Mr Raymond Hancock

Fulford Nursing Home

Inspection report

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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 20 and 23 June 2016 and was unannounced.

Fulford Nursing Home provides nursing and personal care for up to 28 older people. It is an independent, family-owned business. The home has accommodation on three floors and a communal dining room, living room and conservatory sitting room on the ground floor. All floors can be accessed by a lift. The accommodation includes a small number of double rooms. The home also has an outside courtyard garden and seating area which people using the service and visitors can utilise. At the time of our inspection there were 24 residents using the service. As well as people living at the home on a permanent basis, the home takes referrals from the local NHS Rapid Assessment and Treatment Service, for people who required a short stay, with a focus on rehabilitation before moving back to their own home.

The service is required to have a registered manager, and at the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that people's needs were assessed and risk assessments were in place to prevent avoidable harm. The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

The provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers. There were sufficient numbers of suitable staff to keep people safe and meet their needs.

There were policies and procedures in place to ensure people received their medication, but these were not always consistently followed. For example, the date of opening was not always recorded on some medications which had a limited shelf life once opened, and the stock count of some medication was inaccurate. We have made a recommendation about this in our report.

Staff completed a range of training to help them carry out their roles effectively and the majority of staff were up to date with their training. Some staff that were overdue their medication refresher training were booked to complete this training the month after our inspection, so systems were in place to ensure everyone had the necessary up to date knowledge and skills they required.

The registered provider sought consent to provide care in line with legislation and guidance. Staff had completed Mental Capacity Act (MCA) training and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with healthcare services, such as GPs, the community mental health team, podiatrists, the tissue viability nurse and the community dentist.

There was generally positive feedback about the quality and variety of food available, and people told us they got sufficient to eat and drink. Care plans contained information about people's nutritional needs and preferences, and the cook we spoke with was knowledgeable about people's dietary needs. Food and fluid monitoring charts, for people identified as being at high nutritional risk, contained insufficient information to effectively monitor people's food and fluid intake. We have made a recommendation about this in our report.

Most people told us that the staff who supported them were kind and caring. We saw that interactions between staff and people using the service were positive, respectful and friendly and staff were knowledgeable about people's needs and preferences.

The registered provider completed care plans which contained information about people's needs and wishes; these were regularly reviewed.

There was a complaints procedure in place and most people using the service told us they knew how they could raise a complaint if they needed to. People also had opportunity to raise concerns through resident's forums and relatives meetings.

The registered provider had a quality assurance system in place and the registered manager conducted a range of audits. This enabled the registered provider to identify issues and measure the delivery of 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 always safe.

There were policies and procedures in place in relation to the management of medication but these were not always consistently followed, which increased the potential risk of medication errors.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to respond to any concerns. Risks to people were appropriately assessed and managed.

The registered provider completed appropriate checks before staff started work, to ensure that people were supported by staff who were considered suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff received an induction and regular refresher training. Staff told us they had the training they needed to carry out their roles, and could request additional training if required.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People told us they received plenty to eat and drink, but some food and fluid monitoring records lacked detail. People had access to healthcare services where this was required, in order to maintain good health.

Is the service caring?

Good

The service was caring.

People told us that staff were caring and that they had positive caring relationships with the staff that supported them.

People we spoke with felt that staff respected their privacy and

dignity, and we saw that people's independence was promoted.

Is the service responsive?

Good

The service was responsive.

The registered provider assessed people's needs and developed care plans to enable staff to provide personalised care.

There were systems in place to manage and respond to complaints and listen to the views of people using the service.

Is the service well-led?

Good

The service was well-led.

Feedback about the management of the service was positive and staff told us they received the support they needed to deliver the service effectively.

The registered manager promoted a positive and person-centred culture.

The registered provider conducted a range of audits in order to monitor the quality of the service provided.

Fulford Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 20 and 23 June 2016 and was unannounced.

