Four Seasons Mickleton Limited

Four Seasons

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection was carried out on 23, 24 and 29 February 2016 and was unannounced.

Four Seasons provides accommodation and care to a maximum of 21 elderly people. At the time of the inspection there were 15 people living in the home. Services were provided across two floors with a passenger lift for access the second floor. Prior to admission a person's needs had to be particularly assessed in relation to the environment as some areas had space limitations. This meant for example, some areas of the home were not suitable if people required a lot of moving and handling equipment such as a wheelchair and a hoist. Some bedrooms had private toilet and washing facilities. Bedrooms which did not have these facilities had wash hand basins. Communal bathing facilities had been adapted to make bathing easier and safer for the frail older person. A large lounge with a television and music system was enjoyed by several people. A separate dining room provided people with an area to eat and take drinks in. A summer room could be enjoyed in the warmer weather only as this room did not have heating. The garden was well tended with a summer house which people liked to use, also in the warmer weather.

The registered manager had managed the home since 2014. 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.

People did not live in an environment which had been kept suitably clean enough to protect them from potential avoidable infections. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.' We also recommended that the provider seek suitable advice and guidance in relation to the cleaning of particular items of equipment.

Arrangements were in place to protect people from other risks. Risks were generally well identified, managed and monitored. This included risks against abuse. The registered manager ensured there were enough staff with the appropriate knowledge and qualifications on duty to meet people's needs. Good recruitment processes and a commitment to address poor practice also helped to ensure people were kept safe.

People's care was tailored to their needs and delivered by staff who were well trained and supported to do this. People's care was delivered after they provided consent. Where a lack of mental capacity prevented people from being able to do this they were protected under the Mental Capacity Act 2005. This was because the staff understood the principles behind the Act and made sure it was adhered to. People were therefore supported to make decisions about their care and treatment if they were able to do this. These decisions and people's preferences and wishes were very well considered when planning their care. Where people were unable to be part of this process their family or representatives were encouraged to represent them and speak for them. Staff were particularly caring and compassionate. This was recognised by visiting health

care professionals and appreciated by those receiving care and their relatives.

A close working relationship with community health care professionals ensured people's health needs were reviewed regularly and met. Community health care professionals also helped the staff deliver people's end of life care. People's medicines were well managed. Risks related to poor nutrition and loss of weight were monitored and addressed. People received very good support to eat a nutritious diet in order to maintain their well-being. When people required specialised equipment to help retain their independence or keep them safe appropriate actions were taken to ensure this was provided.
People had access to activities and although these were limited, when provided people really enjoyed them. For some people activities helped to alleviate their distress and for others they were used to promote conversation about fond memories and encourage the use of retained skills and interests.

The registered manager worked closely with the provider's representative to provide as good a service as possible. Strong leadership provided necessary support to the staff who shared the same values and who were committed to maintaining people's well-being. Monitoring systems helped the management team ensure that a good standard of service and care was provided to people. Managers were visible and approachable and were happy to listen to people concerns, complaints and suggestions for improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not fully safe. People were not protected as well as they could be from potential and avoidable infection because of a lack of suitable cleaning arrangements.

Additional environmental risks and personal health risks were identified and well managed.

Arrangements were in place to make sure people received their medicines appropriately and safely.

People were protected from abuse because staff knew how to identify this and report any concerns they may have.

There were enough staff to meet people's needs because the staff worked as a team and some worked additional hours to ensure this was the case. Good recruitment practice protected people from those who may not be suitable.

Is the service effective?

Good

The service was effective. People received care and treatment from staff who had been trained to provide this. Where staff were new to care there were arrangements in place to help them learn and improve their skills.

People who lacked mental capacity were protected because the principles of the Mental Capacity Act (2005) were followed.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

Staff ensured people's health care needs were met.

Is the service caring?

Good

The service was caring. People were cared for by staff who were kind and who delivered care in a compassionate way.

