HC-One Limited

Hebburn Court Nursing Home

Inspection report

The Old Vicarage
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29 November 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Hebburn Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Hebburn Court Nursing Home accommodates 55 people in one adapted building, across two floors. There were 38 people using the service at the time of our inspection, including some people living with dementia.

This unannounced comprehensive inspection took place on 26 and 29 November 2017. This means that neither the provider nor the staff knew we would be visiting the home.

We last inspected this service in February 2016 and at that time we rated the service as 'good'. However, during this inspection we found some shortfalls at the service, and have now rated the service as 'requires improvement'.

A registered manager was not in post. The previous registered manager had formally de-registered with CQC in May 2017. A new manager had been employed but was absent at the time of our inspector. The deputy manager, with support from two managers from the provider's other services was responsible for the day to day management of the service whilst the manager was not at work. . 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.

There was a strong unpleasant smell around the home, including corridors, lounges and people's bedrooms. The provider was aware of this smell and was working to address it. We have made a recommendation about this. The décor of the home had not been well maintained, as paint was peeling and in bathrooms the woodwork was damaged. Maintenance staff were working through a list of improvement actions, however some absence meant they were running behind schedule. The home was clean and staff followed infection control procedures.

People who used the service and relatives told us staffing was adequate to run the service safely. During our inspection we found there were enough staff to respond to people's requests and meet their needs. However, staff expressed concern over staff numbers overnight. The provider's regional manager advised us that following a staffing review they were increasing the number of staff to cover the busier times of the night. The night before our inspection staffing numbers had fallen below the usual staffing levels, and the contingency protocol had not been followed leaving the service 'short staffed'. The provider's regional manager advised us they would ensure the contingency plan was followed in the future.

The systems in place to keep people safe had been maintained. Staff were knowledgeable about the safeguarding process. Accidents and incidents were well recorded and monitored to determine if any trends were occurring. Risks were managed. Safe recruitment processes, including pre-employment checks had

been followed.

Medicines were administered by trained staff who had their competencies to administer medicines checked regularly. Medicine administration records were well completed. Health and safety checks on the building and equipment were regularly carried out.

Staff training was up to date. Staff received regular supervision and an annual appraisal. New staff were provided with an induction and opportunities to shadow more experienced staff.

Feedback about the food on offer was positive. People were usually provided with a visual choice so they could decide at the time what they would like to eat, based upon how it looked and smelled. Where people needed support to eat, this was given in a dignified way.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Applications had been made for Deprivation of Liberty Safeguards (DoLS), where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied.

People had access to a range of healthcare professionals to maintain their health and wellbeing. Referrals and appointments had been made with GPs, district nurses, specialist nurses and occupational therapists. Their advice had been incorporated into care records.

Most care plans in place were very person-centred and included details about people's life histories and what was important to them. People's individual needs were assessed and an up to date plan of care was in place.

People told us staff were friendly and caring. They told us they were treated with dignity and respect. We saw that staff knew people well, and observed positive interactions where people and staff shared jokes and laughed together. Visitors told us they were welcome to visit at any time.

People spoke highly of the activities on offer. There were a wide variety of stimulating activities planned within the home. The wellbeing coordinator spent time with people on a one-to-one basis as well as planning group activities. We saw one person had been supported by the activities coordinator to reconnect with an old friend they hadn't seen for 20 years.

Complaints had been responded to in line with the provider's policy.

The quality assurance system included a range of audits carried out regularly by the manager, regional manager and the provider's quality assurance team. Whilst there was evidence that some of the shortfalls we identified had been highlighted through these audits we noted the issues were still on-going.

Feedback about the management team was very positive. Staff explained there had been a number of managers in a relatively short period of time, but described the current management team as stable and supportive. The service had built links with the local community and businesses and arranged a collection of food, donated by people, relatives and staff which was donated to a local food bank.

We found one breach of the Health and Social Care Act 2008 This related to Regulation 17: Good Governance. You can see what action we told the registered provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There was an unpleasant smell in some parts of the home. The home looked tired. In places walls were scuffed and paint was peeling. The provider was working through action plans to address these issues.

Whilst people and relatives told us the staffing level was appropriate to their needs, staff expressed concerns about the overnight staffing arrangements. The provider had plans to increase the staffing levels to address these concerns.

People told us the home was safe.

