Foxleigh Grove Nursing Home

Foxleigh Grove Nursing Home

Inspection report

Forest Green Road
Holyport
Maidenhead
Berkshire
SL6 3LQ

Tel: 01628673332
Website: www.foxleighgrove.co.uk

Date of inspection visit:
10 July 2017

Date of publication:
27 July 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

Our inspection took place on 10 July 2017 and was unannounced.

Foxleigh Grove Nursing Home provides accommodation and nursing care to older adults and people with physical disabilities. The service is in a large, period-style building with expansive landscaped grounds. The service provides ongoing care as well as respite stays. The service is located in a secluded part of Holyport, a village near Maidenhead in Berkshire. The service is registered to accommodate a maximum of 39 people. On the day of our inspection there were 35 people used the service.

The service must have a registered manager.

At the time of the inspection, there was a registered manager. 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.

At our last inspection on 8 June and 10 June 2016, we asked the provider to take action to make improvements regarding people's medicines management, infection prevention and control, compliance with the Mental Capacity Act 2005, and people's nutrition. The provider sent us an action plan and we found the actions were completed.

People were protected from abuse and neglect. We found staff were knowledgeable about risks to people and how to avoid potential harm. Risks about people and the building were assessed, recorded and mitigated. Sufficient staff were deployed and the registered manager had an appropriate system in place for review of staffing numbers. Medicines management was safer, and the service had worked with both the clinical commissioning group (CCG) medicines team as well as the community pharmacist to improve their practices.

Staff training and support had improved. There was a better focus on improving staff knowledge, experience and skills to provide good care for people. The service had improved compliance with the Mental Capacity Act 2005 and associated practices. People's nutrition management had also improved. Appropriate access to community healthcare professionals was available. We saw some refurbishment was completed to modernise the building. We made a recommendation about the continued internal refurbishment of the premises.

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 supported this practice.

People and others told us staff were kind and caring. People and relatives were able to participate in care planning and reviews, but some decisions were made by staff in people's best interests. An improved focus

on people's care participation was required, and we made a recommendation about this. People's right to privacy and dignity was respected.

Care plans were detailed, personalised and reviewed regularly. Some information held in computer-based systems did not match the care the person experienced. The service was receptive of our feedback about this. There was a satisfactory complaints system in place which included the ability for people and others to escalate complaints to external organisations.

There was an increased focus on the safety and quality of people's care. This was led by the head of care and registered manager. Checks and audits were in place to measure the safety and quality of care. Staff demonstrated a positive workplace spirit and enjoyed their roles.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were safely managed.

People felt that they lived in a safe environment and received safe care.

People were protected from abuse and neglect.

People's personal risks were assessed and managed to ensure safe care.

People were cared for by sufficient staff.

Is the service effective?

Good

The service was effective.

Staff training, supervisions and performance appraisals had improved.

The service complied with the requirements of the Mental Capacity Act 2005.

People were supported to maintain a healthy, balanced diet.

People were supported to have a healthy life.

Is the service caring?

Good

The service was caring.

The service needed to improve people's participation in care planning.

People received kind care.

People's dignity and privacy was respected.

People's confidential personal information was protected.

Is the service responsive?

Good

The service was responsive.

People's care was person-centred.

There was a complaints system in place, but improvements could be made.

People's and relatives' opinions were sought about the quality of care.

Is the service well-led?

Good

The service was well-led.

People's safe, effective care was the priority of the service.

Appropriate audits and checks were used to measure people's care quality.

There was a good team culture amongst staff that provided care.

The service was focused on improvement where possible.

Foxleigh Grove 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.

Our inspection took place on 10 July 2017 and was unannounced.

Our inspection was completed by one adult social care inspector, a pharmacist 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. Our Expert by Experience was familiar with the care of older adults who live in care homes.

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

We reviewed information we already held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities, the clinical commissioning group (CCG) and the fire inspectorate. We checked records held by the Information Commissioner's Office (ICO) and the Food Standards Agency (FSA).

During the inspection we spoke with the registered manager and head of care. We also spoke with two registered nurses, six care workers, a cleaner, and two activities coordinators.