The inspection team consisted of one adult social care inspector 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.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from City of York Council's contracts and commissioning team.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with eight people who used the service and six visitors to people using the service. We also spoke with two nurses, two care staff, a cook, the receptionist, the deputy manager, the registered manager and the business manager. We looked at four people's care records, five people's medication records, four staff recruitment files, staff training files and a selection of records used to monitor the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We asked people using the service if they felt safe living at Fulford Nursing Home, and people we spoke with told us they did. Comments included, "Yes, I definitely do [feel safe]," "Yes, very much so," and "Yes, it's okay; there are plenty of staff which makes me feel safe." A visitor to the service told us, "[Name] is definitely safe here; I know this because they are happy and content, so I can see it. They asked to stay living here [after a temporary stay] and are a lot happier now than when they were living on their own." Other visitors also told us they were confident their relatives were safe living at Fulford Nursing Home.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults; staff either completed an on-line training course or a face to face training course run by the local authority. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Care staff told us they would report any concerns straightaway to the nurse in charge or the manager. They also told us that if they had any safeguarding concerns about the management they would report these directly to the local authority safeguarding team.

The registered provider had a whistleblowing policy, which enabled staff to report issues in confidence and without recrimination. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

The registered provider completed appropriate risk assessments in relation to people's individual needs. These included assessments in relation to falls, moving and handling, continence needs, infection prevention, skin integrity, depression and bed rail use. The Malnutrition Universal Screening Tool (MUST) was also used to assess people's risk in relation to malnutrition. The majority of risk assessments were reviewed monthly. We saw examples where the registered provider had responded promptly to risks they had identified to individuals; for example, consulting the orthotics department to get new shoes for one person where there was a potential risk of falls from having shoes they considered were too large for the person. Plus another example where they had re-assessed and provided bed rails for someone following a fall from their bed.

We saw that records of any accidents or incidents were stored in individual files, and reviewed by the registered manager to ensure appropriate action had been taken to ensure these could be minimised in the future.

Personal emergency evacuation plans (PEEPs) were in place for people who would require assistance leaving the premises in the event of an emergency. PEEPs are used to record the assistance people would need to evacuate the premises in an emergency, including any impairment they had, the support they would need from staff and any equipment they would need to use. Some of the PEEPs we looked at lacked individual detail about how the person's sensory impairment would impact on their ability to leave the premises in an emergency, and lacked clarity about the support that would be needed. The registered

manager told us they would address this, to ensure the plans were clearer.

The registered provider had a business continuity plan detailing how they would respond and ensure people's safety in the event of an emergency, such as a fire or flood.

We looked at documents relating to the maintenance of the environment and servicing of equipment used in the home. These records showed us that equipment was regularly checked and serviced at appropriate intervals. This included alarm systems for fire safety, electrical wiring and the gas system. Checks also included legionella sampling, servicing of the lift and hoisting equipment, wheelchair servicing and portable appliance tests. These environmental and equipment checks helped to ensure the safety of people who used the service.

The home had achieved a rating of five following a food hygiene inspection undertaken by the local authority Environmental Health Department in January 2015. The inspection checked hygiene standards and food safety in the home's kitchen. Five is the highest score available.

The registered provider had used an external consultant to complete health and safety inspections; the most recent of which was in April 2016. Recommendations from the most recent inspection, such as fitting a barrier rail and safety film on windows above ground level, had been completed or were underway when we conducted our inspection.

The registered provider had a safe system for the recruitment of staff. We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references, identification checks and registration checks for nursing staff. We saw that the provider also verified the references provided. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We spoke with the registered manager, staff and people who used the service about the availability of staffing to meet people's needs safely. Staff told us, "There are enough staff; things seem to be running smoothly over the last few months and we all know what we're supposed to be doing. There are days where you're busy and flustered but the team you're working with support each other. If you tell them what needs to be done, you know it will get done."

The majority of people using the service and visitors told us that whilst staff were sometimes busy there were sufficient staff available to meet people's needs. One person and one visitor told us that they had experienced longer waits for assistance on a weekend, because staff sometimes took breaks at the same time. However, other people did not raise concerns about staffing on the weekend. The registered provider told us that there were the same staffing levels on a weekend as there were during the week. We looked at rotas which confirmed this. One relative told us, "There are more than enough staff; there's always someone around. Staff attend to [Name]'s needs promptly."