Recruitment processes were robust. Medicines were well managed.

Is the service effective?

Good

The service was effective.

People told us staff were knowledgeable and able to meet their needs.

The provider had identified a schedule of training modules to enable staff to carry out their roles appropriately. Supervisions and appraisals were held regularly.

Staff had a good working understanding of the Mental Capacity Act (2005). Deprivation of Liberty Safeguard authorisations had been submitted where people were unable to leave the home by themselves.

People were complimentary about the food.

People were supported to access a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People told us staff were friendly and kind. They told us they were treated well, with dignity and respect. People's right to privacy was promoted.

Staff knew people very well and had built friendly relationships. Visitors told us they were made to feel very welcome.

Staff had gone the extra mile to reunite one person who used the service with a long lost friend.

Is the service responsive?

Good

The service was responsive.

Care plans were generally detailed with clear information about how staff should provide consistent and personalised care for people.

The service provided a range of activities planned to meet people's personal choices, which were well received by people who used the service and their relatives.

Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance system was in-depth and covered a range of areas. ,However, whilst it had identified some of the shortfalls which we found during this inspection, they had had not been fully addressed.

A registered manager had not been in place since May 2017. People spoke highly of the management team, and staff described them as 'stable and supportive'.

The home had built links with the local community.

Hebburn Court Nursing Home

Detailed findings

Background to this inspection

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

The inspection was prompted in part by information shared with CQC by the relatives of one person who had used the service. The potential concerns detailed by the relatives focussed on the management of the risks of falls, staffing levels, the moving and handling of people, responses to accidents and incidents, meeting people's hydration and nutrition needs and personal hygiene needs, equipment maintenance and complaints handling. This inspection examined the potential risks raised by those concerns.

This inspection took place on 26 and 29 November and was unannounced.

The inspection was carried out by an inspector, a specialist advisor and two expert by experiences. Specialist advisors are clinicians and professionals who assist us with inspections. The specialist advisor on this inspection was a registered nurse with experience in leadership and management. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both of the expert by experiences who were part of the inspection team had experience of a relative using a care home.

Before the inspection, we reviewed the information we held about the service. This included looking at statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. On this instance we did not ask the provider to complete 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.

During the inspection, we spoke with eight people who used the service and six people's visitors. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Throughout the inspection, we spent time in the communal areas of the home observing how staff interacted with people and supported them. With consent, we looked in five people's bedrooms.

We spoke with the deputy manager, the provider's regional manager, a registered nurse, a nursing assistance, and seven care workers. We reviewed three people's care records including their medicines administration records. We looked at four staff personnel files, in addition to a range of records in relation to the safety and management of the service.

Requires Improvement

Is the service safe?

Our findings

During our inspection we noted there was an unpleasant smell throughout the home. The malodour was noticeable in some corridors, lounges and bedrooms, and stronger on the upstairs floor. People we spoke with did not express dissatisfaction about the smell, and everyone told us they thought the home was clean, People's comments included; "I think it's clean, yes, there are funny smells but its soon cleaned."; "I think the building's great, it's clean with no smell." and "The lounge is clean but it could be better." Whilst the smell was still evident on the second day of our inspection, it was not as strong as the first. The malodour had been noted within audits carried out by the manager and the provider. We could see from action plans that a number of steps including deep cleaning of carpets, and replacing some pieces of furniture had been taken to address the smell. The deputy manager told us work was on-going and that specialised odour control products had been sourced and would be used, and lino flooring was to be replaced. They advised that if the issue wasn't fully addressed then new carpets would be purchased. During our inspection we saw domestic staff cleaning the home. Regular cleaning audits were completed. There were risk assessments in place for the control of substances hazardous to health (COSHH).

We recommend that the provider researches and follows best practice regarding odour control to ensure appropriate standards of hygiene are met within the home.

Some parts of the home decoration looked tired. The walls were badly scuffed and paint was peeling. In some of the bathrooms the woodwork which covering pipes was damaged. The deputy manager told us the maintenance staff employed by the home had recently been absent from work, but that they were working through an action plan to address the areas of the home which did not meet the provider's standard.

Prior to our inspection we had received some concerns from a relative about staffing numbers, specifically on a weekend and overnight. We carried out this inspection outside of our usual working hours. We arrived for the first day of our unannounced inspection at 7:45am on a Sunday morning. When we arrived night staff advised us there had been an incident where an agency staff member had left the home in the middle of their shift. This meant there was one less member of staff than had been planned for.

