Tradstir Limited

Sycamore Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 1 May 2018 and was unannounced. At the time the CQC had received a notification of an incident involving the use of oxygen. The inspection did not examine the circumstances of the incident, but examined those risks and other potential risks to people.

Sycamore Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Sycamore Court is purpose built, and was taken over in 2015 by Tradstir Limited. This is the second inspection since the service was taken over by the new provider. Residential and nursing care is provided, across three units, for up to 40 older people with increasing physical frailty, many living with dementia or other mental health needs. Long term care and respite care is provided. There were 34 people resident at the time of the inspection.

At the last inspection on 7 March 2017 the service was rated overall Requires Improvement. At this inspection we found the service remained overall Requires Improvement. At the last inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found robust audit systems maintained and embedded in the running of the service to ensure the quality of the service had not been completed. An external company had also been used to audit in the service. However, action plans to address the issues highlighted had not been developed. We could not identify how the provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. Regular health and safety checks of the building had not been maintained and not all risk assessments had been completed. Records were not fully accessible for senior staff to refer to and ensure essential checks of the building and services had been carried out. We also found areas in need of improvement. Training records were not fully up-to-date, so it was not possible evidence all staff had completed the essential training to support them in their roles. Staff told us they felt well supported by the senior staff who were accessible. However, feedback and records showed us that not all the staff had received regular individual supervision or appraisal. A new electronic care planning system had been introduced into the service, and people's care plans were in the process of being reviewed and transferred from the paper records onto the new system. This process had not been fully completed and care plans were between both systems, and some reviews had fallen behind. It was not possible to fully evidence peoples current care and support needs and any risks that had been identified were being met. People's nutritional needs were assessed and recorded. However, where people were being supported with their fluid intake, records had not been fully completed to inform care staff. Activities for people particularly for those people who stayed mainly in their own rooms were still in need of development. The provider sent us an action plan as to how these issues would be addressed. At this inspection we found significant improvements had been made to address all the issues raised. However, not all the issues had not been fully addressed, or had time to be fully embedded in the practice of the service and were still in need of improvement.

There was a new 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. The registered manager was also the registered manager for another of the provider's services located nearby. They had a good understanding the of the provider's systems and processes to be followed which they had introduced into Sycamore Court. They had divided their time between both the services, and they were supported at both services by a deputy manager/clinical lead and a team of senior staff.

The registered manager told us the service had been through a significant period of change since they had commenced working in the service. With a new registered manager and deputy manager, and several staff changes particularly to the senior staff team who had taken time to be inducted into the service. They told us this had meant the implementation of processes and systems had been delayed and had not in all instances been fully developed and embedded as quickly as they had planned. Senior staff were working closely together following and working to the services action plan to address any outstanding issues. This was evident from the feedback and records we viewed. The provider and their personal assistant were now based in the service for part of the week to support senior staff with the necessary changes, and had received regular updates on the progress from the registered manager. Staff spoke positively of the changes and improvements which had been implemented since the new management team had started. They felt better supported and told us they liked working in the service. A member of staff told us, "The management are now very approachable, and staff are a lot happier."

Although feedback from staff indicated a robust recruitment process was followed for new staff working in the service, supporting documentation did not always evidence the receipt of all the recruitment checks prior to staff coming work in the service. This was a requirement of the services own policies and procedures. To ensure all the information required to safeguard people had been available for a decision to be made as to the suitability of a person to work with adults. Staff told us they were supported to develop their skills and knowledge by receiving essential training which helped them to carry out their roles and responsibilities effectively. Senior staff told us they had audited and identified staffs training needs and were working to provide this. They acknowledged this was still an area of improvement and they were monitoring and ensuring the completion of staff training in supervision. Training records were up-to-date, so it was possible to evidence staffs progress and the improvement in the numbers of staff who had up-to-date training. Feedback and records showed us a system of supervision had just started. Annual appraisals were still to be completed. Senior staff had been given guidance and support to provide staff with supervision and appraisal. However, despite the improvements made training, supervision and appraisal were still an area in need of improvement and not fully embedded in the practice of the service.