The registered provider used a dependency tool to assess people's individual needs. We looked at copies of the staff rotas for the previous four weeks and saw that staffing levels were consistently maintained. Sickness and annual leave absence was covered by other regular staff, or by the occasional use of agency staff. The registered provider had also recently employed an additional member of staff to assist with breakfasts in the morning, due to this being a particularly busy time of day. They had also deployed an

additional staff member to work on the reception desk during the week; dealing with queries and telephone calls, to enable care staff to concentrate on the delivery of care.

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers of staff to keep people safe and meet their needs.

We looked at systems in place to ensure people received their medication safely. The registered provider had a medication policy. Nurses were responsible for the administration of medication and they had received training in medicines management. Four nurses were overdue their refresher training in medicines management, but were booked on this training the month following our inspection. The registered provider did not routinely complete competency assessments to assess staff's competency in the management and administration of medication, however the registered provider told us they observed staff practice on an ad hoc basis and that they also regularly monitored Medication Administration Record (MAR) charts, to check that staff were completing them appropriately and that people had received their medication as prescribed.

People's care files contained a care plan with details of any support required with medication. We saw these were reviewed regularly to ensure they were reflective of people's current needs. We looked at a selection of Medication Administration Record (MAR) charts. We found that the charts currently in use were appropriately completed, to show that people had received their medication as prescribed. There were some occasional gaps in MAR charts from previous months, and the registered manager told us they were considering introducing an electronic MAR system to ensure there was a more robust method of recording medication administration. They were in the process of assessing the potential benefits of changing to this system at the time of our inspection.

We checked the stock balance for a number of medications and the stock held tallied with the stock level recorded on the MARs, apart from for one medication. It was identified that this error had occurred because the last person to complete a stock count had incorrectly assumed that two spare packs of medication held in the cupboard were full boxes. There were protocols in place for people who were prescribed medication for use 'when required'; these protocols gave instruction to staff when and why the person may require this medication and records were completed when people received them. There was some inconsistency in how staff recorded whether they had offered 'when required' medications. We also noted that instructions given to staff about creams prescribed for use 'when required' were less clear, as they did not always describe how the skin would present when cream was required. Topical administration records were completed when people's prescribed creams had been administered.

Medication was appropriately stored. We saw that fridge temperature checks were recorded to ensure that medicines stored in the fridge were safe to use. Some prescription drugs are controlled under the Misuse of Drugs legislation (and subsequent amendments). These medicines are called controlled drugs and there are strict legal controls to govern how they are prescribed, stored and administered. We found that controlled drugs were stored correctly within a suitable cabinet in the medication rooms. We found that records in relation to controlled drugs were not were always easy to follow because the indexing system used in the controlled drugs book was not being used properly and there were also two books in the cabinet. The registered manager agreed to obtain and start a new controlled drugs record book and archive the two old ones, to prevent staff inadvertently completing the old book, and to ensure controlled drugs were clearly and consistently recorded.

We checked that medication which had a limited shelf life once opened, such as certain eye drops, was still in date. Whilst the date of opening had been recorded on some medication which showed that these were in date, we found two examples where the date of opening was not recorded on the medication. This meant it

was not possible to be certain the medication was within date. We also found one bottle of eye drops in the medication trolley that had been opened eight weeks prior to our inspection, and these had an instruction to discard after four weeks. It was therefore not possible to be sure that these eye drops had not been used in the last four weeks. This is significant because some medications are less effective if used beyond the timescale indicated. When we discussed the medication issues with the registered manager and business manager they told us that some of these had occurred because an agency nurse had checked in the medication and failed to follow their standard procedure.

This showed us that whilst there were systems in place to ensure people received their medication, these were not always consistently followed and improvements were required in this area. The business manager updated us after the inspection about actions they had taken to address the issues we had found, including seeking guidance from their pharmacy supplier.

We recommend that the registered provider follows best practice in medication management and reviews systems for ensuring staff have read, understood and follow medication policies and procedures.

The registered provider had a cleanliness and infection control policy, and cleaning schedules were followed in order to ensure the home was kept clean and hygienic. During our inspection we found that the decor and furnishings in the home were tired in places and required some cosmetic attention, however the home was clean throughout. One corridor of the home was uneven, which could be a potential trip hazard. When we discussed this with the business manager they advised us that they had already accepted a quotation for this corridor to be levelled and that work on this would be commencing in due course.