We spoke with seven people who used the service and four relatives or friends. We looked at all medicines

administration records and five sets of records related to people's individual care needs. This included care plans, risk assessments and daily monitoring notes. We also looked at four staff personnel files and records associated with the management of the service, including quality audits. We asked the provider to send further documents after the inspection and these were included as part of the evidence we collected.

We looked throughout the service and observed care practices and people's interactions with staff during the inspection.

Good

Is the service safe?

Our findings

At our last inspection on 8 June and 10 June 2016, we rated this key question as 'requires improvement'. This was because we found unsafe medicines management. We served a requirement notices against the provider for a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service was required to send an action plan and we received this. We have checked this regulation at our inspection and found that the service took steps to improve and sustain the safe management of people's medicines. We consider the service is compliant with the previous breach of the regulation. Our rating for this key question has therefore changed to 'good'.

At our inspection, people and relatives told us about medicines administration at the service. One relative said, "They've tightened up on the tablets for mum, but mum realises it, and they've been very considerate how they helped mum with the transition." A person who used the service stated, "The medication comes three times a day. It's done regularly. The staff are very good like that. My daughter has roughly explained to me about the tablets. It's mainly for Parkinson's [disease]." Another relative said, "The nurses and carers are quite patient with her [the person who used the service]...helping her take her medicines, it can take a while. I see them being patient. At times I suggest we look at her medication to make sure it's not too much and she's not over medicated, and they do listen." These were positive comments about the management of medicines at the service.

Following our prior inspection, we noted that issues we highlighted were outlined and remedied by the head of care accordingly and all relevant staff were asked to read the changes of process, sign and date them. Temperature control issues where medicines were stored were rectified. We saw resettable thermometers and a new tablet crusher were bought. This was a good indicator that the service was serious in ensuring people safety.

We looked at staff training and competency assessments for medicines. We saw most staff had up-to-date training, but a few staff competency assessments were overdue. Since our last inspection, we noted relevant staff had received training in the correct use of fluid thickeners (powder added to fluids to change the texture). We observed at breakfast and lunch that staff followed the correct process and made the drinks to the required consistency.

We commenced our inspection at 7.50am so that we could observe the morning medicines round, as well as those throughout the day. During our observation of the medicines round, we noted the registered nurse did not wear the red apron provided by the service. The idea of the apron was to act as a visual alert to people and others that the registered nurse should not be disturbed, to avoid errors. When we asked, the registered nurse explained that by wearing the apron, people were more aware of her presence and would ask her questions and disturb her concentration needed during drug rounds. We found this was a reasonable explanation for not using the red apron. We saw one person had a swallowing difficulty. Their tablets were properly crushed with a specific tablets crusher, then mixed with a small amount of porridge and swallowed. Another person refused to take their medicines. We saw the registered nurse was patient and encouraged the person to take the medicines. Staff followed the correct process of recording any refusal of medicines.

We looked at the use of 'homely remedies' (over-the-counter medicines). We found the correct process for administration of medicines occurred and the registered nurse washed their hands between different people. We saw there was a policy for paracetamol, senna and lactulose. The homely remedy supply chart was simplified as suggested by the pharmacist subsequent to our prior inspection.

We found the correct management of topical medicines (those applied to the skin). We saw the registered nurse entered information on each person's topical MAR chart at the staff station. We saw all topical medicines together with topical charts were stored in the ground floor staff station as the upstairs stations were too warm for storage. This showed the service followed good practice guidance for medicines storage.

We examined stock ordering from the community pharmacy and stock management on site. We found the stock was correctly ordered with a cyclical pattern, and once medicines were delivered they were counted and entered onto the medicines administration records (MARs). No medicines were missing during observation. The management of medicines stock had improved so that people could be assured their medicines were always available for use. The room where medicines were stored was also changed. Storage had increased and the room had been decluttered to allow free access to bench space. Key cabinets and other items not needed in the room were relocated to prevent disturbance in the room. The room door was locked when staff were not present.

