Tradstir Limited

Partridge House Nursing and Residential Care Home

Inspection report

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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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 14 March 2017 and was unannounced.

Partridge House Nursing and Residential Care Home is purpose built, and was taken over in 2014 by Tradstir Limited. The service provides nursing and residential care, across three units, for up to 38 older people with increasing physical frailty, many living with dementia or other mental health needs. Long term care and respite care was provided. There were 36 people resident at the time of the inspection.

There was a registered manager for the service. 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 the last inspection of the service on 3 November 2015 the service was rated as requires improvement. This was because training records had not been kept up-to-date and it was not possible to fully evidence staff had completed essential training. Training opportunities for nursing staff to update their clinical skills was in the process of being sought. Not all the staff had received regular supervision. Auditing and monitoring processes were not fully in place and embedded in practice. There was no evidence of analysis of the information received and how this had been used to influence and improve the service delivery. At this inspection we found work had been undertaken to rectify this and address the issues highlighted. However, we found although the range of activities people could join in continued to be developed and were provided every day, there were significant numbers of people not engaged in meaningful activities. This is an area in need of improvement.

People lived in a safe and secure environment. We observed staff speaking with people in a kind and respectful manner and saw many examples of good natured but professional interaction. Staff were aware of the values of the service and understood the importance of respecting people's privacy and dignity.

Medicines were stored correctly and there were systems to manage medicine safely. Regular audits and stock checks were completed to ensure people received their medicines as prescribed.

Senior staff monitored peoples dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Staff told us they were supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. They told us there had been good access to training to ensure they had the skills to meet people's care needs. The registered nurses could attend the essential training provided, and were being supported with training updates to ensure their clinical skills were kept up-to-date. Staff told us they felt well supported and had received regular supervision and support.

Safe recruitment policies and procedures were followed in the recruitment of new staff to work in the

service.

Consent was sought from people with regard to the care that was delivered. Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation, which they put into practice. Where people were unable to make decisions for themselves staff were aware of the appropriate action to arrange meetings to make a decision within their best interests.

People told us they had felt involved in making decisions about their care and treatment and felt listened to. People's individual care and support needs were assessed before they moved into the service. An electronic care planning system had been embedded into the service. There were good examples of personalised care plans, and these included detailed information about people's personal histories and preferences, including details about their previous occupation, family, pets, hobbies, interests and food likes and dislikes. Staff spoke well of the new system and there were access points in the service which care staff could use to update the records. They told us this had led to the care plans being more up-to-date and accessible. Supporting risk assessments were in place to protect people. Where people had been assessed as being at risk of developing pressure sores, or from falling out of bed, the equipment identified to be used had been regularly checked to ensure it remained suitable for individual people's use.

People's nutritional needs were assessed and recorded. People told us they enjoyed the food provided.

Procedures were in place for people and their relatives/representatives to raise any concerns. No one we spoke with had raised any concerns, but they felt it was an environment where they could raise issues and they would be listened to.

Staff told us that communication throughout the service continued to be good and included comprehensive handovers at the beginning of each shift and staff meetings. They confirmed that they felt valued and supported by the managers, who they described as very approachable.

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 were cared for by staff recruited through safe recruitment procedures. Staffing levels were monitored to ensure there were enough staff to meet people's care needs.

People had individual assessments of potential risks to their health and welfare, which had been regularly reviewed. Medicines were managed, stored and administered safely.

The building and equipment had been subject to regular maintenance checks.

Is the service effective?

Good

The service was effective.

Staff were aware of their responsibilities from the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS.) Where people lacked capacity to make decisions about their care and treatment this had been considered in their best interests.

Staff had a good understanding of people's care and support needs. People were supported by staff that had the necessary skills and knowledge.

People were able to make decisions about what they wanted to eat and drink and were supported to stay healthy. They had access to health care professionals when they needed them.

Is the service caring?

Good

The service was caring.

Staff involved and treated people with compassion, kindness, dignity and respect.

People were treated as individuals. People were asked regularly about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

People told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People were supported to take part in recreational activities both in the service and in the community. The range of activities had continued to be developed. Family members and friends continued to play an important role and people spent time with them. However, during the inspection there were significant numbers of people not involved in meaningful activities.

People had been assessed and their care and support needs identified. Care plans were in place and being developed to ensure people received care which was personalised to meet their needs, wishes and aspirations.