At the time of the inspection there were 38 people living in the home. The deputy manager told us the home was staffed so that during the day there were nine staff on duty, including at least one nurse. Overnight there should have been four staff including a registered nurse. On the day we inspected an agency staff member had left the home at 11pm, which meant there were three staff, including the nurse, on duty from 11pm until 7:45am the next morning. In addition, there was also one member of staff who provided one to one support to one person on duty all night, and another one to one support staff member who started work at 5am.

The deputy manager told us they had been informed that the agency staff member had left, but had been unable to arrange any other cover. In discussions with the regional manager they told us that there was a contingency protocol to follow, and that the reduction in staff should have been escalated so cover could have been arranged. We discussed the incident with the deputy manager who completed a safeguarding referral, as people could have been put at risk due to the reduction in the staffing numbers.

We reviewed staffing rotas for the six weeks prior to our inspection. We found that the staffing ratios described by the deputy manager had been consistently met. There had been five occasions where, due to staff sickness the home had one less staff member than planned for a few hours, however we saw from the rota and agency invoice records, that additional staff had been arranged to ensure the home met their minimum staffing number. The regional manager said, "I will always sign off on agency use, rather than be short staffed." In discussions with staff they advised us staff numbers were consistent, and that agency staff were used for unexpected staff absence.

People and relatives we spoke with told us staffing was adequate to meet the needs of everyone in the home. One person said, "Yes there is enough (care staff). During the day and overnight is fine." Another commented, "There is normally 3 staff, I think that's enough." A third person stated, "I think so (enough staff), they are always busy though." A relative said, "There are enough, although more is always better." Another relative commented, "Yes I think there's enough to meet the people's needs."

Most people told us staff responded to them quickly. One person said, "They always come if I press my buzzer." Another person said, "I think they respond to the buzzers quickly enough. They do mine anyway." However one person did express that it took "quite a long time" for staff to attend to them after they pressed their call bell. During our inspection we saw there was a good staff presence. Staff appeared busy but people's needs were met. There was always a member of staff in the lounge area to provide support if people needed it and lunch was well managed to provide support to people who needed assistance from staff.

However, seven of the nine staff we spoke with told us there were not enough staff in the home at night. The home was set over two floors, and at night two staff would be based on each floor. Almost two thirds of the people who used the service required two members of staff to meet their personal care needs. Staff said, when the nurse was unavailable due to administering medicines and completing paperwork, that it was difficult to meet everyone's needs. The regional manager told us they had carried out a staffing review using a new tool. The new assessment tool was very detailed and included information about a number of factors such as people's psychological needs and physical needs. The regional manager told us the staffing review highlighted some 'hot spots' where more staff would be beneficial. For that reason they had decided to introduce an additional twilight shift which meant an extra member of staff would work until midnight, and another staff member would start work an hour earlier than usual at 7am to provide extra support in those busier times. The regional manager advised us the home was recruiting more staff to meet these extra staffing hours, but was confident it would be in place within a week of our inspection.

Recruitment of staff remained robust and thorough. Appropriate checks had been undertaken before staff began working for the service, including written references, and a satisfactory Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Registration of nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC).

People told us they felt safe at the home. One person said, "Yes, I do think it's safe. I like it here." Relatives agreed it was a safe home. One relative said, "Yes, I think she's safe, they really do look after her." Staff had undertaken safeguarding training about how to recognise and respond to any concerns. The staff we spoke with were able to clearly describe the appropriate steps they would take if they were worried about people's safety or wellbeing. Safeguarding records showed prompt referrals had been made to the local authority safeguarding team, and investigations had been undertaken where necessary.

Some people who used the service could display anxiety, distress and aggression due to their needs, and therefore could pose a risk to other people using the service. Where this was the case, the risk of causing harm had been assessed, and a number of steps determined to reduce the risk of any harm occurring. Care plans related to people's mental health and behaviour were specific to the individual and included information about any potential 'triggers' and the best way staff should try and diffuse any situations which may arise. One care plan included topics of conversation which the person enjoyed; their favourite music and types of food, and a list of 'indications of deteriorating mood'. Staff were able to use this information to reassure the person if they felt uneasy. We could see staff had made referrals to, and worked alongside the positive behaviour support team, to get specialised support where people displayed behaviours which may be challenging to staff.