We looked at care planning and records kept on computers for people's medicines management. These were accurate and up-to-date but access to mobile technology was not available. This meant nursing staff were required to go to one of two computers to enter information or amend records. We explained to the head of care and registered manager that in order to ensure contemporaneous record keeping, they should consider a laptop computer (or similar) that could be used anywhere within the service. They were receptive of our feedback.

We checked everyone's MAR. We noted no one received covert administration of their medicines (when medicine is disguised in food or drink) or self-administered their medicines but a policy and process was available if necessary. We found that some record sheets were at risk of being misplaced because they were not securely stored in the folder they were placed in. The head of care committed to contact the pharmacy to find a way of preventing this. We saw all MARs had people's photos alongside them, although we were told that pictures of some people needed to be updated. We did not find any gaps of signatures in the MARs. We saw two staff's initials were used on the documentation, as we recommended at our last inspection.

We checked the storage and management of controlled drugs (those subject to more stringent controls, like morphine). We found the stock balances were correct and the proper counting and checking of the medicines. We found one incident with a controlled drug analgesia patch and pointed this out to the head of care. We explained this could be used as a valuable tool for teaching staff about the absorption of the medicine and they agreed with our finding. Checks and audits of other medicines occurred more often. We saw medicines audits of standard packs and blister packs (those pre-dispended by the pharmacy) and staff had implemented counting of the remaining balances. We saw a pharmacy audit was carried out 6 March 2017 and 4 January 2017. Some issues identified were similar to our last inspection findings. The head of care explained and showed what remedial actions were being taken to address the area of risk.

We found an appropriate medicines policy in place, there was access to best practice guidance, registered nurses could access the British National Formulary (BNF) latest edition, and that the head of care had worked with two pharmacists and the GP surgery to improve the safe management of medicines. Contracts were in place for the collection of medicines waste and records were appropriately kept. We found staff followed the correct procedure to dispose of controlled drugs, but one medicine was not disposed of in a

timely manner.

The service used a computer-based program for recording risk assessments. People's personal care risks were assessed by nursing staff. Prior to anyone moving into the service, a staff member undertook an assessment in the community or a hospital setting to ensure that Foxleigh Grove Nursing Home could meet the needs of the person. We looked at one example and were satisfied that as appropriate pre-admission assessment was conducted before the person moved in. This included relevant demographic information, medical and surgical history, functional assessments and the type of care the person needed.

We looked at risks to people's safety that were linked to the building itself. These included fire, Legionella, gas safety, window restrictors and the management of lifting equipment like the passenger lift and hoists with slings. The service managed the risks to people appropriately. Risk assessments were in place in line with health and safety legislation. Where risks were identified, these were noted and acted upon by the provider. The provider had obtained a Legionella risk assessment from a specialist contractor, as we had recommended at our prior inspection. At the time of our inspection, the service had only recently received the report and was working their way through the requirements and remedial actions. Fire safety was satisfactorily managed, and the local fire inspectorate confirmed that the service was compliant with relevant standards at the last inspection. We asked the registered manager and head of care to review the signage and position of the fire assembly point and the frequency of night time staff fire drills. This was to ensure increased safety for people in the event of a fire.

We found the service had safe staffing deployment. Staffing was based on the needs of people who used the service. A variety of aspects of people's care were measured to determine staffing hours. We saw this included ability to mobilise, wash and dress, go to the bathroom and ability to eat and drink. People's capabilities were assessed and monitored monthly and more frequently if required. The registered manager showed us how this was used as the basis for the staffing ratios. Some consideration of the building layout was used in determining whether to increase the care worker and registered nurse rostered hours.

An electronic call bell system was used with information recorded via computer. Regular review of the call bell data was undertaken by the registered manager. We asked to see some recent information for people who used their call bell, and how long it took staff to response. We looked at the period 9 June to 13 June 2017 and saw there were 708 calls for staff assistance during this period. The average length of time for staff to respond was 3.3 minutes. At various times of the day, for example early morning, people sometimes had to wait longer. We saw one instance where the service identified a person's wait was not acceptable. The registered manager and head of care put actions in place to prevent recurrence of anyone waiting too long for help.