People were comfortable talking with the staff, and told us they knew who to speak to if they had any concerns.

Is the service well-led?

Good

The service was well led.

Quality assurance was used to monitor and to help improve standards of service delivery. There were regular opportunities for people to be able to comment on and be involved with the service provided to influence service delivery.

The leadership and management promoted a caring and inclusive culture. Staff told us the management and leadership of the service was approachable and very supportive.

Systems were in place to ensure accidents and incidents were reported and acted upon.

Partridge House Nursing and Residential Care 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 March 2017 and was unannounced.

The inspection team consisted of 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. Before the inspection, we reviewed information we held about the service. This includes any notifications, (A notification is information about important events which the service is required to send us by law) and complaints we have received. This helped us to plan our inspection. We requested the provider to complete a Provider Information Return (PIR) on this occasion. 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 contacted the local authority commissioning team, who have responsibility for monitoring the quality and safety of the service provided to local authority funded people and the Clinical Commissioning Team (CCG) for feedback on the care provided. Following our inspection, we spoke with a health care professional to ask them about their experiences of the service provided.

We observed care and spoke with people, relatives and staff. We spoke with eleven people, and four relatives. We spoke with the provider, the registered manager, the deputy manager/clinical lead, two registered general nurses (RGN), three care workers, an activity co-ordinator, a chef and a maintenance person. We observed the care and support provided in the communal areas, and the mealtime experience for people over lunchtime.

We looked around the service in general including the communal areas, people's bedrooms, and the

garden. We observed medicines being administered and sat in on a staff handover meeting. As part of our inspection we looked in detail at the care provided to five people, and we reviewed their care and support plans. We looked at menus and records of meals provided, medicine administration records, the compliments and complaints log, incident and accidents records, records for the maintenance and testing of the building and equipment, policies and procedures, meeting minutes, staff training records and five staff recruitment records. We also looked at the provider's own improvement plan and quality assurance audits.

The last inspection was undertaken on 3 November 2015.

Good

Is the service safe?

Our findings

People and their relatives told us people were safe and were well treated in Partridge House Nursing and Residential Care Home. When asked if they felt safe one person told us, "Oh I'm not frightened or anything like that, no not at all." Another person told us there were, "Good people here and don't stop us doing things." We observed one member of staff helping a person in their wheelchair say, "Can I put this on you (A strap) (Person's name) you know why this goes on?" The person replied "So I don't fall out. I feel safer I do."

Risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. Individual risk assessments where completed including falls, nutrition, pressure area care and manual handling. There was a system in place to review these on a regular basis. Staff told us if they noticed changes in people's care needs, they would report these to one of the managers and a risk assessment would be reviewed or completed. Where people had been assessed to be at a risk of skin breakdown (pressure sore) we found that current guidance was being followed. People had prescribed creams which had been applied to help support the skin integrity of the person. Records we looked at detailed the areas for application and recorded the applications undertaken. An air mattress (inflatable mattress which could protect people from the risk of pressure damage) had been provided where required. We were informed by staff that air mattresses were checked daily to ensure they were on the right setting for the individual needs of the person. Records we looked at confirmed this. One member of staff told us, "We check the mattresses at the same time as we do the meds." All of the rooms had a sensor that could be switched on to detect movement in the room if a person was at risk of falls that linked to the call bell system. One member of staff told us, "If there is a fall we ask them if they are ok or in pain. We would hoist them into bed and check on their body map and inform the family. We would talk to the GP and fill in an incident form." Another member of staff told us, "We sit together and chat and walk with them at the risky time of day."

We looked around the building and we found the premises were well maintained. The environment was clean and spacious, which allowed people to move around freely without risk of harm. Dedicated maintenance workers were responsible for the general maintenance, alongside external contactors who were used for service checks and repairs. Staff we spoke with confirmed that any faults were repaired promptly. Regular tests and checks were completed on essential safety equipment such as emergency lighting, the fire alarm system and fire extinguishers. Staff told us regular checks and audits had been completed in relation to fire, health and safety and infection control. Records confirmed these checks had been completed. Contingency plans were in place to respond to any emergencies, for example flood or fire.Personal Emergency Evacuation Plans (PEEPs) were in place for people in the event of a fire. The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency.There was an emergency on call rota of senior staff available for staff to access for help and support.