People's preferences were explored and met by the staff where possible. Staff were able to tailor their care to meet people's

personalised needs.

People were respected and their dignity and privacy maintained.

Staff helped people maintain relationships with those they loved and who mattered to them.

Is the service responsive?

Good

The service was able to be responsive. Care plans contained a good amount of detail which gave staff up to date information about their needs. Care was tailored around these needs.

People had opportunities to socialise and partake in some activities. The activities provided were meaningful to people and had therapeutic value for some people.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well-led. People benefited from the service having a strong leader.

People were able to communicate with the management team and express their views on the services provided. The management team were open to people's suggestions and comments in order to improve the service going forward.

Monitoring arrangements were in place and issues were addressed in order of priority.

Four Seasons

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23, 24 and 29 February 2016 and was unannounced. One inspector carried out the inspection.

Prior to the inspection we looked at the information we held about the service. This information included the statutory notifications that the provider had sent to the Care Quality Commission and the Provider Information Record (PIR). A notification is information about important events which the service is required to send us by law. The PIR is requested by us and asks the provider for key information about the service, tells us what the service does well and the improvements they plan to make. It also included concerns received during the period of the inspection, from one person, about the service.

During the inspection we spoke with five people who lived at Four Seasons. We observed the support people received and reviewed four people's care records. This included a review of people's care plans, risk assessments and medicine records. We attended one staff hand-over meeting which discussed people's progress and care needs and we attended an emergency call bell following a person's fall. Three relatives gave us their views on the standard of care delivered to their relative and how well they thought the home was managed. We spoke with eight staff, the registered manager and the provider's representative. We reviewed four staff recruitment files. Five health care professionals gave us their views on the service. In addition we examined records relating to the management of the service. These included: records relating to the overall management of the medicines system, staff training records, the complaints and compliments log, minutes of staff meetings, the service's quality and monitoring audit file and accident records. We also reviewed staff duty rosters and cleaning records. We examined three policies; safeguarding adults, infection control and advocacy. We reviewed satisfaction questionnaires returned by people and staff in December 2014. We carried out a tour of the building.

Requires Improvement

Is the service safe?

Our findings

We had received concerns from one person about the standard of cleanliness in the home. We discussed these concerns with the registered manager who told us what cleaning hours had been made available by the provider. We reviewed the cleaning records and looked at the general cleanliness of the home. We assessed this on the first two days of the inspection and reviewed this again on the third inspection day. On the first two days we found the environment to look as if acceptable levels of cleaning had taken place. The third inspection day followed a weekend and there had been no designated cleaning hours over the weekend. The one employed cleaner had also been absent on the third day of the inspection. At the end of this day the cleanliness of the home was reviewed again and observed not to be at an acceptable level. It was also not known when the cleaner would return. The care staff told us they got rid of people's rubbish and wiped around people's wash hand basins at weekends. The registered manager told us they also carried out some cleaning when they could and that some cleaning was done by the night staff when possible. The registered manager told us they had discussed the need for more cleaning hours with the provider but a decision had not been made about increasing these. Cleaning records showed consistent gaps in cleaning reflecting when the cleaner was not present and in particular during times of annual leave. The cleaner's annual leave was not covered with designated cleaning hours. Cleaning was done by other staff and the registered manager when they were able to do this.

Relevant records showed that when the cleaner was present, bedrooms received a degree of cleaning on a fairly consistent daily basis. However, there were also consistent and regular gaps in relation to vacuuming carpets and cleaning other floor coverings. There was no record of furniture being pulled out and deep cleaning although, the registered manager confirmed this did take place. They told us the cleaner followed their specific instructions in relation to this. Bathrooms were on the cleaning record and cleaning was recorded as taking place. However one bathroom, still used, was in such a poor state of repair it was not possible for some areas to be kept adequately clean. We were told this was due to be refurbished at the end of the year but following the inspection the provider informed us this would be done in May 2016.

