Nynehead Care Limited

Nynehead Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place on 31 October 2018.

We last inspected Nynehead Court in December 2017, during that inspection we found people's legal rights were not always understood and upheld because the service did not work in accordance with the Mental Capacity Act 2005. We also found medicines were not always managed safely and the governance systems were not fully effective.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions safe, effective and well led to at least good. During this inspection we found that improvements had been made in some areas, however we found some concerns which resulted in continued breaches in two of the regulations.

Nynehead Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service also provides care to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care service.

Nynehead Court accommodates up to 44 people (in 38 bedrooms currently all used for single occupancy) in a three-storey historic building with a purpose-built wing for people who are living with dementia. At the time of the inspection there were 32 people using the service. There were two people in receipt of personal care who were living in the extra care housing.

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.

Whilst we found some areas of medicines management had improved, there were still areas that required improvement. Risks to people were not always being identified and management plans put in place to mitigate any risks.

Care plans lacked some specific details to guide staff on how to meet people's needs and they were not consistently person centred. Staff however knew people well and were able to describe how they supported people.

Some improvements were required to the processes in place where people lacked the capacity to make decisions for themselves. The systems in place to monitor the quality and safety of the service still required some improvement.

Staff knew how to recognise and report abuse and felt confident concerns would be acted upon. Staff told us they felt supported in their roles. There were enough staff on duty to meet people's needs.

The provider had procedures in place to ensure that suitable staff were recruited. Staff received on-going training to ensure they were competent to carry out their roles

There were systems in place to protect people from the risk of infection. There were a range of checks in place to ensure the environment and equipment in the home was safe.

The provider had met their responsibilities with regard to the Deprivation of Liberty Safeguards (DoLS). DoLS is a framework to approve the deprivation of liberty for a person when they lack the mental capacity to consent to treatment or care and need protecting from harm.

We received some mixed feedback regarding the choice of meals in the home. There were systems in place for people to give feedback regarding the food and we saw this was acted upon. The home sourced locally produced food and grew their own vegetables and fruits.

People were supported to access a range of healthcare professionals. The home maintained good links with the local community.

People and their relatives spoke positively about the staff supporting them. Staff described how they supported people in a way that promoted their privacy and dignity. Staff spoke positively about the people they supported.

There were a wide range of activities on offer for people to take part in seven days a week. People, their relatives and staff had the opportunity to provide feedback on the service.

Relatives, staff and health professionals commented positively about the management of the service.

We have made a recommendation to the service in relation to the service revisiting guidance relating to the Mental Capacity Act 2005.

We found two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the enforcement action we took at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Some aspects of people's medicines management needed to be improved.

There were not always plans in place to reduce or mitigate risks to people.

There were sufficient staff to meet people's needs. Staff were recruited safely.

People were supported by staff who knew how to recognise and report abuse.

People were protected from the risk of infection.

Is the service effective?

Good

The service was effective.

Where some decisions were made for people in their best interest, these were not always completed in line with the Mental Capacity Act 2005.

People saw appropriate health care professionals to meet their specific needs.

People were supported to have enough to eat and drink. Our observation of people's mealtime experience was positive.

Staff received appropriate training and support to undertake their role and meet people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of the staff supporting them.

People told us they were supported in a way that promoted their

dignity and was respectful.

Staff working for the service knew people well.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People's care plans were not consistently person centred and detailed.

People had access to a wide range of activities to meet their needs.

Where concerns were raised these were responded to and addressed.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

The governance systems to monitor and improve the quality and safety of the service people received were not fully effective.

People were supported by staff who felt able to approach their managers.

The service had good links with the local community.

Nynehead Court

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 31 October and 2018 and was unannounced.

This inspection was carried out by two inspectors 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.

We did not request that the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, tell us what the service does well and the improvements they planned to make. We requested this information during the inspection. We reviewed the information that we had about the service including safeguarding records and statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

Some people who lived at the home were unable to verbally express their views to us, we therefore observed care practices in communal areas and saw lunch being served in all areas of the home.

During the inspection we spoke with seven people who lived at the home and two visitors. We spoke with five members of staff. We also spoke with two visiting professionals. The registered manager and care director were available throughout the inspection.