Prior to our inspection there had been an incident where one person had been seriously injured as a result of another person displaying aggressive behaviours. In response to this more safeguards had been introduced. The person received one to one support, provided by agency staff. Following the incident agency staff were required to sign to confirm they had read and understood the person's care plan related to their behaviours. The person's placement was also being reassessed to see if another environment could better suit their needs. We noted that the person's one to one staff was distracted at times during our inspection and not giving the person their full attention. For example, at one point they assisted another staff member to move a table, and on another occasion they left the room to use a water dispenser. We fed back to the deputy manager that permanent staff had been aware of the agency staff's distraction, and had not challenged it. The acting manager told us they would discuss this with staff and reiterate their responsibility to act to ensure the safety of everyone in the home.

Risks were assessed and where possible, actions were identified for staff to take to mitigate these occurring. For example, within the records we viewed we saw risks such as; the inability to use the nurse call bell, use of the hoist, risk of falling out of bed/chair, use of bed rails, diabetes, moving and handling, mobility, falls, nutrition and hydration, choking, continence and skin integrity. Risks were reassessed regularly.

Accidents and incidents were well monitored. The service had used an on-line system which time-stamped when records had been completed by staff. We saw accidents and incidents records were completed promptly after they had occurred, and were reviewed by the manager and if required the regional manager. The system prompted the manager to consider if staff had acted appropriately, if any further action was required and if any other agencies required to be notified, such as the local safeguarding team, or CQC. Records showed details of investigations and outcomes, and the monthly reports were produced to highlight any patterns or trends.

We looked at the arrangements for the management of medicines. Systems were in place to ensure that medicines had been ordered, received, stored, administered and disposed of appropriately. PRN (as required medicines) protocols were in place. PRN protocols assist staff by providing clear guidance on when PRN medicines should be administered and how often people require additional medicines such those for pain relief. Appropriate arrangements were in place for the use of controlled drugs, which are medicines which may be at risk of misuse. Staff knew the required procedures for managing controlled drugs safely.

We looked at three people's medicines and saw stocks tallied with medicines administration records. Records showed medicines had been administered at the appropriate time in terms of drug and food interactions. We observed staff explain to people what medicine they were taking and why. People were given the support and time they needed when taking their medicines. People were offered a drink of water and staff checked that all medicines were taken. Staff who administered medicines had been trained and their competency in administering medicines safely was assessed annually.

There was a separate record for the application of topical medicines, such as creams, which included information such as what the medicine was for and where it should be applied. However we noted two prescribed creams were not listed on any records. Staff advised us they applied these creams regularly, but the lack of recording meant we could not be sure if the person was having their medication administered as they were prescribed. On the second day of our inspection the deputy manager showed us updated records which included these two creams.

Certificates in relation to health and safety for the premises remained in place and up to date. For example, electrical installation, fire safety and PAT (portable appliance testing) records. The service also had a range of risk assessments for the building and the environment. These included moving and assisting equipment, water temperatures and emergency lighting testing. These were reviewed on a regular basis to ensure they were up to date. Policies and procedures were also in place to ensure safe working practices; the organisation reviewed policies on an annual basis.

Good

Is the service effective?

Our findings

People and relatives told us staff were skilled and knowledgeable to meet people's needs. One relative said, "I think the staff are competent to look after [my relative]." Another relative said, "The staff certainly seem to know what they are doing. [My relative] is happier now (they live at the home)."

Staff we talked with spoke highly of the training provided. All of the nine staff we spoke with told us they felt suitably trained to support people effectively. One staff member said, "The training is good. Always on-going, always something new to do, but it's good. Means we know what we are doing." The provider had identified a programme of training which they considered mandatory for all of their staff, including dementia, moving and assisting, nutritional needs, communication and health and safety. Training was monitored to ensure refresher courses were scheduled so staff training and knowledge remained up to date. We saw the service had a high level of completion for training, with over 80% of training being up to date. Required training had been scheduled for future dates.

Training was supported by individualised information within care records which described to staff how they should carry out each person's care. For example, staff received face to face practical training in the moving and handling of people. Within each person's record were details, such as, how many staff were required and the details of any equipment needed to support the person to get in and out of bed, or into a chair. During our inspection we saw people being supported to move as per their care plans.