There were arrangements in place to reduce the spread of infection although staff had needed to be reminded at times about good practice in relation to this. In a staff meeting in October 2015 staff had been reminded not to carry loose (un-bagged) laundry through the corridors. The laundry had systems in place to segregate soiled washing. This had included the use of dissolvable laundry bags. Soiled laundry was placed immediately into these bags by the care staff and there was no need for further segregation or handling by the laundry staff. This laundry was then washed separately on a specialised washing cycle when the seams of the bag would dissolve allowing the laundry to be washed. According to the registered manager there had been one 24 hour period when the home ran out of these bags but they confirmed that laundry was always segregated and staff always wore plastic gloves when handling laundry. Apart from this one time it was confirmed that the a dissolvable bag arrangement was always in place.

The home used to have a sluice area where the contents of commodes were once emptied. This no longer worked and we were told there were no plans to replace this. The registered manager told us they had become concerned about how commode pans were being emptied and cleaned as staff had carried these

through corridors, uncovered, originally to the sluice but now to toilets. The registered manager had addressed this by introducing cardboard commode liners. These sat inside the plastic commode pan and once used were emptied down the nearest toilet and then disposed of. The registered manager told us commode frames were still cleaned by the care staff after each use. They admitted there had been a four day period when the home had ran out of the liners. They had been ordered at the end of one week but did not arrive until the beginning of the following week. Staff during this time reverted back to supporting people to use their commodes without the liners and the contents was collected in the commode pan. When we asked staff how they cleaned the commode pans one member of staff told us they used the everyday wipes with water and another told us there was a specific sanitiser to use. The provider has subsequently informed us that there is more than one procedure in place with regard to the cleaning of commode pans.

We observed some toilets with an obvious "tide line" around the toilet pan where the level of water had risen before it had flushed away. In one bathroom it was evident that solid matter had also risen as the pan was stained with faecal matter; as were other toilets. The registered manager explained that partially blocked toilets had been an on going problem at the home. They had learnt during past situations that the main public sewer pipe, which took waste away from the home and other nearby premises, was particularly narrow. They explained this was not something they could resolve but they agreed people's toilets should be kept adequately clean.

We recommend that in relation to how items of equipment must be cleaned in order to protect people from avoidable infection, the service seek suitable advice and guidance in line with the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

Minutes of a staff meeting held in December 2015 recorded the registered manager reporting that the cleanliness of people's bedrooms was "slipping". Staff were also reminded in this meeting about best practice in relation to the use of plastic aprons and gloves. There was a domestic services audit which covered all aspects of the home's cleaning. The registered manager admitted that in her opinion there had never been enough cleaning hours designated to the home. To ensure the cleaning hours were used effectively the registered manager implemented a cleaning schedule in January 2015. They told us the cleaner followed this but this inspection found that the cleaning taking place and the hours allotted for this did not meet the home's needs. People therefore lived in an environment which was not kept clean enough in order to protect them from possible avoidable infection.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Cleaning equipment was colour coded, for example, the green mop and bucket was only used for cleaning the kitchen floor and another coloured mop and bucket was only used to clean toilet floors. This arrangement helped reduce the spread of potential infection. Staff had received infection control training as well as hand washing training. We observed them wearing personal protective equipment (PPE) when delivering care and serving or preparing food. PPE included plastic aprons and gloves. Just prior to this inspection the kitchen had been awarded a rating of 'Five' by the Food Standards Agency for food safety and hygiene. This was the highest rating this service could achieve. Four Seasons is a small care home so all staff worked very much as a team and helped each other out. Care staff therefore helped the cook by packing the dishwasher after lunch and carrying out other cleaning tasks when possible. For example, one member of staff had cleaned one of the main storage shelves for the cook during the inspection. We observed staff putting on plastic aprons before they entered the kitchen. Recent advice from the Food Standards Agency had been to ensure tops of taps were cleaned more frequently. The top of a tap is an example of a 'high risk

contact surface'. This is a surface which is frequently touched and which can harbour a high number germs. The registered manager told us actions had been taken to ensure these were cleaned throughout the home. They included for example, hand rails, door handles and toilet flushes. However, these tasks were not included as tasks completed on the cleaning record. The registered manager told us they would address this.