We looked at a number of records relating to individual care and the running of the home. These included five care plans, medication records, four staff personal files, minutes of meetings and records relating to quality assurance.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in December 2017 we found medicines were not managed consistently safely. People were at risk of not receiving their medicines as prescribed, medicines were not always kept safely and professional advice given by a pharmacist was not always followed up.

During this inspection we found some areas of medicines management had improved. For example, medicines were stored safely and securely. However, we found areas that still required improvement. Some people were prescribed additional medicines on an as required basis (PRN). Although there were PRN protocols in place these were not always personalised and did not always provide enough information for staff on when and why people might need them. For example, some people had been prescribed medicine for periods of agitation. Although care plans included suggestions on how to offer reassurance to the person, the PRN protocols did not describe how individual people might present when agitated. They also did not inform staff of steps they should take to relieve the anxiety prior to resorting to the use of medicines. Protocols for pain relief did not specify if people tended to experience pain in certain areas and did not specify whether people were able to inform staff if they were in pain. Staff had also not always documented the reasons why people had been given additional medicines. Documenting this information helps staff to identify any trends which might also indicate that a GP review is required.

The medicine records for three people stated it was these people's preference for staff to dispense their medicines and then leave them for people to take in their own time. Although the guidance for staff included returning to people to check they had taken their medicines, there were no risk assessments in place to inform staff how to ensure leaving medicines unattended was safe. Following the inspection, we received evidence that demonstrated this risk had been assessed.

Some care plans contained risk assessments for areas such as falls, malnutrition and skin integrity. However, this was not seen consistently in all plans. For example, in the daily notes for one person staff had documented for the previous ten days that the person's pressure areas were looking "Slightly sore." On 29 October 2018 staff had written, "Bed sores noticed on right hip."

We discussed this with the registered manager who told us they worked with the district nurses, who oversaw the persons nursing needs. Although the district nurse visited the person twice a week and had implemented a change of cream application in response to the sore area, there was no plan in place to inform staff how to manage the risk. We looked at position change charts for this person which did not show that the person had their position regularly changed. The chart for the day prior to our inspection showed the person was in the same position for 20 hours and for the previous seven days the only position written on the charts was "B" for back. The registered manager told us the person moved themselves around the bed. However, there was no care plan in place, and this information was not documented. The registered manager also said the person did not have bed sores. However, the documents we saw did not confirm this.

In the same plan staff had documented the person was at risk of aspirating. Aspiration is when food or fluids accidentally get taken into the lungs. People who have difficulties swallowing are prone to aspiration.

However, there was no choking risk assessment in place and no guidance for staff on what to do if this happened.

Additionally, in three people's care plans staff had written that people required thickener to be added to their drinks, but the amount of thickener was not specified. When we asked a member of staff they told us one person needed to have one scoop of thickener added to their drinks. When we asked how they knew this, they said it was on the persons MAR chart. However, the instructions on the MAR were "As directed." The dispensing label on the tub of thickener was "As directed." This meant there was a risk staff could add the incorrect amount. We discussed this with the deputy manager who immediately contacted the pharmacist to get the MAR instructions updated and the dispensing labels. They also told us they would amend the care plan immediately.

This was a continuing breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us the instruction for the amount of thickener had been given verbally by a health professional and the instructions for mixing the thickener were on the product information leaflet provided. We reviewed this information and confirmed staff were following the instructions on the leaflet.

Medicines were stored safely. We observed a member of staff administering medicines and they ensured the trolley was not left unattended. When not in use the medicines trolleys were safely secured. The temperature of medicine storage rooms was monitored as was the medicines fridge. Records showed the temperatures of these was maintained within safe levels. Controlled medicines were stored safely. Regular stock checks were carried out. Medicines that were no longer required were disposed of safely. We saw the latest pharmacist advice visit, where no concerns were noted.

We looked at all the medicine administration records (MARs). These had all been signed in full which indicated people had received their medicines as prescribed. We saw that time specific medicines were administered at the correct time.

People told us they felt safe at Nynehead Court. One person told us, "Yes, they [staff] are absolutely wonderful." Another commented, "Yes I feel safe."