There were clear systems for protecting people from abuse. These had been reviewed to ensure current guidance and advice had been considered. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the protection of adults. They had notified the

Commission when safeguarding issues had arisen, and therefore it could monitor that all appropriate action had been taken to safeguard people from harm. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse. One member of staff told us, "The safeguarding training is spot on."

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff we spoke with had a clear understanding of their responsibility around reporting poor practice, for example where abuse was suspected. They also knew about the whistle blowing process and that they could contact senior managers or outside agencies if they had any concerns.

Medicines were administered safely to people. There was a clear system for the ordering of people's medicines and for disposal of medicines no longer in use. We observed medicines being administered and where appropriate, people were assisted to take their medicines sensitively, they were not rushed and simple explanations, appropriate to people's level of understanding were provided. There were no gaps in signing on Medicine Administration Record (MAR) sheets used to record the administration of medicines.. Records detailed special instructions and specific observations for example when administering medicines for one person staff were instructed to, 'Make sure that tablets are taken as she tends to hold them in her mouth.' Some medicines were given as and when required (PRN) for example, for pain relief. Guidance on giving PRN medications were documented in the MAR with needs and preferences given. For example, for one person it detailed, 'Grimaces if she is in pain, check with her through the day and observe her facial expressions.'

People told us they did not usually have to wait long for help when they needed assistance from the care staff, and observations on the day confirmed this. Senior staff showed us the dependency tool they used to help ensure that there were adequate staff planned to be on duty. Senior staff also regularly worked in the service to keep up-to-date with people's care and support needs which helped them check there were adequate staff on duty. Feedback was varied from staff who told us at times it could be very busy . However, they all told us people's care needs had been met and jobs had been completed. Agency staff were used to cover any care staff absences. One member of staff told us, "There are concerns as we can't get nursing staff to do extra hours. We use agency at nights usually." Staff were requested who had previously worked in the service and had an understanding of how the service was run. They also spoke of good team spirit.

People were cared for by staff who had been recruited through safe recruitment procedures. Where staff had applied to work at Partridge House Nursing and Residential Care Home they had completed an application form and attended an interview. Each member of staff had undergone a criminal records check and had two written reference requested. However, for one person who was shadowing as part of their induction only one written reference had been received. We discussed this with the registered manager during the inspection who acknowledged this could not be found and has subsequently confirmed this had been requested again and received. Where registered nurses were being recruited we saw that checks had been made on their pin number. This is an information system which can be accessed to ensure nursing staff were still registered to work as a nurse provided nursing care. This meant that all the information required had been available for a decision to be made as to the suitability of a person to work with adults.

Good

Is the service effective?

Our findings

People and their relatives spoke positively of the service, the support from staff and of the healthcare provided. They felt that the staff had the skills to meet their care needs.

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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the importance of enabling people to make decisions. Staff had knowledge and understanding of the Mental Capacity Act (MCA) and some staff had received training in this area. People were given choices in the way they wanted to be cared for. A member of staff told us about the care provided to one person, "If she refuses her meds we come back. Some don't want to come out of their rooms or don't want to get dressed and she eats when she wants to eat." Another member of staff told us, "We ask, don't assume, they are still a person." A third member of staff said, "It's about decision making and choices, it's about their best interests."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. Applications had been sent to the local authority and notifications to the Care Quality Commission when required. We found the registered manager understood when an application should be made and the process of submitting one.

The registered manager told us all care staff completed an induction before they supported people. This had been reviewed to incorporate the requirements of the care certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of shadowing a more experienced staff member before new care staff started to undertake care on their own. The length of time a new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. Staff told us that they had an induction programme where they were shadowed for a month, where they were shown the routine in the service, as well as paperwork and the computer system. RGNs were shown medication, how to contact other professionals and how to raise a concern, care plan reviews and supervision. One member of staff told us, "They are really good at showing us who is who and shadowing." All care staff were in the process of working through the care certificate, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, and infection control. This included training and guidance on providing care and support to people living with dementia. In addition, staff told us they had received training to ensure they had the knowledge and skills to meet the care needs of people living in the service. The staff received a warning if the training course was not completed within the two

week window and the results were shown and could be tracked electronically. Training was provided by a mixture of E Learning, training provided by the local council and through the service's own 'champions' who had been trained to provided staff with training in the service. One member of staff told us, "A new subject is given every two weeks such as Parkinson's and I am signing up for end of life care as this is an interest of mine." Another member of staff told us, "It's brilliant training on line and practical back care." A third member of staff said, "There is a set amount of training and we are reminded and the manager will remind you." A senior member of staff was working with the RGN's to help them with the revalidation of their qualification and to update their clinical training.

