eating and drinking or were losing weight they were referred to a dietitian. For most of the records we looked at we noted people's nutritional needs were appropriately assessed and acted on. We did note that one person's

care plan stated they had been losing weight yet there was little recorded as to what action the staff had taken to address this. A staff member told us the person had dementia and had been reluctant to eat; however, there was little information about how to support the person to eat more. The interim manager told us they would address this.

The kitchen staff were provided with information about people's food preferences and dietary requirements and regularly sought feedback from people using the service on the food provided.

A four-week menu was in place that offered people a wide variety of food and drink choices. Mealtimes were flexible with people who chose to eat their breakfast later in the day supported to do so. The home has been inspected by the Food Standards Agency who awarded the home a rating of four out of a possible of five for food hygiene practices. This rating is specified as 'Good'. We found the kitchen to be clean and tidy, with all fridge and freezer temperatures within the appropriate range. Food was labelled and stored correctly and there was noted to be a wide selection of fresh produce available. The kitchen manager was knowledgeable about people's special dietary requirements, and they reviewed people's dietary needs regularly with the interim manager or senior care staff. This ensured people continued to receive food they enjoyed, but also did not place their health at risk.

People told us they had access to external health and social care agencies when they needed them. One person told us they could recall their GP being called when they had felt unwell. A relative praised the way the home worked with other healthcare agencies and told us their family member's medication had been reduced since they had been admitted to the care home. They told us they thought this indicated they were being well cared for.

We saw regular involvement of health care professionals had been recorded in people's care records. Records showed that people had access to a range of external health professionals which staff had contacted when changes to their health had occurred. For example, care records showed input from a GP, dieticians, dentists and speech and language therapists.

The home was currently undergoing extensive renovation work. The provider described the changes and how these would benefit all people living at the home. They told us, 'Wherever possible, people living at Rusticus will have direct views and access to the outside, enhancing that feeling of well-being and a connection with nature. All bedrooms will have full disabled access ensuites. All the lounges have been designed to maximise the location and be as light and spacious as possible. They all have their own kitchenettes giving everyone that feeling of independence and self-worth'. The Head of Operations told us that all plans were designed to enhance the lives of all people but also to support people living with dementia to lead fulfilling and meaningful lives. We were shown parts of the home that were finished and people were currently using and enjoying the facilities. We were also shown the plans for future renovations. The provider told us a meeting was planned with people and their relatives in January 2019 to discuss how the renovations were going and to gain feedback.

We also noted that people's bedrooms in both the newer parts of the home and the current home contained people's personal effects. People had photos, pictures and trinkets that were important to them, which helped their rooms have a homely feel.

We observed staff talking with people, asking for their views and responding accordingly. The staff we spoke with were confident that they ensured people could make their own choices and they respected and acted on their views.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

Where people lacked the ability to consent to decisions about their care, their care records contained assessments to ensure decisions that were made adhered to the principles of the MCA. Records showed assessments were completed where needed and covered a wide range of decisions. These included people managing their own medicines and leaving the home unaccompanied. Best interest documentation was in place when a particular decision had been made for people. This documentation is important, as the views of the people who have contributed to the decision, normally the person's relative or appointee, are recorded, to ensure that as wide a range of views are considered before a final decision is made. This ensured people's rights were respected.

The interim manager had made DoLS applications where necessary and authorisations were stored in each person's care records along with a care plan in relation to the DoLS. Where conditions were recorded on the DoLS that had been granted, we found action had been taken to implement them. We did find one example where conditions had not been adhered to as the person's health had deteriorated. The interim manager had requested a review from a local authority DOLS assessor to ensure that the person's rights were not unlawfully restricted. These processes ensured people's rights were protected.

Good

Is the service caring?

Our findings

People and their relatives told us they found the staff to be kind and caring when providing care for them or their family members. One person said, "On the whole they're quite nice, I don't think you could get any better." Another person said, "I'm very well cared for. Staff are caring, the majority are, they do care." A third person said, "The staff are kind, we don't have any problems." A relative said, "I've not seen anyone who has not been kind to [my family member]."