People told us they felt "perfectly safe". People were protected from the risk of abuse because staff had appropriate knowledge and knew how to recognise this and report their concerns. All staff had completed training which gave them the basic knowledge they required to protect people. Staff were able to describe the arrangements for reporting allegations of abuse. They knew which agencies to contact if they needed to report concerns outside of their own organisation. There was information about safeguarding on the home's noticeboard with contact numbers of relevant agencies for people's information. The service had a policy on safeguarding people which was in line with Gloucestershire County Council's safeguarding policy and protocols. The last notification received by the Care Quality Commission in relation to allegations of abuse was in 2013.

People were protected against identified risks. Risk assessments had been completed in relation to falls, pressure ulcer development area and nutrition. These assessments identified potential risks to each person and described the measures put in place to minimise these. The assessments were regularly reviewed and altered where needed. We observed actions being taken by staff to minimise people's risks. For example, one person was helped to the dining room for their meal and staff ensured their pressure relief cushion accompanied them. For some people health care professionals had organised additional equipment to help keep them safe. This included specialised beds, bed rails, padded floor mats and hoists to move people safely. Electronic equipment was also used to keep people safe, such as alarmed pressure mats to alert staff when people who were at risk of falling were standing. Staff were therefore able to respond quickly and provide the person with the support to mobilise safely.

People were also protected from risks associated with fire. Fire safety arrangements were in place and had been checked by a fire safety officer in 2014. Some recommendations were made at that point which had been completed. The service's fire safety risk assessment had been reviewed and updated in June 2015. Since then we were informed that advice had been taken from fire safety specialists before a door had been removed in the main entrance. The fire risk assessment had not been reviewed since this work. However, we were told fire safety assessors were aware of this work and due to review the risk assessment in April of this year. Staff knew what support people needed in the event of an emergency evacuation because these needs had been assessed. Staff had received fire safety training and regular fire drills had been held. Window restrictors had been recently upgraded from a screw on chain device to the recommended cable style fittings that cannot be tampered with. Health and safety arrangements and processes were audited every two months and this included a visual check of all the areas people and staff used for potential hazards.

We carried out a tour of the premises which was not purpose built. The registered manager explained risks to people and staff had to be carefully considered in relation to the environment and what care could be achieved. This was because for example, one corridor was particularly narrow and could not accommodate hoists. Some bedrooms and toilets had restricted space for manoeuvrability. Some of these areas would not accommodate a lot of moving and handling equipment such as wheelchairs and hoists. A recent refurbished bathroom provided an adapted bath and a shower room enabled people with physical limitations to bathe safely.

People's needs were met because the registered manager ensured there were enough staff to meet these. This was done by staff agreeing to work additional shifts and by the registered manager working numerous

care hours on top of their contracted hours. Health professionals commented that people's dependency levels were high and some people had complex needs but despite this, people received good care. The registered manager explained recruitment had been a constant challenge with a recent trend of staff starting work and then leaving soon after. Exit interviews had shown this to be for a number of personal reasons other than staff leaving because they were unhappy. Covering night positions with permanent staff remained particularly challenging and agency care staff were used. Staff worked very much as a team which also helped, for example, the activities co-ordinator helped people at mealtimes and provided supervision in communal areas in the morning when care staff were particularly busy. The registered manager and her deputy often stayed late into the evening and completed their management work when care needs were not so high.