There were systems in place to protect people from harm and abuse. Staff understood their responsibilities to keep people safe. They were aware of the indicators of potential abuse and how to report any concerns, and they were confident that any concerns would be investigated by the registered manager to ensure that people were protected. They were also aware of the whistleblowing policy and that they could report concerns to agencies outside of the organisation such as the Care Quality Commission (CQC). One staff member said, "I would report anything to the senior and the manager and if I wasn't happy anything was being done I would report it to CQC. I am aware of whistleblowing policy and yes I'm happy to use it, although I've never had to." Other comments included, "If I saw something like bruises, I would report it to the senior and document it" and "I would report it to my senior or the manager. I know I can go higher too if it wasn't acted on." This meant people were supported by staff who knew how recognise and report abuse.

Recruitment procedures were in place to ensure staff employed were suitable for their role. Prospective staff had to attend a face to face interview and provide documents to confirm their identity. Staff also had a range of checks completed before they were allowed to support people, these included previous employment references and checks by the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable

people. We noted two staff member's application forms included gaps in their employment history that had not been recorded as explored. Having unexplored gaps in employment could impact on a staff member's suitability to work with vulnerable adults. We discussed this with the registered manager who told us these were explored verbally with the staff members at the time of the interview, however they were not recorded. The registered manager confirmed they would record the reasons for the gaps in employment in the staff members recruitment files.

People told us staff usually came quickly when they used their call bell to summon support. Comments included, "They come far quicker than I expect", "There are always staff around" and "Normally it's a prompt response." However one person commented about the lack of staff response during evening handover, between the hours of 7pm and 8.15pm. We discussed this with the registered manager who told us they had ensured an additional staff member was working in the evening to cover this period and respond to call bells.

There were enough staff on duty to meet people's needs. All the staff we spoke with confirmed this. Comments included, "We're very well staffed and it's the same at weekends too." We spoke with two visiting health professionals during the inspections. One told us, "This place does pretty well for staffing levels. I've pressed the buzzer for help before and the staff come quickly." Another health professional said, "There are always enough staff around." The registered manager confirmed the staffing levels with us and the rotas we viewed demonstrated staffing levels were consistently met.

When incidents or accidents happened in the home staff recorded these on incident forms. Incident forms were reviewed by the registered manager to determine if any action was required. Staff told us incidents and accidents did not regularly occur in the home and records confirmed this. Where an incident had occurred we saw lessons were learned and improvements were made. For example, when people had experienced falls we saw action was taken to prevent the likelihood of another incident. We observed staff using moving and handling equipment. This was done safely and staff spoke to the person throughout the procedure.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system, personal emergency evacuation plans, water temperature checks and regular servicing on equipment. A fire risk assessment was completed by the fire service in April 2018. There were works identified as part of the assessment that needed to be completed. We noted the high risk actions had been completed and following the inspection the care director sent us a plan giving a timescale for the rest of the work to be completed.

There were also risk assessments in place to assess risks in the environment, such as radiators being uncovered and the use of portable heaters. We completed a tour of the building and checked the temperature of the radiators by touch. Nearly all of the radiators were at a safe to touch temperature. We found one radiator in one of the bathrooms was hot to touch. The maintenance person explained this was because if ran off of a different system that the others. He explained the radiator in the second bathroom (which was turned off) also ran off of the same system and had the potential to be hot. We discussed this with the registered manager who put immediate measures in place to prevent people from the risk of scalding themselves on the hot surfaces.

People were protected from the risk of infection. The environment was visibly clean and there were no odours. There was an infection control lead within the service who showed us the infection control audit they undertook each year. They told us this year's audit was due. When we asked to see the audit from 2017 they were unable to locate it. They explained the training that new staff were given in relation to wearing personal protective equipment (PPE) such as gloves and aprons. We saw that PPE was readily available for

staff to use. A process for ensuring PPE was being used correctly had been put in place earlier in the year and this was proving effective.

Good

Is the service effective?

Our findings

At our last inspection in December 2017 we found people's legal rights were not always upheld because the service did not work in accordance with the Mental Capacity Act 2005 (MCA).

The 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.

During the last inspection staff did not have a good understanding of the Act and capacity assessments were not decision specific, in line with the principles of the MCA.

During this inspection we found some improvements had been made. For example, staff had received further training and could describe the principles of the Act and how this applied to the people they supported. We also found that capacity assessments were decision specific. The MCA was regularly discussed in staff meetings to raise staff awareness.