People were supported by permanent staff and agency staff who showed a genuine interest in their wellbeing and engaged with them showing warmth and respect. We observed staff respond quickly to people who showed signs of distress or discomfort. We observed a staff member sit and hold a person's hand after they had become upset. The person responded positively to this.

When the provider commenced managing this home in September 2017, they recognised that changes were needed to the home environment to make it more appropriate for people living with dementia. The aim was to ensure that people living with dementia could lead meaningful and where able, independent lives supported by a safe environment. Alongside the renovation work, staff have received in-depth training to support people living with dementia as well as safely managing situations where people may present behaviours that could challenge others. We observed staff supporting people with dementia with care, respect and confidence. We also saw the provider had led on events in collaboration with the local town council to help people within the community become more aware of dementia. A question and answer session was available for people to raise any concerns they may have about their or a family member's dementia and the support that was available for them.

People and their relatives felt staff treated them or their family member with dignity and respect. A relative said, "They do treat [my family member] with respect and they maintain their privacy and their dignity, yes, they are good." During the inspection we found people to be well presented, with evidence of regular personal care taking place. One relative told us they had raised an issue about their family member's clothing and this had been dealt with quickly by staff. This meant staff were responsive to concerns and ensured people were always treated with dignity and respect.

People and relatives were involved with care planning and making decisions about their or their family member's care. One person told us staff always spoke with them about the care and acted on any issues they raised. A relative said, "I ask about care planning. I check about [my family member's] medication but it seems to come regularly and I want to know that it does. The care is good I have no complaints." Staff knew people's personal histories, what was important to them and the support they required to maintain their interests. Staff told us the care plans provided additional guidance about people's history and backgrounds which they found useful.

People's privacy was respected. There was private space throughout the home should people wish to speak with friends or family away from communal areas, or wanted to be alone. Bedroom doors were shut when personal care was taking place meaning people's privacy was always respected. There were no restrictions

on people's family and friends visiting them.

People had the opportunity to have an independent person to speak on their behalf to support them with making decisions if they wished them to. Information was available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care. The provider told us the advocates reported people's views to the interim manager who used this information to inform care planning.

People's cultural and religious choices were discussed with them and respected by staff. People could practice their own religion and were supported to attend their chosen place of worship if they wished to. A monthly religious service was also provided should people wish to worship at the home. People's cultural background was considered when planning people's care. Should people require specific food or support from staff, this would be arranged. Records showed staff had received 'person centred care' training, which helped them to support people in line with their preferences.

People's care records were stored safely, both in paper and electronic format. Records were locked away from communal areas to prohibit unauthorised personnel from accessing them. Access to computerised records was protected by a password. This ensured the information was treated confidentially. The interim manager was aware of the requirements to manage people's records in accordance with the General Data Protection Regulation.

Requires Improvement

Is the service responsive?

Our findings

The provider offered three types of services at the home. Residential care, nursing care and assessment. The first two offered people the care and support they needed when living permanently at the home. The assessment unit, also known as Hawthorn House, offered people the opportunity to reside at the home for a short period of time to help determine whether they could be supported to return home following a stay in hospital. If people were unable to return home, they were supported to find a permanent place either at Church Farm or at another home.

We noted that pre-admission assessments carried out for people who were coming to stay at the home on a permanent basis, resulted in timely care planning and risk assessment documentation. The care plan we reviewed provided a good level of personalised information about each person's care needs. We saw a communication care plan for a person who had partial sight loss, contained information about how to communicate with the person and reassure them, including using touch.

However, we noted for people coming to stay for a shorter period at Hawthorn House did not always have these records developed in a timely manner. For example, a person was admitted to Hawthorn House four days prior to the inspection. Although risk assessments had been completed for falls, nutrition, pressure ulcers and bed rails, there were no short term or long terms care plans to describe the person's other care and support needs. The only other information available was the initial pre-admission assessment documentation. This meant staff may be unaware of this person's preferences and specific care needs in other areas such as eating and drinking and personal care. We also noted for another person they had a pressure relieving mattress and were re-positioned regularly when in bed. However, this information was not provided in the care plan.