People and relatives gave us positive feedback about staffing levels. One person we asked said, "The staff are fairly the same; same faces. Very rarely is it agency staff. I have a bell in my room. I've only used it twice. There's not long to wait if you ask for something. I think there are enough staff here." The next person stated, "There are a lot of local staff who have been here for years. I have a buzzer. I've not used it in an emergency, just if I want something and they come in about five minutes. I feel there are enough staff here." Another person who we spoke with told us, "I have a buzzer and use it to ask for help if I want something. Sometimes I wait a few minutes sometimes [longer]." The first relative we spoke with said, "There always staff on and they always spend time discussing things." The next relative told us, "I think there is just enough staff." Other comments from relatives included, "More staff is always good. There is less staff at the weekends and no activities then. There's very little staff turnover. Some have been here a very long time and sometimes there is more than one member of a family working here" and "You press the buzzer and you know they can't come immediately but they come as quickly as they can...they all seem to get on well together and they do

the best they can with the time they have." The comments were a good indicator of the staffing deployment.

We observed the shift handover between night workers and morning staff. We observed a good system was used to delegate tasks out to the staff team. This included ensuring an equal workload, staff volunteering to perform certain tasks during the shift and staff doing different tasks on each shift. This ensured that people's care was not neglected and the service also kept a clear audit trail of staff responsibilities during the shift.

We looked at four staff recruitment files. There was a safe system in place for recruitment of any new workers. All of the necessary checks required by the regulation and schedule were completed. These included checks of staff identification and right to work in the UK, criminal history checks via the Disclosure and Barring Service (DBS) and checks of conduct in similar prior roles. We noted that the interview notes kept in file were not specific enough to demonstrate that fit and proper persons were selected when recruiting staff. The registered manager was receptive of our feedback and agreed that having a scribe during interviews would improve the documentation of the questions and answers used.

The internal aspects of the premise were clean and odour-free. Redecoration had occurred in a large portion of communal areas since our last inspection. We noted cleaners attended to the routine tasks of ensuring hygienic surroundings for people, relatives and staff. The head of care confirmed that an infection control lead staff member was not in place, and reassured us this was being organised. The head of care had sourced appropriate training for the selected staff member to attend and had the intention of the worker taking over the infection control audits and monitoring.

We noted some areas of the building required further improvement to ensure that effective infection prevention and control can continue to occur. These areas included communal bathrooms and showers, some hallways with carpets and 'sluice' rooms (where body fluids are managed by staff). The areas contained some surfaces which demonstrated increasing difficulty to maintain appropriate cleanliness. We pointed this out to the head of care and registered manager. The head of care explained one bathroom was scheduled to be changed to a wheelchair-accessible shower room, although work had not commenced.

We recommend that the service assesses and manages the internal aspects of the building which require refurbishment based on infection prevention and control risks.

Good

Is the service effective?

Our findings

At our last inspection on 8 June and 10 June 2016, we rated this key question as 'requires improvement'. This was because we found non-compliance with the provisions of the Mental Capacity Act 2005, insufficient staff training and supervision, and issues with people's nutrition and hydration. We have checked these areas at our inspection and found that the service took steps to improve. We consider the service is still compliant with the relevant regulations. Our rating for this key question has therefore changed to 'good'.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at five people's care documentation for evidence about consent, capacity, best-interest decisions and DoLS. People's consent was appropriately obtained and recorded. The service had made and sustained improvements to ensure that where the person themselves was unable to consent, that a suitably authorised person consented in lieu. The service's care documentation system contained information about attorneys and deputies which was current and accurate. When people could not consent and there was no representative to consent for them, staff made best-interest decisions regarding care or treatment. The best interest decisions were recorded in the computer care system with satisfactory details.

People were lawfully deprived of their liberty in a small number of cases. This was in their best interests and mainly because of 'continuous supervision and control. Where the person lacked the capacity to decide for themselves, an application for DoLS was made. The registered manager had better records at our inspection of which people had applications, which people had active authorisations and where people's DoLS were expired and awaiting renewal. We spoke with the head of care who was familiar with any conditions placed on people's DoLS authorisations. Although the number of DoLS conditions was recorded in the computer system, the conditions themselves were not documented. This meant staff who read people's electronic care documentation would not know the conditions without finding the paper authorisation.