New staff received an induction into the service and were supported by other staff members in the initial days of employment. The induction incorporated 'The Care Certificate'. The Care Certificate is a set of minimum standards for care workers. New staff were also 'buddied up' when they started working at the home, which meant they worked alongside experienced staff and had the opportunity to ask questions and learn about the people they were supporting.

Staff told us they had had regular opportunities for formal supervision, yearly appraisal and had also attended staff meetings. Records confirmed this, and were specific to staff's job role, prompting the supervisor or appraiser to reflect with staff about best practice along with development needs. The service had a clinical supervision system in place for nursing staff. Records were available to demonstrate nurse supervisions were up to date. Records contained feedback from nurses regarding their development.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Some people who used the service did not have capacity to leave the home unaccompanied, as it was considered that they would be unable to keep themselves safe. We saw in these cases that applications had been made to the local authority for DoLS authorisations.

Where people did not always have capacity, assessments and best interest decisions were in place. However we saw variance in how well these had been completed. We saw a number of capacity assessments which were not decision specific. For example, one persons assessment discussed whether they could make decisions about their 'care/safety/treatment/welfare/health and wellbeing'. One of the principles of the MCA is that a person's capacity must be assessed in terms of making a specific decision. The acting manager told us they were confident this was a recording issue, and that they planned to provide more feedback to staff about the level of detail expected in MCA documentation. In discussions with staff they were clear that even where people were unable, due to capacity, to make bigger decisions, such as where they should live, that they were encouraged to make day to day decisions, such as what they would like to wear, when they would like a bath or shower, and what they would like to eat. We did see other examples where decisions were more specific, for example one person had an assessment in place to determine whether they had capacity to understand and consent to the use of bed rails.

Care records showed people had been asked for their consent when their care was being planned. For example, we saw people had consented to the use of photographs on care plans and medical records. Throughout the inspection we overheard staff ask for consent, in ways such as saying, "Can I help you up?", "Would you like some help?" and "Would you like to take your medicines now."

We observed lunch on both of the days of our inspection. On the first day of our inspection we saw people on the upstairs floor were not offered a choice of their meal. We discussed this with staff who advised they usually would show people plates with the two options available so they could choose, however on that day they thought they had only been provided with one option from the kitchen, however on investigation we found they did have two. People on the ground floor on the first day of our inspection, and everybody on the second day were given a choice. We observed that staff showed people both meal choices plated up. This meant they could see and smell the food which was particularly beneficial to people who had a dementia related condition.

People were positive about the food at the home. One relative said, "[My relative] has a good breakfast, they do things like bacon and tomatoes, but they like to have their lunch with us so we bring things in for her and we eat together." Food was well presented and hot and cold drinks and condiments were available. Where people required support to eat their food staff provided this in an unhurried way, sitting next to the person and giving them their full attention. Drinks stations were located throughout the home, so people or relatives could help themselves to cold drinks whenever they wanted to. Staff monitored some people's food and fluid intake to minimise the risk of malnutrition or dehydration. Records had been well completed to allow staff a good understanding of how much the person had taken in. There was good communication between care and catering staff, as kitchen staff had been provided with documentation as to people's food and drink preferences to support people's nutritional wellbeing.

People's care records showed details of referrals to, and visits by, health and social care professionals. Staff had worked with various agencies and made sure people accessed other services in cases of emergency, or when people's needs had changed. For example, where people were determined to be at risk of falls, referrals has been made to occupational therapy for advice on equipment which may help the person to stay independent, GPs to check if people's medicines may be a factor, and the falls team for further investigations. Care plans reflected the advice and guidance provided by external health and social care

professionals. This demonstrated that staff worked with various agencies and sought professional advice, to ensure that the individual needs of the people were being met.

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There was good clear signage throughout the home, for example, using text and pictures as well as colours to assist people to use bathrooms. The registered manager advised the home was planning some refurbishment, which would include a themed beach space to provide an area of interest and to facilitate reminiscence. There were some touchable textured art works on the walls and sets of drawers contained day to day items for people to rummage in, which provided people with opportunities for unstructured activity. Outside was a patio garden and an enclosed area for people to walk around the building. The garden doors were in one of the lounges and accessible to everyone so people could go outside as they pleased. We noted these doors were opened frequently by staff going outside on their breaks. This meant the lounge area was at times quite cold. We discussed this with the deputy manager and regional manager who advised they would reconsider what other outdoor space could be allocated to staff, to reduce the amount of times these doors were opened.

