Foxholes Nursing Home Limited

Foxholes Care Home

Inspection report

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Date of inspection visit:
08 June 2016

Date of publication:
01 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 8 June 2016 and was unannounced.

Foxholes Care Home provides accommodation and personal care for up to 110 older people some of whom live with dementia. At the time of the inspection there were 50 people living at the home. Following our previous inspection of the service in December 2015 we imposed a condition on the provider's registration to prevent them from admitting any further people to Foxholes Care Home because of the concerns found.

There was a manager in post, who had submitted their application to register, however they were not yet registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

When we last inspected the service on 15 October 2015 and 4 December 2015 we found it was not meeting the required standards. We found breaches of the Regulations in relation to safe care and treatment, staffing, consent and good governance. At this inspection we found that the provider had made some improvements, however the governance around auditing and identifying and responding to concerns was still not robust enough and further improvements were still required.

Staff obtained people's consent before providing the day to day care they required. We found that processes to establish if people had lacked capacity for certain decisions were followed in line with the MCA 2005 and where necessary best interest meetings were organised to develop an effective plan of care for people. The manager had submitted Deprivation of Liberty Safeguards (DoLS) applications to the relevant authorities to ensure any restrictions applied to people`s freedom were in line with the current legislation. Some of these applications were still pending an outcome.

People were accommodated in a purpose built environment which was clean and well maintained. Bedrooms were personalised and had en-suite facilities whilst still providing specialist bathroom facilities, several communal areas, dining rooms, an orangery room, a shop, hairdresser room, quiet lounges. People were able to choose where they wanted to spend their time.

At the last inspection we found that people were not always protected from harm, two people developed pressure ulcers whilst they were living at the home. At this inspection we found that staff were knowledgeable about people`s needs and any risks of them developing pressure ulcers. People who required were repositioned regularly and staff followed recommendations from health care professionals when offering care.

Previously when we inspected people told us that they felt their needs were not met safely at all times. They had to wait to use the toilet at times as staff took a long time to answer call bells. This time people told us

staff were quick in responding to their needs and call bells were answered in time.

Staff received training and were knowledgeable in how to safeguard people from any risks of abuse. They were able to describe what constitutes abuse and the reporting procedure they would follow to raise their concerns.

When we inspected previously we found that people had not received their medicines according to the prescriber`s instructions, medicines were not managed safely. At this inspection the provider had made significant improvements. People`s medicines were administered by trained staff who had a good understanding of safe medicine management practices. People told us they were seen by their GP regularly and staff were prompt in requesting a GP visit if they were in need. Previously we were told by some people that they could only see their GP if staff agreed with them they needed it.

The provider was monitoring people`s dependency levels and on the day of the inspection we saw senior staff re-deploying care staff to different units where there was a need for extra staff members.

At the last inspection people told us they were concerned about staff leaving the service and the high number of newly employed staff members who had not had the skills, experience and abilities to meet their needs at all times. At this inspection we found that the staff team has stabilized and staff had received training relevant to their roles. Staff had regular supervisions to discuss and review their performance and professional development.

People told us that the standard of food provided at the home was good. We saw that the meals served were hot and that people were regularly offered a choice of drinks. Staff monitored food and fluid intake for people who were at risk of losing weight and involved people`s GP and dieticians in their care to ensure people`s nutritional needs were met. People told us staff were kind and respectful in their approach. We observed staff were knowledgeable about people`s circumstances and the conversations we heard between staff and people suggested they knew each other well.

At the last inspection people expressed mixed views about the opportunities available to pursue their social interests or take part in meaningful activities relevant to their individual needs. People told us this very much improved and they were offered various activities and outings they were satisfied with.

The provider recorded and responded to complaints in timely manner and where appropriate, lessons were learned and shared to staff to promote improvements to the service.

Staff were complimentary about the leadership of the home and they felt well supported in their role. They praised the commitment shown by the provider to improve the service and the attitude and availability of the newly employed manager.

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.