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. The electronic care planning system had been fully introduced into the service. Senior staff told us the detail of the recording was still being developed. Support had been given and training had been booked to support care staff to ensure records were more person centred. People's care and support needs had been reviewed as the information had been transferred. A system of ongoing regular reviews was in place. It was not possible to fully evidence this had been embedded into the practice of the service. Care staff demonstrated a good knowledge of people's care and support needs. However, not all the care plans reflected changes to people's current care needs. Risk assessments completed did not always detail what actions needed to be followed to mitigate any risks identified.

Medicines were stored correctly and there were systems to manage medicine safely. However, we identified some improvements needed to the recording of medicines.

People told us they felt safe with the care provided. One person told us, "I feel safe and secure here. I can lock my door." People were protected from the risk of abuse because staff understood how to identify and report it. People were cared for by kind and caring staff. One person told us, "I like it in the home, I'm happy here. The staff are very nice. I'm happy and settled here. I don't know how they could improve it." Another person told us, "I like it in the home and the staff are very nice. I can't grumble about anything." The selection of activities people could join in were still being developed. The selection of activities available for people to join in were still being developed. In particular for people living with dementia. One person told us staff were, "Good at encouraging people to do activities which is good as that is good for them." Another person told us, "I take part in activities when I can. I like the singing." A member of staff told us, "I enjoy the company of the people I care for. I like to keep them chatting and debating. It's my job to inspire them."

Senior staff monitored people's dependency in relation to the level of staffing needed to ensure people's care and support needs were met. Feedback from people and staff was that there was usually enough staff to meet people's care and support needs. One person told us they were, "Very happy in the home. The home is so friendly. Not pressurised to do anything. Enough staff in the home. They come quickly if I use the call bell." A member of staff told us, "Not short staffed very often. Usually the same night staff and most staff are happy to do overtime."

People's nutritional needs were assessed and recorded. People told us they enjoyed the food provided. One person told us, "Oh yes I like the food. Empty plates where I'm concerned. Plenty of drinks and snacks if anybody fancies them in between meals." A visitor told us, "I'm impressed by the menu." Where people were being supported with their fluid intake, records had been completed for care staff to refer to. People had access to healthcare professionals when needed.

People received care in an environment that was clean and tidy. Regular health and safety checks of the building and equipment had been put in place and maintained and risk assessments had been completed. Records were fully accessible for senior staff to refer to and ensure essential checks of the building and services had been carried out. There was an ongoing plan being followed to improve the environment in which people lived. Improvements already made had included redecoration, new floorings, new furnishings.

Consent was sought from people regarding 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 plan within their best interests.

We found regular auditing by senior staff in the service to ensure the quality of the service had been completed and regularly maintained and embedded in the running of the service. People had been able to feedback on the care and support they had received. An external company had also been used again to audit in the service and provide feedback on any areas in need of improvement. This had been used to inform the services action plan to address the issues. We could see the progress on these actions. The provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. There was a complaints process in place. People told us they felt happy to raise any concerns.

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 had individual assessments for identifying and monitoring risk to their health and welfare.

There were sufficient staff numbers to meet people's personal care needs. Staff knew how to recognise and respond to abuse appropriately.

People received care in an environment that was clean and tidy. Regular health and safety checks of the building had been maintained.

Medicines were managed and administered safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff told us they felt well supported. However, a system to provide regular supervision and had just commenced to help ensure the quality of the care and support provided. The annual appraisals were still due to be completed. Senior staff were working with staff to ensure they had completed essential training required to meet people's care and support needs.

People's nutritional needs were assessed and recorded. Where people were on a fluid chart used to inform care staff of people's fluid intake these had been fully completed to inform care staff. People had their healthcare needs met.

Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people in the decision-making process where lacked capacity to make a decision.

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 about their individual preferences and checks were carried out to make sure they were receiving the care and support they needed.

Care staff provided care that ensured people's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The range and frequency of activities provided were still being developed. These were organised in line with peoples' preferences and needs. Family members and friends continued to play an important role and people spent time with them.