Good

Is the service effective?

Our findings

We asked people using the service if staff had the right skills and experience to do the job; people told us, "Staff are well skilled" and "Some of them have [the right skills]." Visitors told us, "They [staff] are excellent… They are doing a good job" and "The staff have the right skills, definitely. They do a really good job."

All staff completed an induction when they started in post. This involved an orientation to the home, including; policies and procedures, health and safety information, fire, first aid, personal protective equipment, food hygiene and use of equipment. Staff also completed on-line training in safeguarding vulnerable adults from abuse and the Deprivation of Liberty Safeguards (DoLS). Staff shadowed other workers on shift for at least one week, or up to two weeks depending on when the registered manager and the staff member felt confident they were ready to work on their own. Staff who were new to care completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to in their daily working life. It is the minimum standards that should be covered as part of induction training of new care workers.

Staff completed refresher training to ensure their knowledge and skills were kept up to date. The registered provider stored training records electronically, so they were easily able to identify staff that required refresher training. The training records showed that the majority of staff were up to date with their training. Staff told us, "The training is good. If there is a good trainer they will book them again. If I needed more training in a topic I would go to [registered manager] to ask for it, or would get more information about the subject." Another told us, "I get enough training; we do all the mandatory topics and additional ones about specific topics, like end of life care and team leader training."

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. Handover meetings were held each day to exchange key information between staff. This all showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

We talked to people using the service about the quality and variety of food provided and the responses were generally positive. People told us, "The food is very good," "I like all the food," "It's okay; staff try very hard," and "I like the food, it's good." Others told us the food was "Excellent; plenty of choice" and "Staff know what I like and don't like." One person however told us that the menu was repetitive.

Feedback from visitors about the food included, "My [relative] enjoys the food; they help him with it and feed him if necessary" and "[My relative gets] a good varied diet." One visitor however was not as confident that staff understood their relative's preferences or needs because they said staff didn't always remember to cut up their food.

We observed two mealtimes at the home. There was a relaxed atmosphere in the dining room. People were offered a choice of meal and drinks. People were also offered additional helpings of food and drinks.

When we spoke to the cook about people's special dietary requirements, they were knowledgeable about

people's dietary needs and preferences. They were also able to explain how they catered for individual needs. The cook told us that they got feedback from the resident's forum about food they would like to see on the menu.

Care files contained a section about people's nutritional needs, including information about the type of diet required, people's food preferences and any equipment needed. Nutritional intake was recorded for people assessed at high risk due to their nutritional needs or weight loss. There was no evidence to suggest that people received insufficient support to eat and drink, however we did note the monitoring records in relation to fluid and nutritional intake for those who were identified as being at nutritional risk lacked detail about the quantity of food eaten in some cases. In addition, the target fluid intake and total amount of fluid drunk each day was not always recorded and checked.

We recommend the provider seeks guidance and follows best practice in the monitoring of food and fluid intake.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 process for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the registered provider was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Care files contained mental capacity assessments, and where relevant, information regarding DoLS authorisations that were in place. Five people using the service at the time of our inspection were subject to a DoLS authorisation. One of these had a condition on their authorisation, which the staff were knowledgeable about. Of the mental capacity assessments we viewed, the majority were appropriately completed. We saw examples of clear and detailed records in relation to the attempts made to help people understand the decisions that they were being assessed for their capacity to make. However, we saw one capacity assessment that lacked clarity on the conclusion that had been reached in the assessment. The registered manager addressed this on the day of our inspection.

Staff had completed MCA training. They were also able to demonstrate a good understanding of the principles of the MCA, and the importance of gaining consent before providing care to someone. We saw evidence in care files that people had been involved in decisions about their care, where they had the capacity to do so, particularly in relation to their consent to receiving support with personal care and their medication. The majority of people using the service told us that staff asked for their consent and respected their wishes. This showed us that staff sought consent to provide care in line with legislation and guidance.