Good

Is the service caring?

Our findings

People told us staff were warm, friendly and caring. One person said, "Staff are lovely, they are all very caring." Another person said, "Staff are pleasant, they're all kind here." One relative told us they thought staff responses could be variable depending on the staff member they spoke with. They said, "I've found the care good from some staff but not others. Staff are affectionate but other people get more attention because [my relative] is quiet." We shared this feedback with the deputy manager.

Throughout the inspection we saw staff knew people who used the service well. Staff greeted visitors when they arrived at the home. Relatives told us they were welcome to visit whenever they wanted to. In conversation with us staff were knowledgeable about people and their needs. People seemed relaxed in the company of the staff, and we saw people laughing and sharing a joke throughout the inspection visit. One person was unable to communicate verbally, but we saw them break into a big smile when a staff member approached them. Staff used body language and touch to show their affections. We saw staff hold hands with people when they sat next to them, or putting their arm around people to comfort them.

People's privacy and dignity was upheld. We saw people looked well groomed, wearing clean, matching clothes. One relative said, "Yes they always keep [my relative] clean and tidy, the staff are good. And they always look after me too." Where people were not as smartly presented we saw from their care records that this was due to personal choice.

Staff knocked on bedroom doors before they entered, even when doors were open, to check people were happy for them to enter. One person commented, "The door always gets closed when they're helping." One person had recently returned to the home from hospital, and we saw staff checked on them often. One staff member said, "They are doing great, but we are just popping in so they know we are there."

People were encouraged to be independent. People's care records set out what tasks people could manage themselves and detailed that staff should prompt people to maintain these skills, for example by washing their own face and hands whilst staff supported them to bathe. We observed that staff supported people to be independent where they could. For example, over lunch we saw staff ask people if they would like salt or pepper and handed people the canister to use themselves.

Overall we saw staff were respectful when speaking with people. We did note one member of staff discussed one person's personal care needs in front of other people which did not promote their dignity, but we fed this back to the deputy manager who told us they would discuss this with staff to reemphasis expectations.

Care records had been written with input from people who used the service and their relatives. We saw specific information had been recorded about each person in their life history, which included details about the person's family, past jobs and any particular events which were important to them. This allowed staff to engage people in conversation which was meaningful to them, to understand people's needs and backgrounds and to meet their personal preferences.

Information was provided to people in service user guides about what they should expect from the service. Noticeboards contained information about dementia for people, relatives and visitors. Staff had been assigned as 'dementia champions' and 'equality and diversity champions' which meant they were responsible for promoting information and best practice to people, relatives and colleagues.

At the time of our inspection no one was accessing an advocacy service. The deputy manager told us they would make a referral if they identified anyone who would benefit from this type of service. Information relating to independent advocacy was available on the noticeboard. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

The wellbeing coordinator told us that during their one to one time with people they had talked to one person about a friend they had lost touch with. The person had not seen their friend for over 20 years. The wellbeing coordinator did some research on behalf of the person and found the friend was being cared for at a nearby care home. A visit was facilitated and the friends were reunited after such a long time. The person had been delighted and a follow up visit had been planned.

Good

Is the service responsive?

Our findings

People and relatives told us that staff were responsive to their need. One person said, "I'm well looked after. No complaints from me." During our inspection we saw staff were always available within communal areas. We heard call bells were responded to promptly, and that staff asked people if they needed any assistance when they were nearby.

People's needs were assessed before they moved into the home to make sure the staff were able to care for the individual and had the necessary equipment to ensure the people's safety and comfort. People's needs and plans of care were reviewed and updated at least once a month to ensure they contained relevant information.

Following the initial assessments, care plan were developed which detailed how staff should support to meet people's daily needs such as their physical wellbeing, diet, mobility and personal hygiene. Care plans were varied in how detailed they were. Most had been written in a person-centred way, including specific information about the person and providing guidance for staff to follow to provide the person with consistent care. For example, a care plan relating to one person's epilepsy stated if the person was to show signs of having a seizure, staff were to ensure safety by removing objects and place the person in the recovery position. There was also information on the type of seizure the person experienced, the triggers, what the seizure might look like and when to seek emergency help. This meant staff had the information they needed to support them to recognise if the person was experiencing a seizure and clear instruction about how they should respond.