People had been assessed and their care and support needs identified. Care plans had been reviewed as part of the transfer of information onto the new electronic care plans.

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?

Requires Improvement

The service was not consistently well led.

The completion of documentation was still an area in need of improvement and systems and practices were still in need of being embedded into the service.

Quality assurance systems used to monitor and help improve standards of service delivery had been maintained and fully embedded in the running of the service. People could comment on the care and support provided. The provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided.

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.

Sycamore Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 1 May 2018 and was unannounced.

We previously carried out a comprehensive inspection on 7 March 2017 when the service was rated Requires Improvement.

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. The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. 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. We also contacted five health and social care professionals and received feedback from one.

We spoke with eight people, and two visitors. We spoke with the provider, the registered manager, the deputy manager/clinical lead, the personal assistant, two registered general nurses (RGN), three care workers, two activity co-ordinators, a physiotherapist, a speech therapist, a hairdresser, 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 the lunch time administration of medicines. 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.

Good

Is the service safe?

Our findings

At the last inspection on 7 March 2017 there was a lack of effective risk management. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. However, these had not all been reviewed to ensure current risks had been identified. Health and safety checks had not been completed. Records to demonstrate that regular tests and checks were completed on essential safety equipment were not fully accessible for senior staff to access and to view during the inspection. Senior staff could not in all instances reference, or confirm the schedule in place to ensure essential checks had been carried out. At this inspection we found improvements had been made and this had been addressed.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. There was a maintenance programme which ensured repairs were carried out in a timely way, and checks were completed on equipment and services. We looked around the building and 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. 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. 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.

Medicines were given safely to people. There was a clear system for the ordering of people's medicines and for disposal of medicines no longer in use. One person told us, "I have painkillers and the staff will ask whether I want them or not in the morning and later in the day." We observed medicines being given and where appropriate, people were given a drink and assisted to take their medicines sensitively, they were not rushed and explanations were provided. The member of staff waited and checked to ensure that the medicine had been swallowed before signing the Medicine Administration Record (MAR) used to record the administration of medicines. Medicine was stored safely and correctly.

Risk assessments were undertaken to assess for any risks for individual activities people were involved in to protect them from harm. Individual risk assessments completed included for falls, nutrition, pressure area care and manual handling. 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. Senior staff monitored the outcome following these assessments, for example any falls which had occurred each month. Records of these audits identified trends, such as unusual falls, which enabled staff to pick up early on possible urinary tract infections and repeated falls. Audits also identified where additional supervision, monitoring, referrals to the falls clinic/team and other specialist support such as the Parkinson's Nurse,

assessments for mobility aids and memory loss had been appropriate.

Where people had been assessed to be at a risk of skin breakdown (pressure sore) we found that current guidance was being followed. 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. We checked a sample of the mattresses which were on the right setting and records we looked at confirmed regular checks had been made.

People told us felt they were safe and that there were sufficient staff to carry out duties. One person told us, "I feel safe here. At the moment the home is doing very well. It has almost become a dementia home which is a shame. The staff are nice and friendly. There are one or two who I prefer, but they all do their bits. The manager is very friendly." Another person told us, "On the whole I like it here and it feels safe. The staff are top quality. I love the place." A visitor told us, "He is safe here and much safer than at home. Staff are kind and caring to him."

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. There were clear systems for protecting people from abuse. 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. 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.

People were protected by the infection control procedures. Staff had good knowledge in this area and had attended training. PPE (Personal protective equipment) was used when required, including aprons and gloves. The provider had detailed policies and procedures in infection control and staff had been made aware of these.

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. Staff had time to spend talking with people and supported them in an unrushed manner. A visitor told us, "One of the benefits of the home is the fact that the staff tend to stay." Staff told us that there were enough staff to get through the work. Senior staff showed us the dependency tool they used monthly 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. Care staff were supported by ancillary staff who covered the catering, domestic, administrative and maintenance in the service.