Staff told us that the team worked well together and that communication was good. Staff told us they had received supervision from their manager, they felt well supported and could always go to a senior member of staff for support. Senior staff told us they provided individual supervision and appraisal for staff. This was through one-to-one meetings. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. There was a supervision and appraisal plan in place which the senior staff were following to ensure staff had regular supervision and appraisal. One member of staff told us, "There's not a set day we had supervision two weeks ago and it's documented. You are encouraged to raise qualifications such as NVQ(National Vocational Qualification.)"

During lunch time, we observed there were sufficient staff to ensure that time was taken to support each person who needed assistance. Staff did not rush people, they explained to people what the food was and chatted during the meal. There was a rotating menu based on people's likes and dislikes. One person was taken to the kitchenette to be physically shown what was on offer. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu that they liked. This information was then fed back to the chef, who demonstrated they were aware of people on special diets. People told us they had a choice of either eating their meals in their room or in one of the dining rooms. We noted that if people got up and walked about and chose to sit elsewhere this caused no difficulties. Staff were completely accommodating in acknowledging people's wishes to move about if they could. One staff member told us ,"People sit wherever they're happy." One person told us, "I always have my shredded wheat and a glass of tea in the morning. They know that's what I have, I do enjoy it."

We observed the lunchtime experience for people. Generally it was relaxed and people were considerately supported to move to the dining areas, or could choose to eat in their bedroom or in the lounge. People were encouraged to be independent throughout the meal and staff were available if people needed or wanted support, extra food or drinks. People ate at their own pace and some stayed at the tables and talked with others, enjoying the company and conversation. Generally where people were supported to eat their meal they had a dedicated member of staff to support them, they were not rushed and there was evidence of friendly conversations occurring. One person who didn't want anything to eat was finally tempted with a pot of rice pudding.

A screening tool was used to identify people who were malnourished or at risk of malnutrition. People's weights were regularly monitored to check that they were maintaining their weight or losing or gaining weight as needed. Where people's nutritional intake was being monitored there was recording in place to inform staff of people's food and fluid intake. We saw that these were fully completed and that food and fluid charts were completed where needed. There was information about people's likes and dislikes, and during the lunchtime experience we observed staff demonstrated knowledge of peoples likes and dislikes. Referrals had been made for guidance and support from the speech and language team (SALT) team or dieticians as required and any guidance for staff to follow had been implemented. Care plans were in place for people with diabetes and risk assessments for people who suffered with dysphagia. This is where a person has difficulties swallowing. There was clear guidance for care staff to follow where people had

thickened fluids and the consistency these should be. People's weights were monitored regularly with people's permission and there were clear procedures in place regarding the actions to be taken if there were concerns about a person's weight. One relative told us, " They were worried about (Person's name) as she'd lost a lot of weight but it's coming back on now due to their efforts."

People's physical and general health needs were monitored by staff and advice was sought promptly for any health care concerns. Care plans contained multi-disciplinary notes which recorded when healthcare professionals visited such as GPs, social workers, nurses or dieticians and when referrals had been made. We noted that a person who had been noted as drowsy and not taking meals and medication was reported as being referred to the GP for a visit that day. A relative told us," They know what's what. I can see if (Person's name) isn't feeling so good they go out of their way." Another relative told us, "They had the Doctor out recently, they contacted me first but we agreed it would be a good idea as (Person's name) does this counting repeatedly so the Doctor has changed the medication. Another time (Person's name) had a fall and had to go to hospital and they acted quickly and I feel confident that a Doctor would be sought anytime (Person's name) was ill." A third relative said, "(Person's name) needs to have a bowel screening done for the hospital and I've spoken to (Manager's name) and no problem they'll sort it all out from here."

There was a policy and procedure for nursing staff to follow for wound care. There was guidance for nursing staff to follow, and recording and on-going photographic evidence to help monitor and review how the wound was progressing with treatment. Effective monitoring systems to evaluate and ensure the person's health and well-being was maintained, in relation to any wounds, were in place.

Good

Is the service caring?