However, others were much briefer and more task based, with less specific information to guide staff. Two people with diabetes had care plans which, whilst detailing to staff the action they should take if blood sugar levels were too low or high, did not set out what their usual blood sugar level ranges were or clarified what constituted as a high or low reading. By reading the care plan alone staff would not have been able to identify when to take action. We discussed the two people's care with staff responsible for checking blood sugars. They were clear on the usual ranges of readings, and when they would seek further medical attention. We discussed these care records with the deputy manager who advised us they were of some variance. They advised us they were going to arrange extra staff training, supervision and feedback about the expected standard of care plans to ensure more consistency across records.

Some people were at risk of developing damage to their skin. Preventative pressure relieving measures were in place for those people who required them. We checked four people's equipment and saw each was on the right setting for the person's needs. People had detailed care plans to inform staff of the intervention they required to ensure healthy skin, and staff regularly checked the equipment settings to ensure they were working efficiently. One person had a wound. The treatment plan was clear and evidenced the progress which was being made. This showed people's care was delivered as planned.

Where people had communication needs, these were well detailed within care records. We saw specific information for staff to follow in relation to how they engaged with people, to enable people who could not

always communicate verbally in decision making and interaction. For example, one person's records stated '[Person's name]'s speech is short, soft, clear and simple. Able to respond in simple short sentences or single words and able to follow simple instructions like 'please give your hand' and 'turn to me', but at times with some display of anxiety.' This meant staff were provided with information to be able to provide consistent support.

Daily records were kept for each person. These contained a summary of support delivered and any changes which had occurred, including when people were being cared for in bed and at risk of deteriorating skin integrity. If people needed support to eat and drink, additional documentation to record re-positioning at regular intervals and their food and drink intake were kept. We saw these were well maintained with no long gaps between entries.

People and relatives had been involved in care planning on a 6-12 monthly basis. The care plan documentation was signed by the person where they were able or a family member if they were unable to sign. People's care plans were reviewed on an annual basis, with the person, relatives and other professionals involved in their care. This meant that people were consulted about their care, and thus the quality and continuity of care was maintained.

The service provided end of life care to people with terminal and life limiting illnesses. People and their relatives had been asked to consider sharing their end of life wishes, this meant information was available to inform staff of the person's wishes at this important time when people may no longer be able to communicate those wishes themselves. One staff member described the care staff had recently provided to one person at the end of their life. They said, "Every single day when staff come on shift they make a difference. They give 110% for their job role. One person passed away recently and the care was second to none. Comforting the family, giving reassurance and comfort to them. The family are part of our family. They showed compassion in the way they did it. I'm proud of us all."

People and their relatives were consistently positive in their comments about the activities on offer in the home. One person said, "There's regular entertainment, that's good." A relative said, "There is something going on every day, [my relative] always gets involved." A board displayed the scheduled activities for the upcoming week. We saw manicures were planned for the morning of the second day of our visit, and people enjoyed having their nails painted. Other people played games including noughts and crosses, and passing a ball between themselves. Staff asked everyone if they would like to take part, and people looked to be enjoying themselves. We saw people smiling and chatting with staff. On the afternoon of the second day of our visit a singer had been invited to the home. People from both the upper and lower floors of the home came together to participate. People and staff were singing along, and we saw staff supported two people to dance.

We spoke with the wellbeing coordinator who arranged daily and one off events. They were passionate about their role and told us they tried to match activities to people's individual interests. They told us they regularly held coffee mornings, arts and crafts, board games, musical memories, and took people for meals in restaurants or cafes. Where people were unable to participate in group activities, the activities coordinator spent time with people on a one to one basis. They told us they would sit with people whilst they played music records or reminisced about the local area. Records showed these one to one activities were held at least weekly.

All of the people we spoke with told us they would make a complaint if they had any concerns. One person said, "No I've never had to raise any concerns." A relative told us they had made a complaint after items of their family member's clothes had gone missing. They said, "The staff do help to look for her things when

they go missing and usually they get returned."