Although there were several staff who had worked in the service for many years there had also been a number of staff changes and there had been a recruitment programme to address staff vacancies. The services own bank staff or agency staff were used to cover any care staff absences and whilst new staff had been recruited to work in the service. Agency staff were requested who had previously worked in the service and understood how the service was run. People raised some concerns at the number of agency staff who had worked in the service since the last inspection. We discussed this with senior staff on the day who acknowledged during this period to cover the staff rota there had been a high use of agency staff. However, that recent recruitment of new permanent staff had meant use of agency staff was now less.

Where staff had applied to work at Sycamore Court they had completed an application form and attended an interview. Recruitment checks had then been sought to ensure the suitability of the person to work with adults. Where registered general nurses had been recruited a check with the Nursing and Midwifery Council (NMC) had been made to ensure their current eligibility to work. New staff confirmed this process had been followed.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 7 March 2017 we found areas in need of improvement in relation to the training, supervision and appraisal of staff. At this inspection we found improvements had been made. However, these had not been fully embedded in the practice of the service and were still in need of improvement. There was an improvement plan in place for the service which included the décor for areas used by people living with dementia. But this had not yet been fully implemented.

The service was provided in a purpose building. Level access was facilitated with a passenger lift to all floors. There was an ongoing improvement plan in place to improve the environment in which people lived. Since the new provider had taken on the service work had been completed to improve the building. Work was still ongoing to improve the internal environment. Pictures and decorations were used to ensure an environment friendly for people. There was a garden and outside seating if people wished to go outdoors when the weather was fine. However, work had still to be completed particularly where people living with dementia stayed. The provider and registered manager had an understanding that an older person with dementia could perceive their surroundings differently and it was important when designing and planning refurbishments. Good planning and design can help in making it easier for people to interpret and navigate a service in safety, and the use of colour and contrast can be used in different ways to assist in this. Senior staff spoke of plans to further improve the environment particularly to support people living with dementia and improve accessibility around the service for them. Advice and guidance was already being sought on the best way to facilitate this and work had started to address this. This was an area identified to be worked on in the services action plan for further improvement, and to be implemented. This is an area in need of improvement.

Care staff received training that was specific to the needs of people using the service, which included training in moving and handling, medicines, first aid, safeguarding, health and safety, food hygiene, equality and diversity, infection control and dementia care. Senior staff told us of further ongoing training for example, twenty staff had received training in dysphagia (swallowing difficulties) in April 2018 and the remaining staff were scheduled to attend in May 2018. On the day of the inspection four care staff were on a 'Train the Trainer' course on moving and handling, so that they could provide moving and handling training and support to the staff in the service. Support and guidance had also been provided to staff from the dementia In-Reach Team, a group of professionals who supported staff working in care homes. Care staff told us training they had completed and of training booked for them to attend. This had helped them understand and support people. Staff had been supported to complete a professional qualification. The PIR detailed 23 staff currently held a National Vocational Qualification (NVQ) Level 2 or above or a Diploma in Health and Social Care. However, the new management team had found training records were not up-to-date. They told us of work which had been completed to address this. There were new care staff working to complete the training required. A number of staff had been employed in the service for several years. However, they had not found copies of certificates and records had not always been in place to demonstrate training which staff had completed. It had not been possible to fully evidence all staff had completed the necessary training to ensure they had the up-to-date skills needed to support people. Senior staff demonstrated work was ongoing to ensure that all staff had undertaken the essential training. They had

booked training and were monitoring to ensure the completion of this training and had increased the percentage of staff who had completed the training. This is an area in need of improvement.