We raised the issue of the care planning process at Hawthorn House with the Head of Operations. They told us they were aware of this issue and had already put steps in place to address this. Additional senior staff were soon to commence working at Hawthorn House with the aim to support the nurses and to speed up the writing of care plans. They were confident that when this was in place, this would see a much quicker care planning process.

An electronic care planning system had been introduced to record the daily care and support people received. This had enabled staff to share important information about people's care and wellbeing in a timely manner. All care staff carried an electronic device and could input information about people within minutes of supporting them. Nurses and care staff had the ability to share information regarding changes in a person's health with all staff, to support them in providing people with responsive care and support.

Efforts had been made to support people with making decisions about how they would like staff to support them when they neared the end of their life. We noted some good examples where people's end of life care and final wishes had been discussed with them before they had started using the service. These had been developed into care plans, which included people's personal preferences. However, we did also note that more work was needed in this area to ensure that all people received the same opportunities to discuss their

wishes. For example, one person on Hawthorn House who was in the last days or weeks of their life and did not have an end of life care plan and their short-term care plan did not have an end of life section. Another person, again at Hawthorn House was identified as nearing the end of their life. They had an end of life care plan, but did not contain information about their personal wishes and there was no mention of anticipatory medicines. These medicines are commonly required to control symptoms in the last days of life.

We raised these issues with the Head of Operations. They told us they would address these issues, but was also confident that the planned increase in staffing at Hawthorn House would see improvements in the care planning process for end of life care.

A bereavement support service was provided for people, their relatives and staff. A nurse with experience of supporting people with bereavement was available to meet with people to listen to people's worries and to offer guidance on how to cope with their loss. This service was available to all and could be booked via the interim manager. This empathetic approach supported people with the loss of a friend or loved one.

We spoke with a visiting professional during the inspection. They commented that the quality of the nursing care plans and end of life care plans had improved considerably over the last few months. They felt people living permanently at the home received a good level of care and expressed confidence in the nursing care. They identified there had been initial problems with the assessment service due to ensuring the criteria for admission were correctly applied, but they had no major concerns.

We observed some activities taking place during the inspection. One staff member provided people with a quiz and this was responded to positively. We also saw other staff take some time to sit with people to talk or read magazines and look at photographs. However, we also found several periods of time throughout the inspection where there was little or no meaningful engagement with people. Staff were often observed sitting with people but using that time to update records and not engaging in meaningful conversation.

Relatives raised concerns that there was a lack of activities at the home. A visiting professional raised a concern about the limited activities provided at Hawthorn House. The Head of Operations told us as part of each staff member's role, they were expected to spend time with people and to help them to engage in things that were important to them. Whilst we saw some good examples of this, the approach of staff was inconsistent and not monitored. The Head of Operations and interim manager told us they would discuss this with staff and to remind them of the need to ensure people are provided with the opportunities to engage in meaningful activities.

We did see that the provider's group of services got together locally to provide people with opportunities to meet others from the other homes. BBQs and memory walks were some of the examples where people could leave the home and to meet others to aid social inclusion.

People and relatives felt involved with the care planning process and could give their feedback during reviews. A relative told us they were content with the care given to their family member and they had been involved in care planning, discussing their family member's likes and dislikes.

The interim manager was aware of the Accessible Information Standard, which ensures that provisions are made for people with a learning disability, sensory impairment or communication difficulties to have access to the same information about their care as others in a format that they can understand. We saw some easy read information was available for people who had communication needs. The interim manager told us they would ensure people's care plans and other documentation were presented in a way that ensured more people could be involved with the care planning process. Other documentation provided throughout

the home would also be reviewed to ensure compliance with this standard.

Most people and the relatives we spoke with told us any concerns or complaints they had were normally responded to appropriately. Records showed the interim manager was aware of their responsibilities to ensure that when a formal complaint was made, it was investigated and acted on in good time, with a response sent to the complainant. This response outlined the action that had been taken and if required, apologies were given. Learning from complaints formed a regular part of senior management meetings and where needed, discussions were held with staff to ensure they were aware of improvements that were needed.

Good

Is the service well-led?