We recommend that the service ensures all staff have appropriate access to the conditions on people's DoLS authorisations.

People and relatives felt staff had the knowledge, skills and experience required to perform their roles well. Comments included, "I think they're well trained, yes. They generally keep an eye on me", "The staff seem to

know what they are doing" and "The staff here are very good."

Support to improve staff knowledge, skills and experience had increased. On the day of our inspection, a student was undertaking a work experience placement. We saw they were appropriately supervised and actively engaged with their staff mentor. We also noted that a new staff member was undertaking their practical induction. They too were appropriately supported by an experienced staff member and provided care to people only with the staff buddy present.

New staff members were selected based on their prior knowledge and experience. We found the registered manager aimed to select new staff members with existing NVQs or health and social care diplomas. At the time of our inspection 25 staff had existing qualifications. Out of new care workers, four had commenced or completed Skills for Care's 'care certificate'. We saw new staff commenced as supernumerary until they were assessed by the registered manager and head of care as competent to work within the normal staffing establishment.

We looked at the staff training records. This showed that staff completed the necessary training to work effectively in a care home setting. Topics included protecting vulnerable adults at risk of harm, safe moving and handling of people, fire safety, infection control and nutrition. We noted there continued to be areas for improvement in staff training, as not all staff were up-to-date with all the mandatory topics. The registered manager and head of care acknowledged this. Staff received supervision sessions and performance appraisals to reflect on their practice and set goals for their development. The provider was supportive of staff

At our last inspection, we found that the assessment of people's malnutrition risks was sometimes inaccurate. This was due to the incorrect calculation of the risk scores in the computer-based care documentation system and staff knowledge deficit. We found these risks to people's effective care were resolved. The head of care was very knowledgeable about how to correctly estimate people's weights using the 'mid-upper arm circumference' method. When we checked with them in the computer care records, we saw this was documented and correctly calculated. In addition, nursing staff were provided with refresher training in the use of the malnutrition universal assessment tool (MUST). This led to increased accuracy in calculating people's risk of malnutrition.

Where people were at risk of losing weight or actually losing their body mass, appropriate steps were taken to prevent further loss. This included fortification of food and drink (adding high calorie supplements), referrals to dieticians and speech and language therapists, prescription of meal supplements by the GP and staff encouragement to eat more snacks. We found people's risks were appropriately mitigated and staff had better surveillance in place to avoid and prevent weight loss.

We saw appetising presentation of meals with a variety of choices available for people. The provision of meals was a consistently positive area of feedback from people we spoke with at our inspection. People had the right to choose from different meals and if they did not like what was offered, they could request something else. Staff appropriately assisted people who needed help when eating. We observed three staff members assist people with their meal at lunch. We saw staff sat down beside people, attended to them individually, helped at a reasonable pace and encouraged people to eat enough. We saw staff were patient and people were encouraged to attend the dining room. Staff respected people's right to stay within their room for their meals.

People and relative had positive opinions about the food. One person said, "The food is good. We have a menu for the week in our room. It changes summer and winter and is a five week cycle so there is plenty of

variety. Tea today is egg and chips but I prefer a salad so that's what I'll have. I don't like pasta at all, and they know that, and the chef will prepare something different for me." Another person commented, "We often say what good quality food we get. Good meat and 'veg' and well-cooked. They're very obliging. I'm vegetarian but will eat chicken and fish. Yesterday was lamb, they know I don't like that and they offered me chicken. The cakes at 3.30pm every day – beautiful cakes! Supper is a meal or something like a large salad, very nicely served." Relatives' comments included, "Food is good, fresh food. It's nice and attractively served", "The food is good, I've eaten here with my friend. My friend is an ex-chef and ran a restaurant and the chef here is very accommodating and they chat together about ideas" and "They're good at trying to please mum with the food."

We found people continued to have access to a wide variety of healthcare professionals. This included those that attended the service in person and when the person was transported to appointments or consultations within the nearby community. The service had their own minibus which meant that people could be taken to their appointments without the use of other transport, like ambulances. There were satisfactory records of all interactions with community healthcare professionals in people's care documentation. The GP visited regularly and the service had a well-established rapport with the local surgery. People's health was promoted and maintained by the service.