Complaints had been recorded and the manager had followed the provider's complaints policy in response to formal written complaints and any concerns which had been raised verbally. Where necessary the manager had carried out investigations in response to complaints including reviewing records and taking statements from staff.

Requires Improvement

Is the service well-led?

Our findings

During our inspection we found shortfalls in delivery of the service which had not been fully addressed by the provider's internal quality assurance systems. The unpleasant smell within the home, and the poor standard of decoration had been noted within audits carried out by the manager and the provider in the months prior to our inspection. Whilst we could see some actions had been taken to address these areas, both issues were still evident during our inspection.

Overall we saw people's care records were detailed and specific. However we noted a number of examples where they were task based, brief and needed to be re-written in order to provide staff with important information about people's needs. Capacity assessments did not always follow the principles of the Mental Capacity Act 2005 in being decision specific. Care plan audits were carried out regularly but had not addressed these areas of improvement.

The contingency plan, in place to ensure the home was always appropriately staffed based on an assessment of people's needs, had not been followed. On the first day of our inspection we found an agency staff member had left the home in the middle of their nightshift. This staff member was not replaced, leaving the home understaffed for eight hours.

The quality assurance system was in-depth and comprehensive with schedule of audits and assessment carried out by staff of different designations. The acting manager completed a walk around of the home every day, noting areas to address. Medicines systems, health and safety, infection control processes, the kitchen and dining room experiences were audited regularly. The provider's regional manager visited the home frequently, and prepared a monthly report which included checking records, speaking with staff and people who used the service. Representatives from the provider's quality assurance department also carried out in-depth audits, based on CQC inspections. Whilst we could see that areas for improvement throughout the quality assurance systems were noted, and action plans created and worked towards to address areas for improvement, they had not fully addressed the shortfalls we identified during this inspection regarding the odour and upkeep of the home, and record keeping.

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

At the time of our inspection a registered manager was not in place. The previous registered manager had formally de-registered with the Care Quality Commission in May 2017. Since that time the home had been run by another manager, who was absent from the home at the time of our inspection. When we visited, the deputy manager was being supported by managers from the provider's other services to run the home. Feedback about the leadership of the service was very positive. People told us the management team were friendly and had a visible presence in the home. One person said, "[Deputy manager] is very approachable, he'll come in and talk to us"

Staff comments about the management and the provider organisation were very positive. They described

the management team as supportive and stable, and told us they thought they had the skills to be able to run the home very well. One staff member said, "We've had a high turnover of managers recently. Staff morale went down, but because we are quite close we come together. It is settling down quite a bit now. [Deputy manager] is very approachable, he wants to drive us forward. He will always ask are you alright? Is there anything you need? [Acting manager] is good too." Another staff member said, "[Deputy manager] is fantastic. You can just approach him. I can't speak highly enough of him, he is really fab. He has a way about him. So lovely with the residents." Staff meetings were held regularly to discuss staff performance, changes to the service and future plans.

The culture of the service was open and transparent. During the inspection, the management team displayed openness and transparency towards the evidence we presented to them and were proactive in their response to our findings. The deputy manager and regional manager showed a commitment to making changes and improvements within the home. We saw from staff meeting minutes that this vision was communicated to staff. One entry from a recent meeting stated, "Staff performance at present is superb, we are grasping challenges and moving forwards." In addition to staff meetings, 'flash meetings' were held regularly, which were short meetings held at the start or end of a shift to communicate any important messages to staff.

The service had an information gathering process. A poster on display called, "You said – we did" showed that the service had acted on comments made by stakeholders. Records showed the manager held regular meetings with people and relatives. Meeting minutes were available. The service carried out surveys on an annual basis to capture views of relatives and people who used the service. The recent survey responses contained very positive comments.

The home had built strong links with the community and local businesses. The home's wellbeing coordinator had recently organised a harvest festival collection, with people, relatives and staff contributing to a collection of food which was then donated to a local food bank. The home held event throughout the year, including Christmas and summer fayres which the local community were invited to.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not always operated effectively to ensure compliance with the requirements. Although audits and checks on the service were in place they had not been robust enough to address the issues we highlighted at this inspection. Where shortfalls had been identified, they had not been fully addressed. Risks relating to health, welfare and safety had not been mitigated, due to issues with staffing and because the provider had not ensured that complete records were in place for each person who used the service. Regulation 17(1)(2)(a)(b)(c)