Staff were able to tell us how they were safeguarding people form abuse. They were knowledgeable about reporting under the whistleblowing procedure to local authorities or the Care Quality Commission.

Risk to people`s health and wellbeing was identified and measures were in place to mitigate these.

People felt there was enough staff to meet their needs at all times.

People`s medicines were managed safely by staff who had been trained and had their competencies monitored by the provider.

Is the service effective?

Good

People felt staff were skilled and knowledgeable enough to meet their needs effectively.

People were asked to consent before staff delivered care.

People who lacked capacity to consent had best interest decisions made in their favour following a best interest process.

People were provided with a varied menu and encouraged to have a healthy balanced diet. GP and Dietician's involvement was requested by staff if people had been identified as losing weight.

Staff received regular supervision and training. They felt supported in their role by the provider and the newly employed manager.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

People had developed trusting relationships with staff who had a good understanding of their needs and circumstances.

People or their rightful representatives were involved in planning their care and support.

People's dignity and privacy was promoted.

Is the service responsive?

Good

The service was responsive.

People were provided with a range of activities which enabled them to pursue their hobbies and interests.

People had their needs met by staff who knew their likes, dislikes and their preferences regarding the support they required.

People told us they were able to raise their concerns and complaints and these were investigated and responded by the provider or the manager.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems used to quality assure the service, manage risks and drive improvement were not sufficiently developed to make sure that potential risks and issues were always identified and acted on promptly and appropriately.

People were aware of the management arrangements at the home and felt that the service improved a lot in the last six months.

Staff told us they understood their roles and responsibilities and had confidence in taking matters to the provider and the manager.

The provider had submitted notifications to the Care Quality Commission for incidents as they are required to.

Foxholes 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 was planned to check whether the provider made the necessary improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012.

The inspection was carried out on the 8 June 2016 and was unannounced. The inspection team consisted of two inspectors, a nurse specialist advisor and an expert by experience. The specialist advisor had the experience in nursing and healthcare, elderly and within the field of palliative care. The expert by experience is a person who has personal experience of having used a similar service or who has cared for someone who has used this type of care service.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with eight people who lived at the home, four relatives; six care staff; one domestic assistant; one engagement assistant and three team leaders. We also talked to the housekeeper manager; catering manager; the provider and the manager. We looked at care records relating to seven people and other records relating to the management of the home.

Good

Is the service safe?

Our findings

At our last inspection we found that the service was not always safe, the provider had failed to ensure there were sufficient numbers of staff to meet people`s needs safely at all times. At this inspection we found that improvements had been made in how staff were deployed.

People told us they felt safe living in Foxholes care home and staff were quick in responding to their needs when they asked or rang for assistance. One person told us, "If I ring the bell to get up in the morning, they [staff] are prompt in coming." Another person told us, "I am much safer here than I was at home. Staff are very good in knowing what I need and how to keep me safe."

We observed people had their call bells at hand if they were in their bedrooms. People who were independently mobile had been given a pendant alarm to wear around their neck to be able to call assistance from any part of the home. One person told us, "Whenever I need help in the corridor I can press my personal alarm and the staff are very good and they come within a few minutes."

On the day of the inspection there were sufficient numbers of staff on duty to meet people`s needs. Staff told us there were enough staff to support people adequately. One staff member told us, "When we had the nursing unit we had a lot of agency nurses working here and we went through a difficult time because we could not always rely on them. Since we have closed the nursing unit and stopped using nurses it is much better. We do not use agency. We use a pool of staff who cover shortages and some of us do extra shifts to cover the home when required." We observed the staff supporting people and undertaking their duties at a relaxed pace and in a coordinated manner.

Staff were able to tell us about their responsibilities to safeguard people from abuse and avoidable harm. Staff knew the signs and indicators that could suggest abuse and how to raise any concerns that they may have. One staff member said, "We [staff] respect the people here, these things that you hear on TV does not happen here. We report to managers and the provider. We can also call local authorities and CQC if we have any concerns about people here." Information about safeguarding procedures and contact details for relevant safeguarding authorities were visibly displayed around the home, however we noted that some of these were out of date.