Staff told us that the team worked well together and that communication was good. Staff told us they felt well supported and could always go to a senior member of staff for support. They felt the management team were approachable, knowledgeable and implemented changes which the new management team had implemented had benefited everyone. Senior staff provided individual supervision and appraisal for staff. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. This was through one-to-one meetings and in staff meetings. Senior staff had been given guidance and support in their new role to provide staff with supervision and appraisal. One member of staff told us, "The ultimate aim is to offer a formal one to one supervision to all staff every two months and a supervision matrix has been drawn up to support this." However, a formal system of supervision had only recently commenced. So, the system was not fully up and running and it was too early to fully demonstrate all staff had received regular supervision which had been maintained. This is an area of practice in need of improvement. These processes gave care staff an opportunity to discuss their performance and for senior staff to identify any further training or support they required. New staff had been taken through and supported by a probationary period. For those staff who had been working in the service longer there was a process for annual appraisal. However, this had not yet been implemented. Senior staff told us the priority was to offer training and guidance to senior staff undertaking the supervisions and start the formal supervision process. Then once everyone had been met with this information would be used to help inform the annual appraisal. This is an area in need of improvement. There were also regular opportunities for staff to attend staff meetings. One member of staff told us, "Supervision is very good, definitely feel supported, (senior staff members names) have made lots of improvements since they started as managers, they are both are very good and communication and listening. Can't remember when last supervision was, but it is regular (about two to three times a year.) I have one booked for tomorrow, because I'm going on annual leave."

Registered nurses attended monthly clinical governance meetings which had been newly introduced. The minutes of these meetings detailed areas covered for discussion; Accident and incident analysis, safeguarding, training (moving and handling specifically identified as needed), clinical indicators (pressure sores and weight loss analysis), falls audit, care plan audits, polices and supervision. Minutes included appropriate action points and demonstrated learning.

Senior staff told us all care staff completed an induction before they supported people. This was undertaken as an online learning package, training provided by the local council and through the providers own trainers. Competency was checked via informal observations and working shifts with the registered nurses and care staff. The induction incorporated 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. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. New members of the care staff told us they had recently been on an induction. They had been given an induction information and had shadowed care staff. This had provided them with all the information and support they needed when moving into a new job role. Agency staff had also received an induction and information sought to ensure they had the right skills and training to support people in the service.

A screening tool was used to identify people who were malnourished or at risk of malnutrition. 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. People's nutritional intake was being monitored and there was recording in place to inform staff of people's food and fluid intake. Records we looked at had been fully completed with appropriate action taken where weight loss had been identified. People with variable appetites were on fortified diets, even though weight loss had not been identified, as this helped to maintain a healthy weight. Where possible people were offered full fat milkshakes, fortified diets and additional snacks rather than a prescribed nutritional supplement. 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 where people suffered with dysphagia. There was clear guidance for care staff to follow where people had thickened fluids including the consistency these should be.

People told us, "I like my food," "The food is nice," "The food is pleasant and I get a good choice of food," "Food depends on who is the chef each day, (Chef's name) cooking is best," "The food is very good, there is a choice," and "Plenty of drinks throughout the day." People were consulted about their food preferences each day and were given options. The chef told us there was a rotating menu based on people's likes and people could have snacks and sandwiches whenever they wanted. Two options were always available, and we found that people could also make additional requests if there was nothing on the menu they liked. This information was then fed back to the chef. The chef demonstrated they had been made aware of people on special diets. They told us communication was good and they were notified of people's dietary needs. The chef had been given a 'location dietary summary' with the name, room, guidance, special diet and additional information on it. They were also seen during the inspection going into the service and talking with people.

We observed the lunchtime experience for people. 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. One member of staff told us how they had their lunch in with people in the main dining room and it was an opportunity to have a chat with people. People were encouraged to be independent throughout the meal and staff were available if people 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. Where people were supported to eat their meal, they had a dedicated member of staff to assist them, they were not rushed and there was evidence of friendly conversations occurring.

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. One member of staff told us it was, "Respect people's differences, if someone doesn't eat pork because they are Muslim you would make sure they did not have it, if others were having it you would not point this out to them as this might still upset them. We are all different and like different things. People might have different ideas as they get older from what they had when they were younger, try not to take things personally if you have different beliefs we are here to meet people's needs even if they have different ideas to our own."

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. One person told us the, "Home will call the doctor if I'm not very well." Another person told us, "The doctor

and dentist come to me, the home is very good at arranging this. I have medication twice a day and the nurses are excellent."