People were supported to maintain good health and access healthcare services. We saw evidence in care files that people had received support from other healthcare professionals where required, such as GPs, the community mental health team, podiatrists, speech and language therapists, the tissue viability nurse and the community dentist. There were also instructions in care files where people needed specific assistance to maintain good health, such as support with pressure care, diabetes and catheter care. We saw feedback from a visiting healthcare professional in a recently conducted survey which stated, "Visiting on a

professional capacity I have always found staff very helpful and well informed. A well run home that I am very happy to work in and be part of." The service had also received a commendation from a community matron on the results of a recent continence care audit.

Good

Is the service caring?

Our findings

We spoke with people using the service about whether staff were caring; the majority of the feedback we received was very positive. People told us, "Staff do care about me," "Staff go out of their way to be nice to me; some of them are marvellous" and "They [staff] seem to be caring." Others told us, "The staff are nice people" and "Staff do care about me [and] are kind." One person told us, "[Staff] are very kind, but I like some more than others. Some don't have as much patience."

All the visitors we spoke with told us that they felt that staff cared about their relative or friend. Visitors told us, "[The staff] are just genuinely nice" and "Staff do care about my [relative]. He likes them and they like him."

Feedback we saw from people who had used the service on a temporary basis was also positive. One comment seen stated, 'I would like to say this short stay of mine has been a real eye opener. I have been treat in the most first rate manner by management and staff and nothing is too much for them. Smiles are the order of the day and also good humoured banter. Nursing homes have had a bashing lately and for some, rightly so. This is an old place and needs some cosmetic care and would not fare well against modern clinical new builds but it would leave them standing in the things that matter, which is patient care and understanding.'

We observed staff supporting people throughout our inspection, and interactions were positive, friendly and respectful. During our discussions with staff, they demonstrated a caring approach towards people. They told us, "We're all quite close, like a family. You build relationships with residents and get close to people. We can have a laugh and this in turn makes residents happy." Another told us, "Staff are really caring; the residents are really important to us."

We observed staff offering choices and responding to requests from people. Staff were able to describe how they encouraged people to feel involved in their care and make day to day choices about things like what they would like to wear, how they wanted to be washed, what time they wanted to get up and what they wanted to eat. Staff demonstrated an understanding of people's needs and preferences but also described the importance of continually listening to people and recognising that preferences can change; one staff member gave us an example about a person they supported who had drunk tea for many years, but as their tastes had changed they had starting drinking coffee for the first time. They told us this was an example of why it was "So important to keep speaking to people and asking them."

Most people told us that staff listened to them and involved them in decisions. One person told us they didn't feel listened to, however others did not share this view and told us, "Yes [they listen to me]; if there's something I don't like they get me something else" and "They do [listen to me], and respect my choices to a certain extent." One person told us staff always respected their choices, and another said, "We do talk about what affects me."

Staff told us they promoted people's independence wherever possible. For example, one staff member told

us, "We prompt people to wash the parts [of their body] that they can do themselves, and select what they want to wear. We also use tea pots to encourage people with their re-ablement for instance, because people may be able to pour their own tea. And even if someone can't physically lift the tea pot they can still tell us to do it, so that they are in control." Most visitors told us that they thought staff promoted people's independence where possible, and some gave examples such as seeing staff encouraging people to walk using their frames. One visitor also commented, "Staff know all the residents and treat them as individuals."

Care plans recognised people's emotional needs and we saw that the registered provider had made referrals to relevant professionals, for additional support with people's mental health needs where this was appropriate. We also saw an example of very sensitively written instructions to staff about how to support someone they recognised was grieving.

Discussion with staff indicated that there were no people using the service that had any particular noted diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. The registered provider had an equality and diversity policy, which was reviewed annually. They also had a sexuality policy and a religion and beliefs policy, and a number of people using the service told us they were supported to go to church when they wanted to.