At the previous inspection we found that people were not always safe because risks to their health and well-being had not been managed effectively and they developed pressure ulcers as a result.

At this inspection we found that people who were identified at risk of developing pressure ulcers were well supported by staff who were knowledgeable in what each person needed to prevent pressure ulcers developing. People who required assistance to turn in bed regularly or needed special equipment were supported by staff effectively. Regular checks of people`s skin condition were undertaken and monitored. Air mattresses were in place for people who required them and the pressure in these mattresses was monitored regularly to ensure the settings were correct. The care plans showed that staff requested involvement of other professionals every time they needed professional advice in how to mitigate the risk of

people developing pressure ulcers.

Risks associated with people`s daily living were recognised and risk assessments were in place with clear instructions and guidance for staff how to mitigate these risks. For example, people who required the use of bed rails to prevent them falling out of bed, these were used appropriately, with consent from people or their relevant representative and risk assessments were in place. The staff demonstrated their knowledge of checking for potential risks of people having limbs trapped in the bedrails.

One person had been identified of high risk of falling by the assessments carried out by staff. We found that there was an appropriate level of observations carried out by staff balancing risks to the person with preserving their dignity, liberty and independence. The care-plans gave consideration for the person`s safety balanced with privacy and dignity and had input from a number of professionals like district nurses, GP and physiotherapist. There was a low profiling bed with a crash mattress used by staff to prevent injuries to the person if they had a fall. There were regular reviews of the care plans and meetings to learn lessons from past incidents. One staff member told us, "We have managed to bring the problem under control, but we are still learning from every incident."

Incidents and accidents that occurred were reported to the manager and provider when they happened. The provider told us that the reporting of these had increased significantly since the last inspection, and a review of records confirmed this.

Staff we spoke with were extremely knowledgeable about people`s needs in relation to their mobility and risk of falls. A team leader we spoke with told us about a person being at high risk of falls, their condition and how this affected their mobility, how they needed to observe the person more intensively depending on the type of day they were having, and how they supported the person with their mobility. We observed when on the unit, that staff were attentive, responsive and maintained an awareness of the persons whereabouts at all times. Staff told us and we saw in the care plan that staff requested visits from the GP several times, who had reviewed the person`s medication and mobility. This meant that the risk of falls for this person was mitigated by staff being knowledgeable and aware of their needs.

At previous inspection we found that staff were not following safe medicine management practices. People had not always received their medicines as intended by the prescriber.

At this inspection we found that practices improved significantly. Safe administration of medicines was followed by staff and they had a very good knowledge about peoples` medicines they handled. People had their medicines administered by team leaders. Three team leaders told us they had medicines training, followed by a competency test and shadowing by experienced and competent practitioner before they were allowed to administer people`s medicines independently.

Medicine Administration Records (MAR) were all signed appropriately and there were no unexplained gaps. Staff recorded on the back of the MAR`s in case people refused or had not had their medicines for whatever reason. The team leaders we observed administering medicines to people took time to carefully read through the instructions and the medicine packs and MAR`s. They explained to people what medicines they were administering before handing the medicines to them.

People had been encouraged to administer their own medicines if they were able to. For example one person had been administering their own medicines and staff supported them to remain independent for as long as possible. Staff ordered the monthly medicines for the person however they provided a lockable bedside cabinet where the person locked their medicines and took them when they needed it. Staff

regularly checked with the person if they took their medicines and if they required any assistance from them.

Where people had allergies this was clearly recorded on the MAR`s. After each medicine round the team leaders carried out an audit to ensure the medicines were correctly administered and people received their medicines as intended by the prescriber. One staff member told us, "The audit we do is a new measure introduced to ensure that the residents never run short of medicines and they receive the medicines as they should. Since we are doing this we have had no problems."

Good

Is the service effective?