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. Senior staff told us there was no one with a pressure sore. They also spoke of a good relationship with the local tissue viability team (TVT) who were always available via email and telephone for advice and support with a 24-hour response time. It had been particularly useful being able to send photos of wounds via email as this meant they did not always have to wait for a visit to start treatment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had knowledge and an understanding of the (MCA) because they had received full training in this area. People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments so staff knew the level of support they required while making decisions for themselves. Staff told us how people had choices on how they would like to be cared for and they always asked permission before starting a task. A member of staff told us, "Always ask permission first, don't just do things to people as if they want it first and do it the way they like. Everyone has a right to refuse or say how they want something done; some people like to have a shower every day other like a bath every now and then. Get to know the person, be interested, talk to people about what's happening and show you are interested. Don't leave people out or talk over people, engage with the person rather than doing the task an ignoring them as people." Another member of staff told us, "If people say no I try to coax them or I'll come back later." One person told us, "They always ask before providing care. For example, when I'm showered."

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are the process to follow if a person should be deprived of their liberty for them to receive the care and treatment they need. Senior staff told us they were aware of how to make an application to deprive someone of their liberty. They talked with us about the current applications which were in place. Care staff told us they had completed or were due to complete this training and all had a good understanding of what it meant for people to have a DoLS application agreed.

Good

Is the service caring?

Our findings

People and their visitors 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. One person told us, "The staff are top quality." Another person told us they were, "Happy and settled here." A further person told us," When it was very hot two weeks ago we spent one day on the balcony and then on another day we had lunch out in the garden. It was quite a lot of work for the staff but we really enjoyed it." When asked what the service did well a member of staff told us, "Compassionate caring staff (treat like own family), good at being able to anticipate care needs, good activities keep people engaged and active (mentally and physically)."

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, they made sure their room was tidy and 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. 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, there was sociable conversation taking place and staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people.

People were offered choices and had a degree of flexibility within their daily routines. People looked comfortable and they were supported to maintain their personal and physical appearance. People were well dressed and it was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs. People were consulted with and encouraged to make decisions about their care. They told us they felt listened to. Care provided was personal and met people's individual needs. Care staff demonstrated they were knowledgeable about people's likes and dislikes. Staff spoke positively about the standard of care provided and the approach of the staff.

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. One person told us, "I am treated with dignity." Care staff had received training on privacy and dignity, were aware of the importance of maintaining people's privacy and dignity, and were able to give us examples of how they how protected people's dignity and treated them with respect. A member of staff told us, "If you come across confidence they will feel confident." Another member of staff told us, how respecting people's dignity meant knocking on doors and waiting for an answer, providing personal care in private, making sure curtains were drawn if providing care in a room that can be overlooked or seen into, using towels to cover people when

washing. They always asked people's permission first, did not just support people, but checked it the way they liked their care to be provided. Everyone had a right to refuse or say how they want something done; some people like to have a shower every day other like a bath every now and then. Get to know the person, be interested, talk to people about what's happening and show you are interested. Don't leave people out and talk over people, engage with the person rather than doing the task and ignoring them as people. One person told us staff, "Always ask before they carry out personal care. They treat me with respect. If there are agency staff in they are not usually so good. The home staff treat me with respect and are very good with the hoist."

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 and ornaments. 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. People could use the telephones sited in the service and there was internet access provided. Where people did not have family support, a representative from an advocacy service had been requested. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights. Staff could describe how people's religious customs were respected, and pastoral visitors and church leaders visited. There was a service which people attended during the inspection.

Care records were stored securely. The new electronic care plans were being implemented which would be 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

At the last inspection on 7 March 2017 we found areas in need of improvement in relation to the completion of care plans and activities provided, particularly for people who mainly remained in the rooms. At this inspection we found improvements had been made. However, the activities provided were still being developed and embedded in the practice of the service and were still in need of improvement.

