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Freegrove Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on the 29 February 2016 and the 2nd March 2016. The inspection was undertaken to check whether the provider had made improvements and was now 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 also looked at whether improvements had been made following enforcement action we took in June 2015.

Freegrove Care Home is a small family owned residential care home located in a residential area of Lymington. The home is arranged over two floors and can accommodate up to 17 people but at the time of our inspection there were 12 people living at the home. The home supports people with a range of needs. Some people were quite independent and only needed minimal assistance. Others were more dependent and needed assistance with most daily living requirements including support with managing their personal care and mobility needs. Some of the people being cared for in the home were living with dementia and a small number could display behaviour which challenged others.

The home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The provider is applying to the Care Quality Commission (CQC) to remove the condition that requires them to have a registered manager in place. This was because they were now managing the home themselves.

The inspection found that a number of improvements had been made.

Action was being taken to embed the principles of the Mental Capacity Act 2005 within the care planning process. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

The provider had made significant improvements to the governance arrangements in place. A range of audits were undertaken to assess and monitor the quality and safety of the service. These needed to be embedded and sustained to ensure that they continued to drive improvements.

There were sufficient numbers of staff deployed to meet people's needs and appropriate recruitment checks took place before staff started working at the home. People received effective care from staff that had the right skills and knowledge to carry out their role.

Staff had received training in safeguarding vulnerable adults and had a good understanding of the signs of abuse and neglect. They were aware of what to do if they suspected abuse was taking place.

People's records contained appropriate risk assessments which covered a range of areas. Care workers said that the risk assessments told them what they needed to know about each person and how to deliver their care safely.

People's medicines were managed safely. The home was clean and food was being stored safely in line with guidance from the Food Standards Agency. People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk.

The home worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

People were treated with dignity and respect. Staff were kind and caring in their interactions with people and people and their relatives were involved in making decisions and planning care.

Records were written in a manner that helped to make sure people received care that was centred on them as an individual. Changes to people's needs were effectively communicated within the staff team.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide and displayed within the home.

Everyone spoke positively about the friendly and homely culture within the home. People, relatives and staff had confidence that the provider listened to their concerns and felt able to make suggestions about how the service could improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People told us they felt safe living at Freegrove Care Home. The provider had taken action to improve staffing levels so that people's needs could be met safely. Action had been taken to ensure that staff they employed were of good character.

People's medicines were managed safely. The home was clean food was being stored safely in line with guidance from the Food Standards Agency.

There were a range of systems and processes in place to help identify and manage risks to people's wellbeing. Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect.

Is the service effective?

Good

The service was effective

Action was being taken to embed the principles of the Mental Capacity Act 2005 within the care planning process. CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People received effective care from staff that had the right skills and knowledge to carry out their role. Staff were receiving regular supervision and felt supported in their roles.

People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk. Staff worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff were kind and caring in their interactions with people.

People and their relatives were involved in making decisions and planning care.

Is the service responsive?

Good

The service was responsive.

Records were written in a manner that helped to make sure people received care that was centred on them as an individual. Staff recognised and responded to changes in people's health care needs.

People knew how to make a complaint and information about the complaints procedure.

People took part in a range of activities, but some relatives felt more could be done to ensure that staff provided people with increased opportunities for meaningful interaction.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had made significant improvements to the governance arrangements in place. A range of audits were undertaken to assess and monitor the quality and safety of the service. These needed to be embedded and sustained to ensure that they continued to drive improvements.

Everyone spoke positively about the friendly and homely culture within the home. People, relatives and staff had confidence that the provider listened to their concerns and felt able to make suggestions about how the service could improve.

Freegrove Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 also looked at whether improvements had been made following enforcement action we took in June 2015.

This inspection took place on 29 February 2016 and 2nd March 2016 and was unannounced.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The provider had not been asked to complete a Provider Information Return (PIR) before the inspection. 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. However we referred to other information we held about the home to plan the inspection. We reviewed previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is where the registered provider tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with five people who used the service and four relatives. We also spoke with the registered provider, four care workers and the chef. We reviewed the care records of three people in detail and the recruitment records for three staff. We also reviewed the medicines administration record (MAR) for all 12 people. Other records relating to the management of the service such as staff rotas, training records and policies and procedures were also viewed. We also spoke with two healthcare professionals who shared their views about the home and the quality of care people received.