Our findings

At the last inspection we found that people`s consent to care was not always sought and decisions made on behalf of people had not always been made following a best interest process. During this inspection we found that suitable arrangements were in place to ensure that people's consent to care and treatment was obtained in all cases. We also found that the requirements of the Mental Capacity Act 2005 (MCA) were followed.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had submitted deprivation of liberty applications to the local authorities for people who had limitations of their freedom in place to keep them safe. Some authorisations were approved some were still waiting for approval; however staff and the manager ensured that these limitations were as least restrictive as possible.

All the staff we spoke with told us that the manager and provider gave them support and the training necessary to do their job effectively and further their careers. They told us the manager and the provider often reminded them of the importance of undertaking training relevant to their job role. Comments from staff regarding the training provided for them included, "The company is very hot on training", "In the last two years I have moved from a carer to a team leader, thanks to the training that I have had, my team leader and the manager have supported me to do my training. I have done my NVQ level 3 and diploma in dementia care".

Staff told us that they received supervision and were given feedback from senior staff. All staff said that they felt supported by the management of the home. Newly employed staff told us that they had an induction when they started at the service which included working alongside experienced staff as well as attending training courses. One staff member told us, "During induction I had training, then I have been shadowing a more experienced staff, then the registered manager checked on my training and knowledge and the director really encouraged me." All the staff we spoke with had demonstrated good knowledge about people`s needs and about the training they received. For example, in areas like pressure care and record keeping. This was an area which improved since we last inspected the service.

People spoke positively about the food saying it was good and there was a good choice. One person said, "The food is very good, we have plenty of choices. Snacks are offered as well, but we get so much food, we really don't need snacks." There was a copy of the menu displayed in a number of areas of the home. We observed that drinks were available and were being offered to people throughout the day of the inspection.

The home also had a bistro that people visited for refreshments.

The chef was offering fortified food for people who were identified losing weight or having low food and fluid intake. Mealtimes were relaxed; tables were set with the appropriate cutlery, crockery and table cloths. People were encouraged to sit at the tables and enjoy their meal. There were staff at hand to observe, assist people with their meals if they needed it.

Some people were assisted by staff to eat their meals in their bedrooms. We observed a staff member supporting a person. They showed patience and calm whilst giving assistance to the person. They took their time and explained about the food and offered a lot of encouragement for the person. As a result the person finished their meals and drank well.

We observed people eating their meals in the dining area. Some people walked away and came back to their chair during meal times. Staff were being observant; however they did not try to restrict their movement. People were encouraged to finish their meal, however if they walked away staff put plates with finger foods out and we saw people eating whilst they had a walk. This meant that staff recognized the different needs people had and they promoted a good food and fluid intake by adapting their approach to people`s needs. One person said that they did not like the food they chose from the menu and would prefer something else; the staff duly obliged to the satisfaction of the person.

Staff were monitoring people`s nutritional intake. People were weighed regularly and where a weight loss was identified staff involved the person`s GP and a dietician to ensure they had specialist advise in meeting people`s nutritional needs. This was an area which improved since we last inspected the service.

People received visits from a GP who visited the home twice a week. One person told us, "They [staff] are ever so good. They will ask the doctor to come and see me if I am not well. They worry more than I do." We saw that staff involved health care professionals in people`s care if their needs changed. For example a person had problems with their teeth. Staff arranged for the dentist to visit. People whose mobility needs changed had involvement from a physiotherapist and an occupational health therapist. This meant that staff had sufficient knowledge about people`s needs and when these changed they were able to promptly ask for professional input to prevent people`s health declining.

Good

Is the service caring?

Our findings

People and relatives praised the staff at the home. They told us that staff were kind, caring and had a respectful approach towards them. One person said, "Staff is very kind and always respectful." Another person said, "Staff here is lovely. They are really nice and help me a lot."

People told us staff understood their needs and they were treated with respect and dignity. One person told us, "Everyone treats you with respect." Another person said, "The staff are good and respectful of my dignity." One visiting relative told us, "The staff treat [person] with respect and dignity. [Person] is always clean and fresh whenever I visit here and they come in to give them sips of drink, change and reposition them."