Our findings

People and their relatives spoke positively about the kindness and caring approach of the staff. They told us they were happy with the care and support provided in the service. People commented, "That one over there, she gives me my tablets, she's ever so nice," " Everyone's nice to me here," " I am happy here yes," " No complaints its good," and " Look how they all laugh and smile here." One member of staff told us, " I have been in this game a long time and there is a nice atmosphere here and the staff are approachable and knowledgeable." People were seen to be comfortable with staff and frequently engaged in friendly conversation. A compliment received in the service detailed, 'We are happy she was able to stay with you until the end, cared for in a familiar environment by people who know and cared for her.'

We saw that positive caring relationships had developed between people and staff. Observations showed that staff were very kind and caring in their relationships with the people they supported. Everyone in the service had their own key worker, which is a member of the care staff who took a special interest in their care needs, for example to make sure their room was tidy and that any shopping needs were identified and fulfilled. When staff were around people there was a calm and supportive atmosphere. People were treated in a kind and compassionate way. Interactions between staff and people were observed to be positive and respectful. "Is that sun on you a bit too much there (Person's name), would you like me to close the curtains?" Another member of staff said to another person, "Your arm looks a bit uncomfortable there (Person's name) shall I support it a bit with this cushion?" One person was heard to say to a member of staff, "Who are you?" The member of staff communicated, smiled and said "I'm (Staff member's name) and I'm here to help you. Would you like some help with your tea". Staff responded to people politely, giving people time to respond and asking what they wanted to do and giving choices. We heard staff patiently explaining options to people and taking time to answer their questions. Staff were attentive and listened to people, and there was a close and supportive relationship between them. Throughout the day we observed staff checking on people and noticing when someone's comfort may need attending to. One person told us, "I asked for some more blankets on my bed as I was a bit cold and they did it without any fuss. You only have to ask them really." Another person wanted to go outside for a cigarette and was asked if they needed a blanket to keep them warm. Another person told us, " I sometimes fancy a banana and I just mention it and they chop it up for me."

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to. Care provided was personal and met people's individual needs. People were addressed according to their preference and this was mostly their first name. Staff spoke about the people they supported fondly and with interest. People's personal histories were recorded in their care files to help staff gain an understanding of the personal life histories of people and how it influenced them today. Care staff demonstrated they were knowledgeable about people's likes and, dislikes. People and staff shared non-task conversations about family life, children, pets and staff knew people well. One person had been an architect "Are you checking that's all lined up properly (Person's name)?" said one carer to a person busily checking the structure of the tables. The person smiled and nodded happily going about their work. We observed that people who were capable were able to walk around the building freely and without restriction. One person used the lift regularly to visit various parts of the building to walk independently.

People and their visitors told us care staff ensured their privacy and dignity was considered when personal care was provided. They told us that staff always knocked before going into their room. We observed staff knocking on people's doors and waiting before entering. One member of staff told us, "We respect their privacy, for example some don't want male staff for personal care." People were supported to maintain their personal appearance. On the day of the inspection people were seen to be dressed appropriately in clean clothes. One person told us, " I decided I wanted pink today so I chose my pink blouse to put on, they just helped me get it on." Another person told us, "I have my hair done on a Wednesday, they do my nails for me and my toenails get seen to. It's very good here, they do it all for you."

Observations through the day were of many kind and careful care interactions by care staff, good skills in assistance to eat, allowances for communication difficulties and explanations given. Routine service of drinks was accompanied by acknowledgement and conversation. The atmosphere in the service was calm and relaxed, but there was also a general hum of activity.

People had their own bedroom and ensuite facility for comfort and privacy. They had been able to bring in small items from home to make their stay more comfortable such as small pictures. People had been supported to keep in contact with their family and friends, and told us there was flexible visiting. Visitors said they were always welcomed and this was evident during the inspection visit when staff were observed chatting to visitors and offering them cups of tea. People were able to use the public phones sited in the service and there was internet access provided. Where people needed support when making decisions about their care and did not have family support, a representative from an advocacy service had been requested. Senior staff were able to confirm they knew how to support people and had information on how to access an advocacy service should people require this service.

Care records were stored securely. The electronic care plans were password protected. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all staff. Staff demonstrated they were aware of the importance of protecting people's private information.

Requires Improvement

Is the service responsive?

Our findings

People were asked for their views about the service. Relatives told us they felt included and listened to, heard and respected, and also confirmed they or their family were involved in the review of their care and support. People told us they enjoyed the activities provided. One person told us," I'm a bit of a loner, always have been so I like to stay in my bed sometimes, its comfy and quiet." Another person told us, " Singing is my favourite." Staff told us of the work completed to develop the range of activities people could access. However, despite these positive comments people's access to activities provided in need of improvement.