We did find however, that the records relating to capacity assessments and best interest decisions needed some further improvements. Although people's capacity to consent to aspects of their care had been assessed, it was not always clear how the outcome of assessments had been reached.

We looked at an assessment for one person for them to consent to having personal care. Staff had not documented how they had tried to explain to the person what the assessment was for or described in enough detail how they had done this. The question on the assessment form was, "How did you know the person couldn't retain information?" Staff had written, "Unable to respond appropriately." In another person's daily notes staff had written, "It was in [person's name] best interests that we assisted with all personal care." However, there was no capacity assessment in place and no best interest documentation. We discussed with the registered manager who demonstrated there had been a capacity assessment and best interest decision for personal care in place, however they had been advised this wasn't required. They explained this was because the person was happy to receive personal care and was able to give some sort of consent.

Some people had been assessed for their capacity to consent to the use of bed rails. Again, it was unclear how staff had tried to explain because it had not been documented. Best interest decisions had been made, but no information had been documented to describe whether any less restrictive options had been considered. We looked at the best interest decision documentation for one person with a sensor mat in place. The reason why the decision to use the mat had been reached was unclear because staff had documented, "[Person's name] has dementia. Is unaware of surroundings and other residents personal space, so in [their] best interests at night to have a call mat in situ outside bedroom door which alerts staff if leaves bedroom." This explanation did not provide enough information for why it was in the person's best interests.

Another person's best interest documentation did contain enough information because it was written that the person still felt able to walk without the use of mobility aids or staff support. Their risk of falling was high and therefore the use of a sensor mat was in their best interests.

Despite this, we heard staff regularly ask people's consent prior to assisting them. For example, we heard staff ask, "Can I help you with that?" and "Would you like to go back to your bedroom?" We also do not find that people were being unnecessarily restricted.

We recommend that the service revisits guidance relating to the Mental Capacity Act 2005 in relation to recording how they support people to make decisions.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made seven DoLS applications to the local authority and they were waiting for the outcome of these.

People told us they thought staff had the right skills and knowledge to carry out their role. Comments included, "I think they are trained, on the whole. I know they have training sessions and so on" and "Yes, most of them, most are excellent."

Staff told us they received an induction when they started working in the home and they commented positively about it. One member of staff who was new in post told us they had completed shadow shifts as part of their induction process. They said, "I did shadow shifts until I felt confident to work on my own. I wasn't under any pressure." The induction was linked to the Care Certificate. The Care Certificate standards are recognised nationally to help ensure staff have the skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received on-going training to ensure they were competent to carry out their roles. Staff spoke highly of the training available. One member of staff said, "I've done lots of training. Health and safety, equality and diversity, mental capacity. I feel trained to do my job." Other comments included, "The training is good, I've just completed the care certificate and my diploma, it was very hard but I had the right support to do it" and "The training is great, I feel supported with it."

We reviewed the training records and they demonstrated staff had received training in subjects such as, safeguarding adults, fire awareness, moving and handling, dementia care, medicines and infection control. Staff also received training to support people at the end of their lives.

Staff told us they had one to one supervisions (meetings with their line manager to discuss their work) and they found them supportive. One staff member said, "I have supervision quite often and find them supportive." Another commented, "I have supervision every month, we go through my training and make sure Im up to date. They give feedback, I like to hear I'm doing ok." The registered manager told us their policy was for staff to receive formal supervision twice a year, they said staff received informal supervision on an ongoing basis.

We received some mixed comments from people regarding the meals in the home. One person told us the meals were, "Very nice." Other comments included, "I find the meals bland. We get choices though", "The food is not bad at all. There's a choice for supper, but lunch you have what's put in front of you. There are very good puddings", "I think it's quite good. There's choice of some things. The evening meal I can choose. The pudding we choose" One person commented that they weren't satisfied with the evening choices of

meals and that they found it difficult to keep asking for alternatives. They told us they thought they would benefit from a written choice of alternatives to choose from. We fed this back to the registered manager who told us they would arrange for this to be out in place. The home had recently conducted a satisfaction survey and had received feedback on meals and they were monitoring choices and standards.