We observed staff interacted and responded to people in a positive manner and spent time with them doing activities they enjoyed. Staff were calm and got close to people when talking to them. Where needed staff would repeat information over again until the person understood what was being said.

Staff knocked on bedroom doors and asked whether they could enter. They closed doors behind them when giving people personal care. Staff spoke to people appropriately and respected their choice of what they wanted to do each time and how they wanted it done. For example, we saw staff asking people how they would like their food or what activity they would like to do. One person told us, "Staff are very good here they ask you when you want your bath, is the water ok, what type of clothes would you like to wear, and they show a lot of patience. I have a lot of respect for them because they show me respect. I look forward for them coming to my room." Another person told us "One of the staff brings me a cup of hot chocolate in the morning because she knows I like it." This demonstrated that staff knew people`s likes and dislikes and they offered care and support to people in a caring and respectful way. One staff member told us, "I know the residents I am working with because I talk to then all the time and I take an interest particularly with the ones I am key worker to. This is to ensure that they get the best care. I believe that I have developed a good relationship with them because every time I come in the room there is a big smile on their face. And I also have my picture in front of their care plan."

Staff had a good understanding of end of life care. We observed staff supporting and caring for a person who were nearing the end of their life. Staff approached the person in a caring and compassionate way, they attended to the person`s personal hygiene needs regularly and made them comfortable. They involved the person in decisions about their care and took account of the person`s wishes. For example they discussed with the person and their family the need to use a special mattress to prevent the person`s skin from breaking down. However the person preferred a soft mattress opposed to an air mattress because they could not sleep on it. After consultation with the GP, the district nurse and the palliative care nurse the soft mattress was put in place and staff repositioned the person regularly to prevent pressure sores from developing. One relative told us, "This is the best place my [person] could be. They receive the best care."

We observed staff were regularly communicating with the person, they encouraged fluids and checked that the person was not in pain. One staff told us that end of life care means, "Giving all the care that they [people

nearing the end of their life] and making sure they are comfortable and not in pain, most important show them respect and dignity". They continued, "Make sure that they have food and fluids, they are able to breathe without pain, making sure they are repositioned regularly so that they don't develop pressure sores and make sure they are not isolated".

At the last inspection we found that people who had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) directive in place were not always involved in the decision making process, neither their rightful representative.

At this inspection we found that people or their rightful representatives were involved in taking decisions regarding their care and treatment including DNACPR`s. For example in one of the records we checked we saw a DNACPR for a person which showed involvement of the person, relatives and a health care professional. The form was signed by all parties and had review dates recorded when this decision was re-discussed with the person to ensure they did not changed their mind.

Good

Is the service responsive?

Our findings

People`s care plans were detailed, up to date and provided good information for staff about how to meet their needs, such as maintaining safety, personal care, eating and drinking. There was personal information about people's preferences, dislikes and preferred routines detailed enough for staff to know how to offer care and support for people in a personalised way. One person told us, "I spend most of my time in my room because I have plenty to do. I like reading books and magazines and watch nature programmes and the news on TV. I have a lot of visitors and this keeps me busy. The staff comes in to check on me and have a chat and bring me hot drinks and snacks. I get the daily newspaper. I am happy as you [inspector] can see." The person showed us that they were doing crosswords and had their call bells nearby. They had a number of magazines and the TV in front of them with the remote control at hand. They had a jug of water on their table with a basket of fruits.

There were a range of varied activities provided by the engagement staff and care staff. This offered a lot of choice to people who enjoyed group activities or individual activities. The home also provided activities for those who enjoyed their own company and who were restricted to their room because of poor mobility. One person told us, "There is a church service here every week. The priest comes here and is quite happy to visit us individually if given enough notice." We saw that the engagement staff contracted outside entertainers who regularly offered an entertainment programme for people. There were sing along, table tennis for more able people, movie nights, exercise sessions, Scrabble and other activities people could choose from. Church service was organised weekly by the engagement staff. They recognised the need to have diversity in leaders from different religions visit people who had different religious beliefs. This was advertised visibly around the home and people could attend the religious service of their choice.