People spoke well of the activities provided. One person told us," I played snap with someone the other day it was great fun." Another person told us, "They put the football on the telly for me last night. I think England won." A third person said," We had a party at Moulsecombe Hall and they took us up there." A further person said " I love the shows they put on." Staff told us activities were provided seven days a week. One member of staff told us, "They have two activities every day and the coordinators do individual activities." Another member of staff told us, "We do activities if there's time like doing their nails or going into the garden if it's safe." Activites had included a vintage tea, music therapy, bingo , cheese and wine, decoupage, colouring sheets and rummage boxes. A vintage trolly had been made and was used as a sweet trolley which was taken around the service each Saturday. External entertainers had also visited the service providing musical entertainment, or with visiting animals. A cinema area had been built and staff told us a cinema experience was regularly facilitated. We observed an activities coordinator working with a small group of residents doing flower arrangements. The activity coordinator also asked people if they wanted to come and do an activity in the garden. Staff were observed during the inspection to provide reassurance both verbally and by offering a guiding hand to assist where required and asking where people wanted to go and what they wanted to do. One member of staff spoke with one person, "Do you want to hold my hand, are we going down there? I can put a musical on for you if you like. Which one do you fancy?" The person chose the Sound of Music which was then put on the large screen in the theatre area. This then led to conversations with people about the film and the songs played. However, care staff told us they didn't have time to engage in meaningful activities with people. One member of staff told us, "The majority of the time we get through the work but would like to spend more time with the resident, need one to one time. "Although there were a range of activities being provided in the service there were still significant number of people who were not occupied in a meaningful activity during the inspection. This is an area of practice in need of improvement.

People received a comprehensive assessment undertaken before someone moved into the service. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. If they felt they did not have enough information to make a decision they requested further information. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met in the service. Records we looked at confirmed this. Electronic care plan documentation had been introduced into the service. Staff had received training in how to use the new system and there was ongoing monitoring to ensure the quality of the detail recorded. The care and support plans were detailed and contained clear instructions about the needs of the individual. They included information about the needs of each person for example, their communication, nutrition, and mobility. Individual risk assessments including falls, nutrition, pressure area care and manual

handling had been completed. There were instructions for care staff on how to provide support that was tailored and specific to the needs of each person. For example for one person it was recorded, ' Staff should assess (Person's name) mood before attempting to give care, try sensitively and if aggressive leave until later.' Where possible people were supported to be independent and make choices. One member of staff told us, "We ask them if they want to do things for themselves such as do their hair, clean teeth and follow the care plan looking for improvements." Care plans detailed the care people liked to undertake themselves and where they needed support. Where possible there was information on people's life history. One member of staff told us, "It's about knowing your residents and what their lives were like before dementia. We are friendly with their families and look at the care plans and the history page, their likes and dislikes. They are sometimes lucid and we have a conversation and get a bond with them. We tell them about us and can connect with them, for example (Person's name) is an artist and I am a dancer and we can relate with similar interests." A nominated RGN had been allocated for each person to ensure care plans were reviewed and updated. One senior member of staff told us they checked staff were, "Doing it properly and will check what they write on daily records and if they need help they let me know." A relative told us, " They're very good at contacting me and the care plan gets changed as (Person's name) changes but we do get together routinely for a meeting with the nurse to have a proper meeting." The care plans had been reviewed and audits were being completed to monitor the quality of the completed care and support plans. Care staff told us the care plans gave them the information they needed to support people. Where appropriate, specialist advice and support had been sought and this advice was included in care plans. For example, records confirmed that advice and support had been sought from the speech and language team (SALT). During our discussions with staff we found that they knew people and their individual needs and it was evident that they knew them well. People and their representatives were able to comment on the care provided through regular reviews of people's care and support plans.

Staff told us that communication throughout the service was usually good and included comprehensive handovers at the beginning of each shift between health and social care staff and regular staff meetings which they used to update themselves on the care and support to be provided. Senior staff used handover notes between shifts which gave them up-to-date information on people's care needs. There was a shift plan in place which described tasks that needed to be undertaken either 'am' or' pm' and also recorded the staff member allocated to complete each task.

People and their representatives were able to comment on the care provided through reviews of people's care and support plans, and by completing quality assurance questionnaires. There were also residents and relatives meetings.