The last inspection of this service was in September 2015. That was a focused inspection and was undertaken to see if improvements had been made to ensure that people received safe care and treatment. Prior to that we had undertaken inspections in January 2015 and June 2015. During those inspections we had identified a number of new and continuing breaches of the legal requirements. In response we took

enforcement action, imposing a condition on the provider which prevented them from taking any new admissions without our written approval.

Good

Is the service safe?

Our findings

People told us they felt safe living at Freegrove Care Home. One person said, "There's never a question of being safe, I'm quite happy". A relative said, "I have seen real improvements, there is a higher ratio of carers and we see a lot more aprons and gloves being worn".

At our inspection in June 2015, we found the service had not ensured that there were, at all times, sufficient numbers of staff deployed to meet people's needs and ensure their safety. At this inspection we found that improvements had been made. People told us there was sufficient staff to meet their needs. One person said, "You just have to say when you're ready for bed". Another person told us staff were always available to support them to the bathroom when they needed it. In addition to the provider, shifts were currently staffed by three care staff one of whom was a senior care worker. During night shifts there were two care staff on duty. The provider told us these target staffing levels were based upon the dependency needs of the people using the service and we were able to see that each month the dependency levels were reviewed to ensure that the staffing levels remained appropriate. We reviewed the staffing rotas for a four week period and found that the service had been staffed to target levels. The rotas showed that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them well. A number of ancillary staff were also employed including a full time chef, a laundry assistant and a housekeeper. The service did not employ staff specifically to provide activities or entertainment and this remained the responsibility of the care staff.

All of the staff we spoke with told us that the staffing levels were adequate and enabled them to perform their role and responsibilities. One staff member said, "There are three carers on now and it works a lot better". Another said, "We normally have three carers on, if someone calls in sick it can be difficult, but it is generally fine". This feedback from staff was much improved upon previous inspections and demonstrated that the provider had taken action to improve staffing levels so that people's needs could be met safely.

At our inspection in July 2014 we found that the provider had not taken proper steps to ensure staff they employed were of good character by obtaining comprehensive and appropriate information about them before they started work. At this inspection we found that improvements had been made. Staff had well organised personnel files which detailed the checks that had been undertaken before they started work. The provider had obtained references from previous employers, a full employment history and checked with the Disclosure and Barring Service (DBS) to ensure prospective staff had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. We did note that in one staff members file, the manager had not retained a copy of the Adult First Check they had undertaken. Adult First Checks are provided by the DBS and can be used in exceptional circumstances to permit staff to start employment before their full DBS check is completed. The provider told us the staff member concerned had only worked supervised until their full DBS check had come ten days later.

We looked at the arrangements for keeping the service clean and for the prevention and control of infections. We checked the fridge and found that food was being stored safely and in line with guidance from the Food Standards Agency. Temperatures were being taken daily of the fridge and freezer to ensure that

foods were being stored at safe temperatures. Cleaning schedules were in place for the kitchen and the service had been awarded the highest food hygiene rating when assessed by food safety officers. Protective clothing, including gloves and aprons, was available and was used by staff appropriately. A cleaner was employed for three hours each weekday and cleaning schedules were in place that set out the frequency with which areas of the home and items of furniture were to be cleaned. Records were maintained to show that the cleaning schedules were followed. At weekends, staff had to complete cleaning tasks alongside their caring duties. Overall, we found the standard of hygiene in the home to be satisfactory.

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. Monitored dosage systems (MDS) were used for the majority of medicines with others supplied in boxes or bottles. Medicines, including controlled drugs, were stored safely and only administered by staff that had been appropriately trained and assessed as competent. We observed some people being given their medicines during our visit; this was managed in a person centred manner. The staff member stayed to ensure that the medicines had been taken and then signed the medicines administration record (MAR) to confirm this. People's MAR contained relevant information such as their photograph and information about any allergies. Where people were prescribed topical creams, the service had developed topical medicines administration records which were clear and fully completed. We did note that one person who was prescribed an 'as required' or PRN medicine did not have an instruction sheet in place, which explained how and when the medicine should be used. We discussed this with the provider who arranged for a PRN protocol to be put in place that day. Records relating to homely remedies needed to be reviewed to ensure they were accurate and contained all of the relevant information. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds. We discussed this with the manager who took immediate action to amend the recording procedures and to seek confirmation from a healthcare professional about which homely remedies were suitable for each person and did not for example interact with any of their prescribed medicines.