Staff recruitment records showed people were protected from those who may not be suitable to care for them. Appropriate checks were carried out on staff before they started work at Four Seasons. Clearances from the Disclosure and Barring Service (DBS) had been requested. A DBS request enables employers to check the criminal records of employees and potential employees, in order to ascertain whether or not they are suitable to work with vulnerable adults and children. References had also been sought from previous employers and employment histories were requested. Reasons for gaps in employments were also explored.

People's medicines were managed safely. Medicines were stored securely. Medicines administration records (MARs) had been completed appropriately with no gaps in the recording of administration on the MAR charts we reviewed. There were records of medicines received and of medicines disposed of. Medicines were administered to people by staff who had received appropriate training and their competency to do this was regularly reviewed. Daily checks on the medicine stock and completion of the MARs were carried out to ensure people received the medicines they should at all times. A weekly audit ensured a more detailed and overall check of the medicines system. Where people were unable to take their prescribed medicines a review was carried out and if needed medicines were prescribed in a different form. For example, one person needed pain relief but had problems swallowing the tablets so the GP was asked to prescribe this in liquid form. Good communication between the main visiting GP and the registered manager ensured anticipatory end of life medicines were prescribed and available when needed.

Good

Is the service effective?

Our findings

People told us they were looked after well and health care professionals confirmed this was the case. One person said, "I'm very content with how they look after me" and another said, "I think the care is very good. It's a comfort that I'm looked after so well". Two health care professionals specifically commented that they considered people to be very well cared for at Four Seasons. A card sent to the home from family members said, "Words are not enough really to describe my heartfelt thanks to everyone at Four Seasons for the excellent care shown to my (relative)" and similar sentiments were expressed by a person who received care for a short period of time, they said, "Many thanks for looking after me so well while I was with you."

People were cared for and supported by staff with appropriate knowledge and skills. One person said, "They (the staff) are very knowledgeable you know". Health care professionals told us staff were knowledgeable and showed an interest in learning new things when they visited. The training record showed all staff had received training in basic subjects required to carry their jobs out safely. All staff held a nationally recognised qualification in care or were working towards achieving one. For example, nearly all staff held the National Vocational Qualification (NVQ) and half those held this qualification at a supervisory level or more. The training record was a working document so it showed training which required updates and training already booked. This showed that training was an on-going process. One member of staff said, "It's training, training, training here (registered manager's name) is very keen on training and makes sure we keep updated".

The registered manager had already made arrangements to introduce the new care certificate for new staff. Four staff had completed the care certificate's mentor course in readiness to be able to support new care staff. The certificate lays down a framework of training and support which new care staff can receive. Its aim is that new care staff will be able to deliver safe and effective care to a recognised standard once completed. The registered manager had also started to take existing staff through some of the certificate's modules to update their existing knowledge. New staff to date had completed induction training and had received training which enabled them to carry out tasks safely. Where staff had not fully completed all the required basic training they did not perform related tasks without supervision. This for example, included the use of hoists to move people. Regular competency checks were carried out and staff received a good level of support from senior staff. This came in the form of designated one to one sessions and by working alongside experienced and senior staff.

People's care and support was delivered once they had given their consent. Care records recorded people giving their consent and staff were fully aware they could not provide this unless people had done this. We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked capacity to make certain decisions, assessments had been made of their mental capacity. Records showed that people could often make simple day to day decisions and they were supported to do this.

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). Where people were receiving a degree of control and supervision the registered manager had considered whether there had been a need for an application for DoLS. For example, one person's movement was monitored through the use of an alarmed pressure mat. This was used to alert staff if the person stood because they were at risk of falls. Staff could attend to the person quickly and avoid a potential fall. The registered manager explained this was not used as a restriction and when this had been explained to them the person had understood and agreed to its use. This person was also free to go outside of the home when they wished. This however had some restrictions applied to it. For example, if they then attempted to leave the grounds of the home staff would not allow them to do this un-escorted. The registered manager had not considered an application for DoLS necessary but we recommended they discuss this with the supervisory body (the County Council in this case). How staff supported people to make their own decisions and how they applied the least restrictive measures when supporting people was a key part of Four Seasons care planning and was recorded in people's care plans.