We observed a positive dining experience at lunchtime. There was one choice available on the menu for the main course, and there were three choices of puddings. Tables were laid with tablecloths and placemats, with napkins and condiments on each table, including apple sauce. Glasses and cutlery were brought to each resident individually. People were offered a choice of five different juices as well as wine and water. Staff were present throughout the meal and they were quick to respond to people's needs and requests. We observed staff saying, "Did you like it? Have you finished? Would you like some apple sauce? What would you like to drink?"

Although there was only one main choice of meal on the menu at lunchtime staff said they would offer people alternatives if they did not like what was on the menu. We saw that people were offered regular drinks throughout the day. We heard one member of staff asking people what they would like to order for supper. There was a choice of two meals and when one person said they couldn't decide, the staff member said, "Shall I order both for you? Then you can have a look and choose which you fancy." The person agreed to this.

We saw in resident's meetings that people's feedback regarding the menus was sought. The chef had a list of people's likes, dislikes and dietary requirements in the kitchen. The registered manager told us how people could request specific meals and the chef would arrange for these to be cooked.

The home used locally sourced and home-grown products to ensure people received good quality and nutritional food. Nynehead employed gardeners who were responsible for overseeing the vegetable and fruit gardens and they supplied the chef with seasonal fresh fruit and vegetables.

People were supported to have enough to eat and drink. People had been assessed for the risk of malnutrition and people's weights were monitored. When people lost weight, advice was sought. Although some of the care plans contained information on what people disliked, they did not always detail people's preferences for what they did like to eat and drink. The chef had a list of people's likes, dislikes and dietary requirements in the kitchen and staff had good knowledge of what people did and did not like to eat. When people had specific dietary requirements such as thickener, this was not always included within care plans. Some people were having their fluid intake monitored; however, the target intake had not been documented. Fluid charts had not always been totalled at the end of the day and because of the lack of targets it was unclear how staff would know if people had received enough fluid.

People had access to ongoing healthcare. Records showed people were reviewed by the GP, district nurses and physiotherapists. Staff supported people to attend appointments when necessary. One visiting health professional said, "The staff are very good at calling us when they want somebody to be reviewed. They send us information outlining their concerns, a set of observations and any action they've already taken." We reviewed a positive comment from a family member that said, "We were so appreciative of all the staff who coped so well with [family members] medical problems."

The environment was suitable for the people living at the home. There were a range of areas throughout the home where people could spend their time such as the drawing room, lounges and seating areas throughout the home. There was a shop where people could purchase items and a hairdressing salon which was open twice a week. One person was an artist and we saw part of the home had been adapted to enable

them to have an art studio area.

The Mulberry area was specifically designed to meet the needs of people living with dementia. This included light and spacious corridors, signage on bathrooms and bedroom doors. There were well maintained gardens that people could access if they chose. There was an orangery within the grounds where events were held for people living in the home and the public. The registered manager showed us their refurbishment plans for the home which included replacing carpets, refurbishing a bathroom and consideration of a replacement lift.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. People told us the staff were caring, One person commented included, "They [staff] are absolutely wonderful. They are so nice and cheerful. The staff are good characters, who are carefully selected. My family all agree, too." Other comments included, "It's very nice, the staff are very helpful", "They are very helpful and kind" and "I feel everyone [staff] has time. They were instantly friendly when we came through the door [on their initial visit]. Nothing is too much trouble." One person commented, "They make me very comfortable, but just one or two staff I find difficult." We discussed this with the registered manager who demonstrated they were aware of the comments and had addressed this with staff.

We observed many positive interactions between people and staff. People appeared relaxed and were smiling and chatting to staff. We heard staff greeting people during the morning. One staff member said to one person, "Hello [person's name]. How lovely to see you up and about." On another occasion we heard a member of staff say, "Are you warm enough? Let me just pop this blanket back on your legs." The person replied, "Oh, you look after me so well."

We saw one member of staff speaking with one person's relative. The relative said, "Thank you so much. [They] look so comfy." The staff member replied, "It's our pleasure. I'll pop to see [person's name] in a bit and check they're still ok."

Visiting professionals also commented positively about the staff. One visiting professional said, "The staff here are very caring, particularly those that have been here a while. It's a caring atmosphere and I'm confident this home does things right." Another professional said, "I do feel the staff are caring here. I have no concerns at all. I'd send one of my relatives here, or I'd be happy to live here myself."