We discussed with people whether staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing. Comments from people were generally positive and included, "Yes they do [maintain your dignity], they never rush you" and "They respect my dignity." One person however told us that having to wait for staff to provide support to use the toilet sometimes did not maintain their dignity. Staff we spoke with described how they maintained people's privacy and dignity by covering people when washing them, asking if they would prefer a male or female carer and by covering over a female's knees if she had a shorter skirt on for example. Throughout our inspection we saw that staff always knocked on people's bedroom doors before entering, were discreet when exchanging information about people and were respectful when engaging with people using the service. Some of the accommodation at the home was double rooms, and where this was the case there were privacy curtains in place to enable people's dignity to be protected when receiving personal support.

Nobody using the service had an advocate at the time of our inspection, but information about advocacy services was available at the service. An advocate is someone who can support people to express their wishes and views, help them access information to make informed decisions and understand their rights. Staff told us that the majority of people using the service had relatives or friends who could support them to express their wishes if needed. All the visitors we spoke with told us they were able to visit at any time and were made to feel very welcome. One told us they were always given cake and refreshments when they visited and another said "They look after me too!" Another visitor told us, "The last home my [relative] was placed in was so different. I dreaded visiting, didn't know the names of any staff and my [relative] was so depressed. It is so different here. Staff are so welcoming; I know their names; I enjoy coming here. I enter with a spring in my step and my [relative] is so much happier."

Good

Is the service responsive?

Our findings

People using the service all had a care plan, and there was evidence that people had been involved in developing these, where they had the capacity to do so.

Prior to people using the service, the registered provider completed an assessment to ensure the service could meet their needs. This assessment, along with information from social service or families, where relevant, was used to develop the care plan. There were care plan sections in relation to a range of key areas, including; mobility, personal hygiene, nutrition, skin integrity, continence, communication, medication, sleep, social activities and end of life care. We found care plans contained comprehensive information about people's individual needs and preferences, and the support required from staff. We found one care file where the impact of a person's sensory impairment was not well referenced throughout all the other relevant sections of the care plan, such as in the mobility care plan. However, other than this, care plans were generally comprehensive and sections cross referenced each other well. This meant that staff had the information they needed to provide personalised care to people.

Care plans were reviewed monthly and updated where required. The monthly review page of the care file did not always say which sections of the care plan had been updated that month, and we discussed this with the registered manager, who agreed to make this clearer. This would make it easier for staff to see, at a glance, what had been updated in the file and ensure important changes were not missed.

When we spoke to staff they were knowledgeable about people's needs and preferences. Staff told us they got to know people by spending time talking to them and their families. One told us, "We do have the time and the information to get to know people." Staff also showed us how they used small wipe boards in people's rooms; these had key information about the person listed on one side, for staff's reference. The boards were reversible, with a picture on the other side, so that when they were hung up they were discreetly faced with the picture outwards.

Monitoring records in relation to specific issues, such as re-positioning and oral care, were also in place for people who were assessed as requiring them. We found these were generally well completed, but the registered manager agreed to make the required frequency of re-positioning clearer on one care plan and re-positioning record we viewed. These records enabled the registered provider to monitor that the care delivered was in accordance with the identified need in the person's care plan.

The home acknowledged in their Provider Information Return that they wanted to increase the variety of activities available to people, and had employed a member of care staff who had a specific responsibility for developing activities at the home. There was a weekly 'motivational' group, run by an external facilitator, in which people could take part in chair exercises, motivational games, mental stimulation activities, relaxation and music therapy. The home also organised one-off events and had good links within the community, including the local school and church. During our inspection we saw people having a 'movie afternoon' on one of the days, and a volunteer came to do craft work with people on the other day.

People told us they took part in activities. One person said, "We go to the monthly 'time out' at the church hall; it's a great afternoon out" and another told us, "I enjoy reading, I like the music days and I go on trips." Other comments included, "I go all over the place and I go to church" and "There seems to be plenty going on."

In a relative's questionnaire we viewed, one person commented, "I think residents need more mental and physical activity and stimulation." However, the majority of visitors we spoke with during our inspection told us that activities were available for their relatives to take part in, should they choose. Comments included, "There are activities and things to do," "[Name] attends whatever is on" and "[Name] enjoyed the music activities and is going on the day trip to Bridlington."

This showed us that people received personalised care that was responsive to their needs and there were a range of activities available to people.