People were supported well when they were at risk of not eating enough, losing weight or experiencing other problems with their eating and drinking which may affect their health. People's weight was monitored and any concerns discussed with their GP. People who were assessed as being particularly at risk were monitored more closely. They had their intake of food and drink recorded at each mealtime so staff could keep a record of exactly what people were actually consuming. We saw staff doing this during the lunch time. We also observed staff supporting one person who had been very poorly and who had lost their appetite. A member of staff sat with this person encouraging them gently to eat. Staff offered the person several different foods to tempt them and in the end they settled for a favourite pudding. Other people received similar support. Another person's swallowing had been assessed by a speech and language therapist and to help them eat they had their food in pureed form. This person told us about what they had to eat and confirmed that staff always gave them what they wanted. They said, "The food is very good here. The plates are a little too full for me which puts me off a bit. They weigh me and I have put some weight on which is good". People had cold drinks available wherever they sat and hot drinks with biscuits and cake were provided in-between meals to provide additional calories where needed.

People's health care needs were assessed, monitored and managed well. Staff liaised well with visiting health care professionals. This was on a routine basis and when people's health altered. People had access and visits from these professionals when they needed it. There was extremely good support from a local GP surgery which included a designated visit from a GP every week. One relative said, "A doctor, the same doctor, see's my relative every other week – that is good. She (the doctor) has rung us at 8pm in the evening before now and updated us on her visit – that is excellent". Some people's needs were complex and they required treatment from registered nurses. This was provided by community nurses who were visiting the home between four and five days a week. Other professionals were involved in supporting people as needed. These included occupational therapists who assessed people's needs in relation to specialised equipment, a continence nurse assessed people's needs in relation to their toilet needs and mental health specialists provided support when needed. Some people attended dental and optician appointments with their relatives. The staff in the home organised these appointments and helped people attend these if relatives were unable to do so. Regular foot care was also provided by a Chiropodist.

Good

Is the service caring?

Our findings

People told us they felt staff cared about them. One person said, "They (staff) are very caring, you only have to ask and they will help, they are very thoughtful". Another person said, "This is my home, they're (the staff) good to me". One relative said, "They are so kind". One health care professional told us they really liked "level of compassion" shown to people, another commented staff always put the people they looked after first and a third professional said, "They (staff) are very caring". Comment cards sent to the home from relatives included comments such as: "The consideration and thoughtfulness shown to (name) and all her family has been amazing" and "You were all very kind and helpful".

We observed kind and caring interactions from the staff towards people. People looked as if they were relaxed with the staff that were around them. Staff asked people how they were and listened to their comments back. Staff spent time with people, for example, at mealtimes or when they were distressed; really trying to encourage and support people in a very kind way. It was evident that the people staff looked after really mattered to them. One person in particular required staff to understand why they behaved in a certain way. Their behaviour, which could be perceived as challenging, was often triggered by personal upsets. This was the case during the inspection and staff demonstrated that they had a good relationship with the person which enabled them to offer and provide them with the support they needed. This was done in a particularly patient and non-judgemental way. Another person could get distressed easily and required one to one interaction from staff to alleviate this. One member of staff interacted with this person in a very calming manner and used conversation and activities to divert the person's distressing thoughts. Another person fell during the inspection and staff responded very quickly and efficiently to this emergency. However, we observed an unrushed and calming approach from staff which we could see helped the person to feel cared for and more relaxed. This person later told us that they had felt shaken but the staff were always very "able", "kind" and "calming" when they attended to them.