Every person had individualised care plan with respect to their personal preferences. They were allocated a key worker. One of the team leaders we spoke with told us, "Each service user is allocated a key worker who spends time with them to get to know them well. The team leader writes the care plan with the help of the service user, the relative and key worker. The team leader, key worker and the service user all sign the care-plan." We saw that a copy of the care plan was given to people and was kept by them in their room. People and their relatives if appropriate were involved in creating their own care-plan which was written in people`s own words. One person told us, "Of course I know I have a care plan. Staff discussed it with me several times." We found that care plans were regularly reviewed to reflect people`s changing needs. This was an area which improved since our last inspection.

People and relatives told us they were consulted and updated about the service provided and were encouraged to provide feedback about how the home operated. They felt listened to and told us that the manager and the provider responded to any complaints or concerns they raised promptly. We saw complaints were logged and responded to appropriately.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection on 04 December 2015 people and relatives told us they had no confidence in the management team, they felt that their concerns were not taken seriously by the manager or dealt with appropriately. The manager had left the service after the inspection and the provider recently recruited a new manager, who had begun working at Foxholes Care Home in March 2016. At the time of the inspection the manager in post was not yet registered, however they had submitted their application to the Care Quality Commission to do so.

Since our inspection the provider had reviewed their service and made the decision to no longer provide nursing care at Foxholes Care Home. At the time of our inspection on 08 June 2016 they had applied to the Care Quality Commission to have this part of their registration removed. People with nursing needs were re-assessed and moved to more suitable services.

At our previous inspection on 04 December 2015 we found that a lack of oversight from management had adversely impacted on the monitoring of the service for safety and quality. During this inspection on 08 June 2016 we found the provider and manager had taken actions to make some improvements, however further improvements were still required.

The Provider and manager had implemented a daily system of reporting that they reviewed weekly to enable them to monitor each unit on a weekly basis. These daily reports then formed part of the monthly review for each unit completed by the unit managers. These were reports that audited areas such as people's health, staffing levels, professional visits for the month, activities, and call bell response times. However, these checks did not seek to evaluate or effectively mitigate the risks to people living on each unit. For example, when reviewing resident's health, the report provided a commentary on how that person had been, but did not review staff actions where issues were identified.

We found that incidents were not always thoroughly investigated and did not always trigger a review of a person's care. For example, we saw one person had sustained eight falls resulting in minor injury such as skin tears or bruising within a four week period. Following three falls the person had in one day the manager instructed staff to place the person on 30 minute observations. We found that this had not happened until 16 days later. We asked the manager why this was and they told us, "[Person] should have been, the records must be in the records because I told them [staff] to do it." However when we looked at the records for that period there were none in the folder. We confirmed with the manager these had not taken place. The monthly manager`s report identified the high number of falls, however the report gave no details to say if any referrals were made to specialist services, that the mobility risk assessment were reviewed, or if any other appropriate actions were taken.

The provider told us at the last inspection that they would ensure they analysed data available to monitor areas such as the length of the call bell response times and incidents. In relation to call bell analysis, the reviewer had not effectively considered the causes of delays. For example, they had not used the information to consider whether staffing levels were sufficient or other issues which may have been

contributing to the length of response times. The provider told us that due to the size of the building, it was not always feasible to respond to a call bell within a minute or two and they set a target of an average of six minutes however they agreed to review this policy to ensure people who were calling for assistance received support in a timely way. The provider also told us they had identified incidences where staff attended to people but did not turn the bell off when assisting them. However, because they had not evaluated the information effectively, there was no evidence to support this. People we spoke with told us they had their call bells answered promptly by staff. Following our inspection on the 8 June 2016 the provider had increased staffing levels for the times of the day when these increased response times were identified.