There was a complaints procedure in place and a system to record and respond to complaints. The complaints procedure was available to people who used the service, and we saw from minutes of recent resident's forums that people were reminded and encouraged how to use this procedure if they ever needed to. Records showed that six complaints had been received in the year prior to our inspection; most of these were informal complaints that had been raised verbally. These issues had all been resolved promptly. We saw a recent example where a complaint had been received from a visiting professional in relation to one person's oral hygiene. We saw that the registered provider had promptly put measures in place to address this issue, including commencing new oral hygiene monitoring records, using different recommended equipment and re-training staff in oral care.

Four compliments cards were held in the complaints and compliments file, however we did also note there were a further 17 thank you or compliment cards on display in the entrance to the home.

Most people we spoke with told us they knew how to raise a complaint and would feel comfortable doing this, if they needed too. Comments included, "I know how to do it [raise a complaint], but never have" and "I don't think I would need to make a complaint, as they are such nice people." One person told us, "I would tell my friend and they would sort it out." Visitors told us, "They always ask your views whenever you come" and "I would feel comfortable raising a concern if I needed to."

As well as the resident's forums, people also had opportunity to share their views about their care and issues at the home in resident's surveys, and the registered provider was acting on this information. This showed us that people's views and opinions were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager who had been in post for over five years. The registered manager understood their role and responsibilities, and was supported by a deputy manager. The registered provider's business manager was also based at the home; they worked closely with the registered manager, and was responsible for the financial and strategic aspects of running the service and ensuring policies and procedures were in line with current legislation.

When we spoke with people about the management of the service the feedback was positive. People told us, "[Registered manager] is very nice" and "I talk to the manager sometimes and ask their advice" and "[The registered manager] is very pleasant." One person though, told us that they did not know who the manager was.

Comments from staff included, "The service is well managed and well led" and "I feel supported. There are always nurses you can go to, or [registered manager] or [business manager]." Another staff member told us, "[registered manager] or [business manager] are very kind."

Visitors we spoke with described the management and leadership of the service as "Outstanding," "Excellent" and "Pretty good." One visitor told us, "The home is well organised and run."

The registered manager told us they kept up to date with best practice and legislation by subscribing to the Nursing Times and National Institute for Health and Care Excellence (NICE) guidance, attending events and conferences and by being an active member of local clinical commissioning group care home forum and community matron meetings. The registered provider had also worked with the local clinical commissioning group (CCG) to pilot some new initiatives, such as a tool designed to assist in reducing unnecessary hospital admissions and improve quality. They had been invited by the CCG to present this work to other care homes in the north west of the country as an example of best practice in involving care homes in quality improvement. The registered provider had also trialled new specialist bedding aimed at reducing pressure sores. They told us this had been successful and they had therefore implemented this on a permanent basis. Examples like this showed that the registered provider was proactive in working with partners and implementing new initiatives.

The registered provider conducted staff meetings, and we saw from minutes of these meetings that topics discussed included care documentation, equipment, reminders about conduct and respecting dignity, as well as issues in relation to people using the service. We also saw that practice concerns raised by staff were addressed.

The registered provider conducted annual satisfaction surveys, to seek feedback from people using the service, visitors and stakeholders. At the time of our inspection, this year's survey responses had just been collated in order to analyse the responses. Initial feedback received was generally very positive.

The service had systems in place to audit the quality of the care they provided to people. As well as the

satisfaction surveys conducted, the registered provider completed monthly audits in a number of areas, including care plans, pressure care, wound care, medication, catheterisation, dignity, accidents and incidents, call bell response times, supervision and appraisals, nurse's registration checks, staff spot checks and complaints. The registered provider completed audit corrective action forms, which listed any action identified to be required, and the timescales for completion. We saw that in some instances, such as a care plan audit, these forms had not been signed off to confirm that the action had been completed. The registered manager agreed to ensure these were consistently completed.

We found that systems were in place to monitor and review the delivery of care and the quality of service that people received.

The registered provider had policies and procedures in place and these were regularly reviewed. As a relatively small independent provider, the home used the services of an independent company to assist them with ensuring policies were in line with up to date legislation and guidance. We asked for a variety of records and documents during our inspection. Overall we found these were easily accessible and stored securely.