People's care plans documented their personal histories and preferences well so staff were able to tailor people's care around these. Care plans documented how staff were to help people make day to day decisions and how choices should be provided. We observed many examples throughout the inspection of people being supported to make decisions and their choices being respected. Staff therefore listened to people and respected their views. Staff had good relationships with people's family members. Where a person could not make decisions or express their preferences their relatives were encouraged to represent them and to be as involved as they could be. Relatives and friends were welcomed without any restrictions and although this is a good thing we were able to enter the home and walk around it unchallenged before, we, approached a member of staff to say who we were. This had also been the experience of one other visiting professional. We fed this back to the registered manager who agreed this needed some thought in order to ensure people's safety but still ensure visitors felt welcomed and unrestricted.

People were treated with respect at all times. The way staff spoke with people, about them when discussing their care needs and the way people's care records were written showed this was normal practice at Four Seasons. People's care was delivered in private and information about them held confidentially. Conversations about people's care and health were carried out privately.

The registered manager explained that when people were admitted to Four Seasons they were often very elderly and very frail. For example, thirteen people were in their late 90's and early 100's at the time of the inspection. The registered manager explained that this meant staff provided a lot of end of life care. The registered manager said, "I believe we do end of life care very well here. I'm proud of it". They said, "There is always a person/member of staff sat with someone when they are dying". Staff go over and above to make sure this is the case". They explained staff had sat with people in their own time to ensure this was the case if they did not have relatives to do this. The registered manager explained that they had slept in one person's bedroom because the person had not wanted to be alone at all during the night and there had been no relatives. They told us they had also sat with another person at the end of their life, with their relative who had found the experience very distressing.

People's end of life wishes were already well documented because staff had conversations with people about this. Details from any advanced directives were also included. The registered manager was due however to introduce a new end of life care plan, which at an appropriate time would take over from all existing care plans. This would record the person's end of life wishes and give direction to staff on how to meet the person's needs during the time they were 'actively' dying.

People's medical needs were met well at this time because senior staff reviewed people's health regularly with the relevant GP. Good communication and working relationships with community nurses also meant people's health care needs were met. A senior member of staff told us anticipatory end of life medicines were always organised before they were needed. This was to ensure people had access to the necessary pain relief and other medicine they may require at this stage of their life. They told us community nurses were very good at supporting the staff when these medicines needed to be administered by a qualified nurse. They told us people were never left in unnecessary pain or distress without everything being done to avoid this.

Good

Is the service responsive?

Our findings

People received personalised care. This was achieved by involving people in the planning of their care wherever possible. Before admission people's needs were assessed to ensure these could be met once the person had been admitted. Once admitted, this information and people's further involvement enabled staff to formulate accurate and very individualised care plans. Care plans recorded people's needs, their likes, dislikes, preferences and choices about how their care would be delivered. Where people were unable to provide this information their relatives and representatives were actively encouraged to do this on their behalf.

Care plans also detailed what people could do independently and where they needed additional support. For example, one person's care plans recorded the fact they were aware they had dementia but, also detailed what they could still make decisions about and what they still felt confident in achieving independently. Another person's care plans recorded the person's altered and improved abilities following their admission to Four Seasons. They showed how the person had become more independent with support and encouragement from the staff. Care plans were generally reviewed on a monthly basis and when people's needs altered. When people's mental capacity altered changes in people's mental ability were also incorporated into the care planning. Health care professionals confirmed the staff responded well to people's altering needs and that they took the right initiative in managing these. Well maintained care records meant staff and visiting health care professionals had access to up to date information about people's needs. This helped people receive consistent and safe care and treatment.