Staff spoke positively about the people they supported; they demonstrated empathy and were able to tell us about people's likes, dislikes and what was important to them. For example, staff were aware that some people liked to wear makeup, have their hair done and dress smartly. They were also aware of people's family members, food likes and dislikes and their hobbies and interests.

People were involved in day to day decisions about their care and support and that staff respected their wishes. One person told us, "The staff are friendly and listen to us." A relative told us, "She gets to choose what she wants to do and is treated as a person." During the inspection we observed some people chose to stay in their rooms; whilst others chose to spend time in the communal areas. Staff were aware of the importance of people having their own private time when they wished.

Staff supported people to develop and maintain relationships with those important to them. One person told us, "I get quite a lot of visitors." They went on to say they would go to their room or go down into the garden if the weather was nice. We saw evidence of staff and the registered manager enabling a person to attend a family wedding some distance from the home. They made arrangements for transport, staffing, the hairdresser and a manicure. The person and their family were noted to be extremely happy with the support

they received.

People told us staff knocked on their doors before entering. Comments included, "They will knock on the door" and "There's no issue. They knock on the door."

Staff understood how to maintain people's dignity and privacy. One member of staff said, "I always make sure the door is closed, curtains drawn and keep people covered up during personal care." Another commented, "I think about how I would want to be treated." We saw that staff put signs on doors to inform others that personal care was taking place. Some of the wording used by staff in documentation indicated a task focussed approach to care rather than a person centred one. For example, we saw staff had written in daily notes phrases such as, "creamed, toileted, fed and turned. "Our observations of staff interactions however were respectful.

Staff spoke highly of their roles. One member of staff said, "We provide good care. We've got as long as we need with people, we don't have to rush." Another staff member said, "The team here is good and the care we give is brilliant. Families will all agree we look after people like they're our own grannies and granddads."

The service kept a record of compliments they received. We reviewed a file that contained written feedback to the service to express their thanks. Comments included, "We would like to thank everyone at Nynehead for all the care, attention and affection [name of person] received" and "I am writing to express my thanks for making the last two and a half years of my mother's life so happy."

Requires Improvement

Is the service responsive?

Our findings

Each person had a care plan that was personal to them. Although there was evidence of people being involved in their care plans, we found they were not consistently person centred and did not always provide staff with enough information on how to meet people's needs. We saw some good examples of personalised information however this was not consistently found. For example, we saw one plan that detailed the person's preferences in relation to their personal care in detail. This included their preferred toiletries, and the colour of the flannel they liked to use to wash with. Another person's plan detailed how the person liked to dress each day.
Other plans were not as detailed. For example, in one person's plan staff had documented the person could sometimes decline personal care, but there was no guidance for staff on how to manage this. In another person's plan it was written that they did not like soap or water on their face, but there was nothing to inform staff if the person preferred to use something else to keep their face clean. This meant there was a risk people's personal preferences would not be met because the information was not available to staff.

We looked at the care plan for one person who had been prescribed medicine for agitation. Staff had completed charts to identify any trends for things that could cause the person to be anxious or agitated. There was some information available for staff to support the person, such as offering support and reassurance and allowing them to walk around. However, there was no plan in place to inform staff how to support the person during incidents. This meant there was a risk that staff would not respond consistently to the person to support them when they were anxious.

Staff told us one person was visually impaired. We looked at the care plan for this person and there was nothing documented to inform staff the person was registered blind until the last but one page when it was written in a falls risk assessment. There was no plan in place to inform staff how to support the person in relation to this. This lack of information meant there was a risk the persons communication needs would not be met. Communication plans were also not consistently detailed. For example, in one person's plan it was written the person could answer "Yes, no questions." There was nothing else documented to inform staff how to communicate with the person or how to understand their needs.

We discussed this with the registered manager who told us following the feedback received at the last inspection staff had received training in care planning, and their care planning system had been updated. They told us this was to assist care plans to be more person centred. Although some good examples were found, the new style was still in the progress of implementation and as a result there was some inconsistency in the completion of care plans.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some of the plans contained details of people's lives prior to moving to the service, but not all. The registered manager said they had worked closely with families to try and gather this information.