Our findings

Since the provider commenced managing this service in September 2017 they have made significant changes to the home. Some of these changes have been in relation to modernising the home environment and to improve the facilities for people. Also, improving staff awareness of dementia and increased training in specific areas such as the management of actual or potential aggression. Thirty-six staff have been trained as first aiders with a further 13 trained as fire wardens. This increase in staff training and responsibility is designed to enable staff to take a leading role is supporting and caring for people and to improve people's experience.
The Head of Operations acknowledged that it has taken time to instil the values of the provider of the Church Farm group of services to this home. However, they felt that, alongside the current management team had a clear action plan in place to ensure the home continued to develop and improve to provide people with high quality care and support. Staff spoke highly of the provider. They have embraced the changes and are keen to work with the provider to instil their ethos across the service. The changes have resulted in a high turnover of staff since the provider started managing the service, although we found this was because of the provider trying to ensure that only the highest quality staff were available to support people. Recruitment is on-going, and new staff are being recruited regularly. All staff attend a compulsory corporate induction which explains the values and ethos of the provider and what is expected of them. Staff we spoke with could explain what this ethos was and how they contributed to providing it and supporting people.

The issues highlighted within this report were known by the provider and they were in the process of addressing them. The issues raised formed part of an on-going action plan which was reviewed by the head of operations on a regular basis. Provider-wide meetings took place with other representatives of the other homes within the provider group and best practice and learning points were discussed and acted on. These processes were designed to continually review and improve the quality of the service people received.

The registered manager was not currently working at the home but was due to return after a period of leave. In their place an experienced interim manager was covering their duties with the support of the Head of Operations. We found the interim manager to be knowledgeable and understood what was required of them. They had ensured the CQC was informed of any notifiable incidents such as serious injuries or allegations of abuse. Records showed that when incidents needed to be reported to us, they had been.

The provider had measures in place to develop their staff and to empower them to take lead roles in key areas of care. The provider participated in a study co-ordinated by the East Midlands Health Academic Network that provided quality benchmarks around continence, tissue viability, nutrition and hydration. The provider told us they used this opportunity to develop 'champions' in these areas and saw this as an important way to improve staff knowledge and expertise resulting in higher quality care and support for people.

Daily 'flash' meetings were held in addition to twice-daily handovers. These meetings enabled lead staff on shift from all departments to come together to share any concerns, issues and plans for the coming day.

This approach empowered staff to respond quickly to risks to people's health and safety.

Quality assurance processes were in place and they enabled the interim manager to identify and act on any areas where improvements were needed. Daily walkarounds, weekly and monthly audits as well longer-term strategic reviews were carried out to ensure issues were identified and acted on. The interim manager and head of operation were aware that the focus for improvement needed to be the quality of the agency staff and the implementation of the additional staff to support the nurses at Hawthorn House. The Head of Operations was confident that in the coming months, with the renovations completed and more experienced staff in place that this would help to address these issues.

The service had an open and transparent culture. People, staff and relatives were asked for their views about how the service could develop and improve. The staff we spoke with told us they felt comfortable to report any incidents or accidents which occurred and that any learning or recommendations from incidents were shared with them.

The staff felt comfortable raising any issues of concern and were familiar with the service's whistleblowing procedure. Whistle blowing is a term used to describe the reporting of concerns about the care being provided by a person who works at the service. The staff felt confident to raise concerns and were confident these would be dealt with.

People and relatives were overall pleased with the quality of the care provided. People told us they would recommend the service to others and found the management team responsive to any issues they raised. One person said, "I would recommend it, definitely." Another person said," I like it here, it's a nice place there's quite a few people here so you can chat to others and wander around." We noted people and relatives had expressed a wish for more meetings to discuss their overall views of the home. This was acted on. We were informed by the Head of Operations that, after the inspection, a meeting was held with people and their relatives to discuss their views on the renovations and further plans for the home.

Positive feedback from surveys showed that people and their relatives were happy with the quality of the service provided. The Head of Operations told us another survey was due to be sent out in December 2018, ensuring that people continued to be able to give their formal views about the home on a bi-annual basis. The feedback from these surveys was then used to inform action plans and to aid continual improvement.