People told us they felt it was an environment where they could raise any concerns. People generally felt that if they had any complaints they would tell a member of staff. One person told us, "I'd go to one of the carers." Another person told us, "I'd go straight to the top man." We looked at how people's concerns, comments and complaints were encouraged and responded to. People were made aware of the complaints, suggestions and feedback system which detailed how staff would deal with any complaints and the timescales for a response. It also gave details of external agencies that people could complain to. This information was contained within the service user's guide which was available in people's bedrooms. No one we spoke with had raised any concerns. People and their visitors told us they felt listened to and that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. Where any concerns had been raised these had been recorded and responded to appropriately. In addition to the compliments and complaints procedure, the registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors were able to raise any issues or concerns.

Good

Is the service well-led?

Our findings

People, relatives and staff all told us that they were happy with the care and support provided at the service and the way it was managed and found the management team approachable and professional. People looked happy and relaxed throughout our time in the service. People and their relatives were asked for their views about the service. One person told us, " I think the manager is good and I know he makes sure I'm alright" Another person told us, "(The manager's name) is very approachable I'd say and I feel confident he would act upon anything I'd say to him. "A member of staff told us, "The teamwork here is great and we constantly getting advice and help there is teamwork, the RGNs know their staff and the chain of command is clear, each carer has a chain and a mentor." Another member of staff told us, "Can't fault the management they are good at listening." A third member of staff said, "Management is pretty good but they need to sort out staffing. I'm confident to go to the managers."

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager/clinical lead, and a team of registered nurses. Head of department meetings where held every Monday, to discuss the working of the service. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff were able to comment on the standard of care provided and influence the care provided. Staff members told us they felt the service was well led and that they were well supported at work. They told us the managers were approachable, knew the service well and would act on any issues raised with them. One member of staff told us, "Relating it to other homes I've worked the deputy manager is doing managing and nursing and they very rarely do this and I respect him for this. The manager helps us with suppers and if we are down he will give us a hand. I feel I could talk about everything with them and any concerns." Another member of staff told us, "This is a good home it's clean and approachable, they are knowledgeable and put in the effort working towards the greater good and the residents are happy." A third member of staff said, "The manager is approachable and wouldn't ask you to do anything he wouldn't do themselves; there is no separation of management and staff."

Policies and procedures were in place for staff to follow. Staff supervision and staff meetings had provided the opportunity to both discuss problems arising within the service, as well as to reflect on any incidents. Staff meetings were held throughout the year. Staff told us they felt they had the opportunity if they wanted to comment on and put forward ideas on how to develop the service.

Care plans are accessed by senior staff daily to check that all care had been carried out. Senior staff carried out a range of internal audits, including care planning, checks that people were receiving the care they needed, medication, and infection control. They were able to show us that following the audits any areas identified for improvement had been collated into an action plan, work completed to address any shortfalls and how and when these had been addressed. Additionally an external group had been commissioned to carry out audits in health and safety housekeeping, infection control, maintenance, recruitment and medicines. There was a system in place for recording accidents and incidents. We reviewed a sample of these and found recordings included the nature of the incident or accident, details of what happened and any injuries sustained. The deputy manager reviewed these and monitored or analysed incidents and

accidents to look for any emerging trends. Managers were able to access collated data from the electronic care system such as for accidents/falls.. One senior member of staff told us, "We can look at trends such as a falls analysis with time, place, frequency, whether they were wearing shoes. We can summarise the information and e mail it as an attachment."

The visiting health and social care professionals told us staff have worked well with them, and ensured the correct information was available when they visited, or undertook a review. Staff were helpful, approachable and available to discuss people's care needs, whilst also ensuring people in their care were safe. The organisation's mission statement was incorporated in to the recruitment and induction of any new staff. The mission statement was detailed in the service user's guide for people, visitors and staff to read. The aim of staff working in the service was, "To deliver high quality nursing and residential care that enables service users to maximise their independence and feel supported in the decisions they want to make." Staff demonstrated an understanding of the purpose of the service, with the promotion and support to develop people's life skills, the importance of people's rights, respect, and diversity and understood the importance of respecting people's privacy and dignity.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). Senior staff had submitted notifications to us, in a timely manner, about any events or incidents they were required by law to tell us about. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. The registered manager was able to attend regular management meeting with other registered managers of the provider's services. This was an opportunity to discuss changes to be implemented and share practice issues and discuss improvements within the service.