Despite all the above, staff we spoke with knew people and their support needs. Staff spoke in depth about people and provided us with more information about people's needs than was documented in the care plans. Staff said they had learnt this from speaking with colleagues, speaking to people and their families. One member of staff said, "The care plans have changed so many times. We've had some conflicting advice." One visiting health professional said, "I do think staff understand people's needs really well here." However, the information would not be available for a new or unfamiliar member of staff to support the person.

The staff worked closely with local healthcare professionals to ensure people's comfort and dignity at the end of their lives. At the time of the inspection there was no one who was requiring end of life care. There were advanced plans in place. These provided staff with information about people's preferences for the care and support they wanted at the end of their lives. These were detailed.

The home had achieved the National Gold Standard Framework (GSF) for end of life care. This is a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their life. Staff described the support they gave people when they were reaching they end of their lives. One staff member said, "We make sure all the correct equipment is in place and understand the importance of good mouth care. We have just in case pain medicines if we need them. Some residents have done advance wishes care plans, we speak to family. We consider whether they would like the vicar to come out, what music they may like and if they want flowers in the room. We want them to have a peaceful passing and that their wishes and views are respected, this is their home."

There was a wide range of activities on offer and these were provided seven days a week. People and relatives told us they were happy with the activities on offer. One person told us, "When there are activities, I can always go. We have a letter with information, it comes out once a month. I have been on the bus trips which I enjoy quite a lot, and the music and quizzes. I am friendly with the people who are here." Other comments included, "We go to the pub every now and then", "I do go out in the garden. I am always being pushed around in the wheelchair and I like to read" and "There was an activity this morning, but I didn't feel up to it. I go to quizzes, singing, playing the piano. There's a programme [of activities] and I ask the staff."

A relative told us, "[Name of person] loves gardening and flower arranging. Gardening is part of the activities' sheet. They took her to a church recital. You can also borrow the wheelchair accessible car."

There were a team of four activities coordinators employed by the home. They produced a newsletter each month detailing the activities on offer. One of the activity coordinators told us, "I like to think I am doing activities for the home, and do things that can be modified for all groups." They went on to describe how they brought reminiscence into most activities by talking to people about what they like and about what they may have sung or played to their children in the past.

The activities coordinator told us they visited each person daily to see what people would like to do. They commented, "We ensure we make contact on a daily basis. Sometimes it's a walk, or in a wheelchair, around the garden, a trip into Wellington, one to one, depending on the resident's need. We also have a bus outing twice a week."

The activities on offer included; musical entertainment, bell ringers, choirs, art class, flower arranging, quizzes, fitness, knitting, bingo, ping pong and board games. There were also craft markets held in the orangery, and outings such as coffee and shopping trips, as well as seasonal activities such as bonfire night and Halloween celebrations.

There was also a church within the grounds and people could attend services if they chose. One person told

us, "Every fortnight we go to the local communion service in the local church. Staff take us in a wheelchair." Services were also arranged in the home for people who did not want to attend the church. One person told us, "The local people are very good, they give a simple service based on the Anglican communion service [in the home] on a Sunday morning when communion is not in church. At least 12 people attend, quite a few." Another commented, "The church service is usually held here [in the home] and I sometimes go to church."

The service had a complaints procedure in place and we saw that complaints were responded to when they were raised. Most people told us they would raise any concerns with staff. One person told us they would speak to their family member. Two complaints had been received since the last inspection and these had been addressed and resolved.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in December 2017 we found the systems in place did not ensure people were fully protected from the risks of unsafe or inappropriate care and treatment. The provider was failing to assess, monitor and mitigate risks, maintain accurate and complete records and evaluate and improve practice. During this inspection we found improvements had been made in some areas for example, there were some improvements to medicines management and the application for the Mental Capacity Act 2005 (MCA). However, we found some similar concerns to the last inspection which resulted in breaches of the regulations.

There were a range of systems in place to monitor and improve the quality and safety of the service. These included audits relating to medicines, incidents and accidents, catering, care plans maintenance and an administration audit. Whilst we found some of these audits were identifying shortfalls in the service and the action required to remedy them, they were not identifying all of the concerns we found during this inspection.

The systems in place to monitor care plans had not ensured they identified all areas where people were at risk. We found areas where people were placed at risk and there were no risk assessments in place. The auditing systems were not effective in ensuring care plans contained guidance for staff covering all areas of needs. The systems in place to audit medicines had identified areas of improvement and the action required to remedy these, however it had not identified the shortfalls we found during the inspection.