We reviewed the policies for the home that provided the framework for staff to follow when providing care to people and responding to risk. These were in place, however many were out of date and referred to out of date legislation. The manager had sent us a sample of an admission policy prior to the inspection, and they were at that time informed by us that the regulation referred to in their policy was incorrect, however when reviewing this on the day of the inspection we found they had not made the required changes. They told us they had taken the policies from a previous organisation they worked for. This meant that the policies for Foxholes Care Home were not developed specifically for the needs of the service and may have not followed the specific reporting requirements the provider had. They told us they were continually reviewing the policies for the home and would update these accordingly. However we found that the manager and provider were not fully aware of the current CQC methodology and new regulations which was an area that required improvement to ensure they were providing care that met current regulations and good practise guidelines. This was an area which required improvement.

People, staff and relatives we spoke with were positive about the new manager. They told us they felt comfortable approaching them to report concerns, or discuss issues relating to the running of the home. One person told us, "I know the new manager. They told me their door is always open if I need anything." One staff member said, "What I like about the manager is that they really care for staff and people. We are encouraged and we have confidence to report everything." Another staff member said, "The new manager made a big difference, they are very supportive."

Staff told us they felt supported and valued by the provider and the manager. They appreciated that both the provider and the manager were visible on the floor and talked to them as well as people. One staff member said, "The director comes here every day and walks around and talks to the staff. She encourages staff to do training. The director looks at the care-plans and asks staff about how things could be improved. She talks to the residents." Another staff member told us, "The manager provides you with the tools and training that you require. They support you by providing you with both time and equipment to do the training. Here, going up the ladder does not depend on your colour, race, religion, sex or how tall you are. There are equal opportunities for all." They told us that the manager and the provider were supportive towards staff who part of their religion were fasting. Staff gave us examples where the manager had changed their shift pattern temporarily to enable them to keep to their religious celebrations. This meant that the manager and the provider were respectful of staff's cultural and spiritual needs.

The provider and manager had developed a service improvement plan following on from reviews by CQC and the local authority. This identified areas such as management of medicines, training, complaints, completion of supervisions, monitoring of call bells and response times, incidents and accidents and staffing levels as areas to improve. We found that some areas of the action plan had been completed such as ensuring staff received appropriate supervision, medicines were managed safely and complaints were properly investigated and responded to. The provider entirely reviewed the arrangements for managing medicines and implemented a new system of recording and auditing. At this inspection we found this system was robust and ensured people received their medicines safely and when required. The governance

system implemented meant reviews effectively identified and mitigated any risks or errors found.

At the time of the inspection the provider had purchased a new home management software system. This system was currently being used by the manager, however had only been installed very recently. The system enabled the provider to replace the existing paper audits which were in place, with a complete care planning and risk management system that was designed to allow staff and management to develop care plans, alert staff when reviews were due, compile dependency assessments based upon risk assessments of people's needs, and give a full overview of the governance systems within the home. We were unable to review the assessments from this system during the inspection, however the provider told us they would send us the first complete set of findings and resulting action plans at the end of June. It was expected that this system would remove the ambivalence and lack of consistency when monitoring the quality of care provided.

At our previous inspection notifications required to be submitted to the Care Quality Commission of events or incidents had not been made. At this inspection we found improvements had been made and notifications had been submitted where required. The manager had developed a complete business continuity plan that instructed staff what action to take in the event of an emergency, such as power failure, fire, and infection etc.

The provider had recently conducted a satisfaction survey that was completed by an independent organisation. This provided them with an unbiased and independent assessment of the quality of service they provided, and also a completed action plan for them to implement. The responses to the survey were positive from people who said they felt safe, were supported by staff they felt were sufficiently trained, and that they could raise concerns and felt staff listened to them. The manager and provider had held regular team meetings with staff, relatives and people, where issues relating to the management and quality of service provided were discussed. We saw that particularly relevant were the discussions held around the previous CQC inspection, the issues raised, and how the management team were addressing these. This demonstrated that people's views were sought, and people were openly consulted about both the management of the home and the quality of the care they received.