Senior staff acknowledged there was still work to be completed to improve the frequency and range of meaningful activities available for everyone to join in. Particularly where people were living with dementia. To try to address this there were two activity co-ordinators who worked in the service with increased hours. Which meant where possible activities were now run six days of the week. Further training and support had been booked for the activity co-ordinators to develop the range of activities available. There was also support from visiting healthcare professionals. Staff also told us how they had accessed the internet and been trying out new ideas to get more people involved in the activities. A cinema area was in the process of being built to provide people with a cinema experience. One person told us, "I like the new big TV which will be part of the cinema and will be good." Another person told us, "I'm looking forward to the cinema." On the day activities were being run in the downstairs lounge for a group of people. Where people had joined in the activities there was a very social atmosphere. Peoples comments received included, "I like to join in with activities, floor snake and ladders, sing-alongs. A singer came last Friday evening and he was very good. We had a bit of wine. It was a really nice evening," "(Staff member's names) do activities and they are both very good," and "There was a trip to Eastbourne last year." People were encouraged to do drawing and there were many framed pictures of their work in the main lounge. External entertainers had also visited the service providing musical entertainment, or with visiting animals. Not everyone chose to join in the activities. Staff spoke of one person who stayed in their room who liked to watch 'Carry On' films and had access to 'Netflix'. Where people stayed in their rooms some people in their rooms had had a manicure. Some people in the other lounges particularly those living with dementia had not joined in an activity. This is an area in need of improvement.

Senior staff completed a detailed assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. Pre-assessments were used to develop a more detailed care plan for each person. These detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Documentation confirmed people or their relatives were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews. The electronic care plan documentation had now been fully introduced into the service. Staff had received training in how to use the system and there was ongoing monitoring to ensure the quality of the detail recorded. One member of staff told us, "Having electronic care plans has improved our records, now everything is in one place and information is easy to find." Another member of staff told us," (Member of staff's name) and nurses talk us through any new service users before their admission. Pre-admission assessments offer lots of information on persons wants, needs, likes, dislikes. We read care plans, daily care notes and share information between ourselves (staff) and families. With everything electronic it makes access quicker and easier as well as recording information. Managers are very approachable and we can ask

them as well as the nurses for information and support." Senior staff were responsible for monthly care plan audits.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with the Equality Act 2010 and the Care Act 2014. Services must identify record, flag, share and meet people's information and communication needs. Senior staff told us this was looked at as part of the comprehensive initial assessment completed, and they had ensured peoples communication needs had been identified and met. Where required people's care plans contained details of the best way to communicate with them. Records confirmed this. Information for people and their relatives if required were created in a way to meet their needs in accessible formats such as in large print or in another language to help them understand the care available to them.

Technology was used to support people with their care and support needs. An emergency call bell system was in place in the service for people to access and pendants for people to wear. People had access to Wi-Fi connection in the service which people had used to maintain links via social media and skype. Computer tablets had been purchased and these had been popular with people and they were observed to watch 'You Tube' clips of favourite artists and played games.

No one at the time of the inspection required end of life care. Senior staff told us peoples' end of life care would be discussed and planned and their wishes respected. People could remain at the service and were supported until the end of their lives.

People and their representatives could comment on the care provided through reviews of people's care and support plans, resident and relatives meetings and by completing quality assurance questionnaires. One person told us, "We have resident's meetings. They ask whether we like the food, whether the laundry works well etc and things usually get put right if people complain." Minutes of the meetings views detailed people had been able to discuss any concerns over the food provided, had been provided with staffing updates. People in attendance stated they were happy with the level of activities provided which had been so much better since the employment of a further activities coordinator.

There were systems in place to record any compliments, concerns or complaints. People were encouraged to raise any concerns and knew who to speck to if they had any concerns. 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. 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. One person told us, "I've never fallen out with anyone. I have no concerns." No formal complaints had been raised since the new management team had commenced working in the service. The registered manager told us they operated an 'open door' policy and people, their relatives and any other visitors could raise any issues or concerns.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 17 March 2017 we found there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Senior staff had carried out some internal audits, including care planning, checks that people were receiving the care they needed, medication, and infection control. However, these had not been carried out regularly. Fire and health and safety checks of the building had not been completed and embedded into the practice of the service in line with the provider's policy and procedure. There was a system in place for recording accidents and incidents, but these had not been collated. It was not clear how the provider monitored or analysed the information received to look for any emerging trends or make improvements to the service provided. At this inspection we found improvements had been made.