People were supported to take part in social activities, if they wished to do this, by an activities co-ordinator. This person worked from 10am until 2pm Monday to Friday. They told us they often worked longer hours when able to do so in school holidays. They made sure people were updated on the day, date, month and year by putting this information in the lounge each day. Records showed that the activities provided were fairly limited and people told us they felt bored at times. They told us the television was often on for long periods of time and they "wished it was not". However, they also told us that when activities were provided they enjoyed them. One person's records recorded behaviour which could be perceived as being challenging. The use of activities had been successful in de-escalating this person's distress. For example, by the use of a familiar topic in conversation and knitting this person had been helped to feel calmer. Another person enjoyed taking delivery of their newspaper each day. They said, "This is delivered to me each day and it lasts me all day. I enjoy it". Another person had been out with their family but also told us they enjoyed taking part in the activities held by the activities co-ordinator. The activities co-ordinator told us that the old fashion sweet cart, parked in the lounge, with its jars of sweets and old fashioned advertising posters was used to start conversations about fond childhood memories. They said, "They (the people) love it". A comment from the satisfaction survey carried out in December 2014 had said that activities were "much improved". This had coincided with the provision of designated activity hours by the provider.

There were arrangements in place to listen to and respond to concerns and complaints received. Information about how to make a complaint was on the home's noticeboard. We checked on complaints made since the last inspection. One complaint had been recorded. This had been made by the emergency

services. It had been very well investigated by the registered manager who had responded fully to the issues raised. They had provided the complainant with information which showed that there had been confused communication between two sets of emergency services. The registered manager told us they were always "out and about" and talking with families and visitors who were able to talk to them about any concerns they had.

Good

Is the service well-led?

Our findings

The registered manager had managed Four Seasons since April 2014 and was fully committed to making sure people received the best care they could. They worked closely with the provider's representative to ensure the home ran economically but as effectively as it could. The registered manager provided strong leadership and staff were committed to their values which were to ensure people were always at the centre of whatever took place at Four Seasons and for them to be treated kindly and with compassion at all times. There were several challenges to managing Four Seasons which were discussed during the inspection and which were managed well. These included difficulties in recruiting suitable and permanent staff in an affluent rural area, managing a service on county boundaries which often resulted in additional complications when resourcing support (an example of this being the home's recent complaint) and very frail people needing care near to where they lived but not qualifying for free nursing care. For all of this evidence gathered as part of this inspection showed that Four Seasons was very much part of the local community and with good community support it delivered a much needed service. It did that well under the registered manager's leadership.

Comments from the December 2014 satisfaction survey said, "The home is now well managed" and "We have been able to discuss issues with the manager as they arise". Relatives expressed great support for the registered manager and spoke in terms of this still being very much the case. One said, "The service is second to none and the manager is top drawer". Another visitor said, "She always makes sure we are updated. We can't fault it or her". The registered manager had an open and very visible management style. She said, "I try to make myself as available as I can. My office door is always open; I'm usually out there working anyway". The difficulties in covering care shifts meant she and her deputy were often working as part of the main care team delivering people's care. Regular meetings were also held with staff, both formally and informally so the senior management team were very in touch with the home's culture. One member of staff said, "(Registered manager's name) is really encouraging, she wants you to feel confident. She wants us to work alongside her as a team and yes, I feel valued". Another member of staff described the registered manager as being "brilliant really".

The management team carried out various audits across a period of a year to help monitor the standard of the services provided and the home's levels of compliance. Some audits were carried out every two to three months. In January 2016 a maintenance and grounds audit was carried out and this had included the issues we had been notified about relating to the lift breaking down. The provider had recently addressed this and a fully refurbished lift was in now in use. This had experienced a few 'teething problems' which had been addressed by the lift specialist. The last medicines audit completed by the management team had been completed in January 2016. Staff had been identified as needing update training and photographs were needed for people's administration records. These actions had been completed. The last infection control audit in February 2016 found no required actions. We discussed the on-going planned improvements to the environment with the provider's representative. These had been identified and future work included: the replacement of some window frames, the refurbishment of one of the bathrooms (now moved forward to May 2016) and on-going work to provide individual radiator controls in people's bedrooms.

Satisfaction questionnaires had not been sent out since December 2014 although the registered manager explained that because of her visible presence in the home and her frequent talks with people, visitors and staff she received views on the service from these groups.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises used by people were not kept suitably clean enough. Regulation 15(1)(a).