Good

Is the service caring?

Our findings

People who lived at Foxleigh Grove Nursing Home continued to receive kind and compassionate care from the service's staff. People and relatives told us this during our inspection. One person stated, "Staff are very nice and friendly. I'm happy here, I am, honestly. Everyone is lovely and it's a nice place." The next person told us, "It's tolerable here. Most of the staff are very good. Very thoughtful." Another person who used the service commented, "It's been wonderful here, great! The staff are delightful and so willing to help. It's perfect here. Very, very nice." Other comments we received from people included, "Staff are all very good and they're very kind. I'm very happy here" and "The staff here are very good. The staff stop by and have a chat with me here." Relatives told us, "I think they do exactly the right job. I feel happy mum is in the best possible hands. They are kind and support her" and "They'll come along and give her a cuddle and a kiss. They're very affectionate."

We noted staff that provided direct care to people such as care workers and registered nurses were friendly, patient and respectful. They addressed people by their preferred names. We observed they knew people's likes and dislikes and tried to provide support in line with people's usual routines. When people asked for help, staff were obliging and willing to help. Each person had a 'key worker' (a named care worker responsible for ensuring their care was appropriate and recorded). People however did not have 'named nurses', although this was not a mandatory requirement. People's 'key worker' was signposted on their bedroom door and this meant people, relatives and other staff knew each person's assigned worker. This was a good method of ensuring each person had an ongoing established connection with at least one staff member. People could communicate with any staff member however and the information would be passed on to the 'key worker' responsible.

As most staff had worked at the service for lengthy periods of time, they had developed a good knowledge of people, their medical history, their social history and the way they liked to be cared for. When we spoke with staff, they were knowledgeable about people and what support they required. Staff were not reliant on care documentation to understand the needs of people. However, when needs changed, care records were updated to reflect the person's preferences.

The inclusion of people in their care planning and review was difficult to evidence. As the service used primarily computer-based records, and the desktop computers were in staff only areas, it was not possible to determine that people were included in making decisions about their care. When we spoke with the registered manager and head of care about this, they had already self-identified this as a priority for change in practice. The registered manager explained they planned to obtain a laptop computer that could be taken anywhere within the building. This would enable staff to sit with people who used the service, and relatives, when care was planned or reviewed. In addition, during multidisciplinary meetings such as those with social workers or during GP rounds, the laptop computer could be used by staff to record reviews, changes to care or decision-making.

We found the computer-based documentation system populated a large portion of care plans automatically. When we reviewed people's records, we saw these were sometimes repetitive. The head of

care explained that care workers and registered nurses could add additional notes to demonstrate that people were involved in decision-making about care. There were limited examples where this had occurred. However, daily records of care provided were unique and accurately explained any decisions people had made or participated in on each shift. We will check at the next inspection whether there is an increase in people's participation in care, support and treatment decisions. This can only occur after a mobile device is successfully in place to electronically capture decision-making with people during their care reviews.

People's confidential personal records were protected. Computers used for recording care were password-protected and the system closed if staff were not actively using it. Limited paper records of care were maintained, but where these existed they were locked away so that there was restricted access to staff. Staff records or documents pertaining to the management of the service were also locked away.

Peoples' privacy was respected. When personal care occurred it was carried out with the person in their bedroom and never in communal spaces. We saw bedroom doors were closed when care was provided to people. We also saw staff always knocked on people's doors and asked permission to enter or announced their presence. People's dignity was also continuously respected by all staff. We observed staff called people by their preferred names. When people were seated in communal areas, we saw they were appropriately dressed and tidy. When people became soiled, for example during lunch when the person ate and dropped food, staff promptly assisted the person to clean up.

Good

Is the service responsive?