However, senior staff acknowledged there was still work to be done, and had identified areas through their own quality assurance process for further development and improvement. For example, the contingency plans were in place to respond to any emergencies, for example flood or fire. However, the plan followed was the one created by the last provider and was not up-to-date with current guidance and information for staff to follow. Senior staff confirmed this was in the process of being updated. Although recruitment processes were in place, two of the recruitment files viewed did not have a record of all the checks had been completed as detailed in the services own policies and procedures. This meant that not all the information required to safeguard people had been available for a decision to be made as to the suitability of a person to work with adults. We discussed this with the provider and registered manager who told us a more robust system had already been implemented. A member of staff had been identified and was working on the co-ordination of staff recruitment to ensure all checks had been completed and received and recorded. Work had been completed to ensure people had a detailed care and support plan and supporting risk assessments in place to inform care staff of their care and support needs. Senior staff were aware further training was needed to keep these up-to-date through ongoing review and to develop a more person-centred care plan, particularly where people were living with dementia. A visiting healthcare professional confirmed they were providing training and supporting care staff with this. Risk assessments completed did not always detail what actions care staff described to be in place to be followed to mitigate any risks identified. There were some gaps in signing on MAR when administering medicines and inconsistencies of recording. Records did not always include a photo of the person or a personal information sheet which included any known allergies. This had not ensured all the checks to be used to ensure the right medicine was given to the right person were in place to inform staff, particularly where new care staff and agency staff were administering medicines. However, senior staff had already identified this and could show us the work already completed with care staff to address this. Minutes of staff meetings we looked at detailed this had also been on the agenda for discussion. These are areas in need of improvement.

There were systems in place to monitor the quality of the service provided. The audits focused on standards and showed how the quality of the service was closely monitored. Regular health and safety checks were carried out on all aspects of the service; these included the premises and equipment. Other audits were undertaken weekly and monthly and looked at areas such as, food safety, infection control and fire safety. The provider had also employed an external group to check the quality of services. Senior staff monitored

the quality of the service by regularly speaking with people and their relatives and visitors to ensure they were happy with the service they received. This was by completing reviews of the care and support provided to ensure that records were completed appropriately. People and their relatives and staff were asked to complete a quality assurance questionnaire. The information gathered from regular audits, monitoring and feedback was used to recognise any shortfalls and make plans to drive up the quality of the care delivered. Any areas for improvement were identified in an action plan. Staff supervision had commenced to ensure that the care staff understood the values and expectations of the provider. Staff meetings were held regularly and had been used to keep care staff up-to-date with developments in the service.

The registered manager had regularly sent information to the provider to keep them up-to-date with the service delivery. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run. The provider also arranged for internal audits of the service to ensure the quality of the care being provided and this met current guidance. The registered manager told us that where actions had been highlighted these had been included in the development plan for the service, and worked on to ensure the necessary improvements.

People, visitors 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. The visiting healthcare and social care professionals told us staff had 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.

There was a clear management structure with identified leadership roles. The registered manager was supported by a deputy manager, and a team of registered nurses and two senior care staff. There were also 'Heads of Department,' for example to domestic services and maintenance. All senior staff attended weekly 'Heads of Department' meetings. These were opportunities to monitor progress, to offer and request support and to discuss the working of the service. The senior staff promoted an open and inclusive culture by ensuring people, their representations, and staff could 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.

Policies and procedures were in place for staff to follow. 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 had a clear understanding of their responsibility around reporting poor practice, for example, where abuse was suspected.

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 was committed to keeping up to date with best practice and updates in health and social care. They were also aware of the CQC's revised Key Lines of Enquiries that were introduced from the 1st November 2017 and used to inform the inspection process. Services that provide health and social care

to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager was aware of the need to inform the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.