This was a repeated breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us since our last inspection they had introduced a new quality assurance system and this was still in the process of being embedded into the service. The registered manager also had meetings with the care director to review the quality and safety of the service. The meetings covered areas such as the environment, training, feedback received, health and safety and activities. Where any areas for improvement were identified as part of this process, action points were set and reviewed.

There was a registered manager in post. People told us they knew who the registered manager was and they felt able to approach them with any concerns. One person told us, "She is accessible because she is in her office. I think she approachable, she is friendly and I have quite often spoken to her." Other comments included, "I think it's very well organised, very well run" and "I see the manager infrequently, but if you have a question you can go and ask."

Staff also commented positively about the registered manager. Comments included, "[Name of registered manager] is brilliant, I always feel comfortable going to speak to her if I need to. She asks if we need help and is approachable" and "She is very supportive, I don't think I would have got this far without her support, she is caring she listens, she takes on board people's feelings and thoughts." A visiting professional said, "[Registered manger] always gives me an update when I visit here. Then when I finish seeing people I have a

debrief with the senior on duty and the manager."

The registered manager kept their knowledge and skills updated thorough on-going training, online resources and subscriptions to health and social care publications. The registered manager told us they were well supported by the provider's senior manager, who provided them with supervision and visited the home regularly. They also told us of other areas of support such as managers from other areas and managers meetings.

The registered manager maintained a regular presence in the home. They had knowledge of the people who lived there and the staff who supported them. They told us they visited each person at least once a week to have the opportunity to receive any feedback. There was a clear staffing structure and the registered manager told us since the last inspection they had introduced a deputy manager to support them with management tasks. There was also a senior in post who was responsible to overseeing the care to the people living in Mulberry.

Staff meetings were held which were used to address any issues and communicate messages to staff. Staff said they attended regular meetings and they were encouraged to speak up during these. One staff member told us, "Team meetings are regular and I feel we are listened to." Another commented, "Team meetings are ok and in depth which is good, we talk about teamwork, shifts, the residents and whether they are happy with what we do. I feel able to speak up and feel listened to." Meeting minutes demonstrated meeting were used to discuss items such as, health and safety, awareness of the MCA, teamwork, feedback received from people, medicines and infection control.

There was a positive staff culture in the home. Staff commented positively about working at Nynehead Court and the staff team. Comments included, "We are a very good and hardworking team, we always help each other out" and "The staff team work well together, it's really good." Staff also said they felt well supported. One staff member said, "Yes, I feel supported here. The manager is always available." Another member of staff said, "[Deputy manager] has worked all roles since taking on the role. That means they really understand what we all do. They are always available for advice." A relative commented, "The staff create a respectful atmosphere."

The home maintained strong links with the local community. These included local nursery children attending the home and public events being held in the orangery and the grounds. People attended local flower shows and a bell ringing group had been developed by one of the people living at the home. The registered manager told us they were in the process of supporting people to set up a WI group. During the inspection a Halloween activity had been arranged in the grounds of the home which was attended by the public.

There were a range of systems in place for people and their relatives to give feedback on the service. A relative told us, "There's a survey every six months. I did get some feedback. We filled in the questionnaire and then we had an email from [manager] on the outcome, and what they hoped to do as a result." The survey covered areas such as the food, environment, activities, how they were treated, feeling safe and secure and the manager. Where feedback was received actions were put in place and feedback to people and the staff team. For example, comments were made that some people did not know who their key worker was and what the role entailed. An action point was for all people to have a picture of their keyworker and for an update on the role to be sent out in the next newsletter.

Resident and relative's meetings were also held quarterly to enable people to discuss matters relevant to the home. One person told us, "They do have these meetings and I think they do produce a report of the

meetings." We reviewed the minutes of the latest meeting and saw items discussed included, feedback from the last survey and the actions taken, feedback relating to the food and activities. A newsletter was also sent to people to keep them updated on what was happening in the home.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some areas of medicines management were not being managed safely. There were not always plans in place to mitigate risks to people. Regulation 12 (1) (a) (g)

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service were not fully effective. Care plans did not always include a complete record in respect of each service user relating to their care and treatment. Regulation 17 (2) (a) (c)

The enforcement action we took:

We imposed conditions on the providers registration