Our findings

One relative we spoke to wanted to tell us their loved one's personal experience of the responsive care. They showed us the content of a photo album of their loved one. We saw it contained pictures of when the person had arrived at Foxleigh Grove Nursing Home with an expectation of palliative care. The relative showed us pictures of the person which tracked their progress over the following months where they appeared healthier and happier. We spoke with the person who used the service who we found was lively and active within the service. The relative told us, "That's what they have done for her (the improvement in health). It's all down to these great folk." This showed the person had a recovery of health and quality of life since they moved into the service.

We found people who used the service preferred not to give their feedback in a formal manner. However, we saw the service had received many compliments about the standard of care. This was via letters or cards from loved ones. The service also offered a relatives and friends questionnaire, and we looked at the last one completed in June and July 2017. We noted some people's comments were included when the survey was completed by their relative. The survey asked relatives and friends to answer questions about the staff, the provision of activities, and give an overall rating of the service. Scores were recorded about the topics using the same rating we use in our reports; from 'inadequate' to 'outstanding'. We looked at 15 responses provided. In all of the responses, everyone had rated the service as 'good' or 'outstanding'.

Positive comments we saw in the questionnaire results included, "Peaceful and welcoming – a place of safety", "As a long-distance relative I have always felt that the home could be relied upon to look after my [loved one]", "Good choice of food and flexible to individual needs", "A big 'family' atmosphere; staff always welcoming [and] can't do enough to help" and "Whenever I have had any issues, I have been listened to and there has been an immediate response and effort to find a solution."

People and relatives also provided suggestions for improvements. Examples of feedback from the survey included, "[My loved one] enjoys the food although would like more fresh fruit", Redecoration and replacement of carpets is due in bedrooms" and "Encourage [head of care] to speak with each resident every week to pick up on things." As the survey results were only recently received, the service did not have a plan in action at the time of our inspection to address the constructive criticism received.

'Residents' meetings were occasionally held. We saw the last one was convened on 21 June 2017. Topics discussed included the use of agency staff, refurbishment of the premises, a trip to the Ascot races, other activities and the dining room experience. People's feedback about the dining ambience was noted by the registered manager and steps were put in place to ensure this improved.

We reviewed the management of complaints and concerns. We found there was a process in place for adequately dealing with any complaints. These were addressed by the registered manager, and any other staff that were necessary. Only one complaint was received by the service in the year prior to our inspection, and we found no evidence of complaints to community stakeholders or to us. We examined how the one complaint was managed. We found this could have been better handled. A statement was taken from the

complainant and the other party involved. The registered manager made a decision on the balance of probabilities and a specific decision was made to rectify the situation. The complainant was satisfied by the service's response. However, formal documentation including letters of acknowledgement and outcome, and a robust investigation report were not used. We pointed this out to the registered manager who acknowledged this.

Further signage and documentation was required to point out the complaints process. For example, there was no poster in reception or communal areas about how to make a complaint or who to complain to. Again the registered manager was receptive of our finding and stated they would address this after our inspection.

We recommend that the service further focuses on gaining feedback from people, relatives, friends and community stakeholders and has a clearly displayed process for making complaints within the service.

People told us the service was very responsive to their needs. Comments included, "I have breakfast in my room – tea and toast. There's nothing wrong with the care, they do treat you like a person", "I'm as independent as I want to be. I prefer to be in my room. I'm a huge book reader. I go to the lounge sometimes, I prefer my own company and I write letters and read. I have lunch and dinner downstairs, there's a table with a few friends and we sit together" and "They took me up for a bath last week in a wheel chair, with my [medical equipment] and just let me get on with it. It was wonderful." Relatives' sentiments echoed those of the people who lived at Foxleigh Grove Nursing Home. Their feedback included, "They (staff) very much respect mum's wishes. Mum had a diagnosis of [a medical condition] and the matron has helped mum understand all the information and [has] been very supportive. Mum fell over a few weeks ago and they were straight on to it and phoned us immediately" and "They created a lovely little balcony outside mum's room, just for her."

People's care was personalised. We observed care provided to people was specific to their needs. Care documentation also reflected the personal care requirements for each person who lived at Foxleigh Grove Nursing Home. There were appropriate care plans for all activities of living. For example, we saw these included washing and grooming, eating and drinking, social life and activities and mobilising. The service's computer care system required staff to input a lot of information relevant to each person. The system then formulated parts of the care plans automatically, but we noted that staff had inserted additional relevant information about the person. Care plans were updated monthly or more often if changes occurred. We did note in a document outside the care plan that two people were subject to frequent falls. When we checked the care plan on the computer, the falls risk assessment showed high risks, however the information about the frequency of the falls was not accurate. For both people the computer care plan stated one fall had occurred but there were multiple. This was demonstrated to the head of care who stated they would review both of the care plans to ensure the information was correct.

People had the opportunity for an active social life. Two activities coordinators were employed and there was a clear programme for each day. People could choose to participate in group events or the activities coordinators could provide personal choices in people's bedrooms. There were regular events and trips into the local community. People we spoke with were satisfied with the activities on offer.

Good

Is the service well-led?

Our findings

The service continued to be well-led. We asked people their opinions about the management of the service. One person said, "The manager is very good. If there was anything not right, he would get straight to it." The next person we asked told us, "The management is perfectly adequate." Other statements from people were, "The management are fine" and "The manager is very good. If my daughter mentioned anything it's done immediately." Relatives also gave positive comments. They included, "Yes, the management are fine", "The manager is very approachable and is very nice. If there were any issues he'd always sort things out. He's on the ball. The matron has made a big impact here", "The manager seems to have a good grip of things. He doesn't just sit behind his desk. The matron seems to be in charge of everything."

Staff we spoke with were satisfied with their roles. There had been a change in the head of care since our last inspection, and the person was very enthusiastic in their role. We noted a jovial, team-based approach to care during our inspection. Staff were happy and we observed they liked to provide care and support to people who used the service. None of the staff we spoke with expressed any areas of concern. We observed good communication between staff at shift changeover and throughout our inspection.

Staff used a solution-based approach to deal with any issues arising from people's conditions. For example one person had a reported abnormal behavioural disturbance during a shift. Staff opted to care for the person in the lounge room during the night, to ensure they could supervise them at all times and ensure their safety. The head of care asked that tests be performed to rule out any infections and that staff liaise with the GP about the person's care. Another person who had increased difficulty with their breathing was flagged by the management team for review by the GP as a priority. In another example, staff spoke about a person's call bell pendant being misplaced, and the head of care organised a specific staff member to search for the item. On the day of our inspection, one person had an outpatient's appointment at the hospital, and this was highlighted at the beginning of the shift to ensure the person's needs were attended to. Effective communication between the staff team meant people received appropriate care.

We saw that each shift used a 'reflective discussion' tool to record issues arising from people's care. Shift leaders consulted with all staff who worked to record 'what went well', 'what could be improved' and 'actions in place to address specific concerns'. The tool was used in addition to standard care documentation about people and was designed to review the continuum of care in an ongoing fashion. We looked at some of the completed records. We saw there were positive features of the tool which assisted in the provision of good care. For example, in one instance a person wanted to have their medicines half an hour before their breakfast, which was not the routine method of administration for the service. The 'reflective discussion' tool documented this and the solution, so the person's request could be accommodated. As the document had recorded the issue and the solution, all staff were able to review the request and gain the knowledge of the person's individual change in care. The tool also increased the volume of staff reflection on care provided throughout the shift and at the end of each shift. The risk that important person-centred information would be missed or forgotten was reduced, as the tool was always used.

Appropriate audits were completed and documented. We saw these were regularly maintained. Examples of audits included infection control, premises and equipment, health and safety and care overview. Where improvements or changes were required, the head of care and registered manager took action to ensure this occurred. The actions were sometimes delegated to other staff members but the management team always ensured they followed up on the outcomes.

People and relatives felt that Foxleigh Grove Nursing Home offered high quality care. We asked them if they recommended the service. People said, "I'd recommend it - oh yes", "I can recommend the place", "I'd definitely recommend it", "I'd have no hesitation recommending this place to anybody", "They're good staff and it's good value here", "I can go on holiday tomorrow knowing mum is going to be well-looked after and I don't have to worry about anything" and "We're booking our place!"

Our prior inspection rating poster was conspicuously displayed within the service and on the provider's website, in accordance with the regulation.