People's care plans contained appropriate risk assessments which covered a range of areas. Where people were at risk of skin damage, relevant risk assessments had taken place and were reviewed monthly. One person who administered their own medicines had a risk assessment in relation to this. Screening for the risk of malnutrition was routinely carried out and people's weight was regularly monitored. Where necessary people had falls risk assessments. One person's had recently been updated to reflect their increased falls risk following a period of illness. Following falls or other incidents, staff were completing an observation record for 24 hours which helped to monitor whether the person was experiencing increased pain, bruising or loss of mobility that might require a review by a healthcare professional. People had a 'maintaining a safe environment' care plan. These considered whether the person had the capacity to judge risks for themselves and how this might impact on their safety. Care workers told us that the risk assessments told them what they needed to know about each person and how to deliver their care safely.

Incidents and accidents were monitored by the provider and we were able to see that they maintained a record of the actions taken in response to mitigate any risks and prevent reoccurrences. Each month they completed an audit of the incidents and accidents to see whether any trends or themes could be identified allowing further preventative actions to be planned. Staff were more informed about how and when to record incidents and accidents and guidance about this was displayed within the service.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Prospective staff were asked to think about safeguarding scenarios at their interview and the provider told us that staff were also reminded of their responsibilities with regards to keeping people safe and reporting any concerns at staff meetings and in supervision. The numbers of the local authority safeguarding teams were readily available within the service. This ensured staff had clear guidance about

what they must do if they suspected abuse was taking place. Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager of the home. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

Good

Is the service effective?

Our findings

People, their relatives and healthcare professionals told us Freegrove Care Home provided effective care. A healthcare professional told us that a person they visited "Had thrived" since coming to the home. They said people were "Comfortable, clean and well cared for". People told us staff were "Very good", "Very careful" and "All wonderful". Our observations indicated that people were provided with effective care and support. We saw staff effectively supporting one person to stand. They provided clear instructions and encouraged the person throughout the process.

At our last inspection in June 2015, we found the provider was not meeting the requirements of the Mental Capacity Act 2005 (MCA). People who lacked capacity to make decisions about their care did not have a clear mental capacity assessment. 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. At this inspection, we found that improvements were being made. Staff had received training in the Mental Capacity Act 2005 (MCA) and were aware of the principles of the Act and how they should be applied. For example, staff knew they must assume that people had capacity and that where people lacked capacity, any decision made on their behalf must be in the person's best interests. Staff were aware that it was important to try and help people to make their own decisions and to respect their choices and wishes. One care worker said, "If someone refuses care, I leave the room, try again or tell a senior and let them try, you can't force them, you can try and encourage, but you can't say, you've got to do this".

We reviewed people's records and found that mental capacity assessments had been carried out to determine whether some people had the capacity to choose to live at the care home. The assessments had been carried out in line with principles of the MCA (2005). Where it was deemed that the person lacked capacity to make a decision about living at the care home, there was evidence that staff had consulted with relatives and the professionals involved in the person's care to reach a decision that was in the person's best interests. There was increased evidence that the MCA 2005 was being considered as part of the care planning process. People had a 'Capacity Summary Record' which recorded which elements of their care plan they had capacity to consent to. Two people's records stated that they were not able to consent to any of the care and support being provided, however, we were not able to see that the person's mental capacity had first been assessed. Further work is needed therefore to ensure that the MCA 2005 is fully implemented and embedded within the care planning process.

At our inspection in June 2015, we found that the provider had not acted in accordance with the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people lacking capacity by ensuring that, if there are any restrictions to a person's freedom or liberty, these have been agreed by the local authority as being required to protect the person from harm. At this inspection we found that improvements had been made. The provider's knowledge and understanding of the safeguards had improved and where required, relevant applications for a DoLS had either been authorised or applied for.

At our inspection in June 2015, we found that staff did not have all of the training relevant to their role and new staff had not always been provided with a robust induction. At this inspection we found that improvements had been made. Staff had completed training in a range of subjects such as infection control, Mental Capacity Act (MCA) 2005, fire safety, safeguarding, health and safety, dementia care and manual handling training. Staff had completed detailed workbooks on the safe handling of medicines and those staff that administered people's medicines had been assessed as competent to do so. The provider had developed links with other local providers so that training could be provided more frequently and within the local community making it easier for staff to attend. The provider and one of the senior carers had also attended training for managers on supervision, medicines and the deprivation of liberty safeguards (DoLS). Where necessary external professionals such as the community infection control lead had been contacted for additional advice and support. The service supported staff, where appropriate, to enrol on nationally recognised health and social care qualifications at a local college. All of the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively. Most of the training was up to date, although we did note that one staff member's manual handling training was out of date. We spoke with the provider about this; they advised that the staff member would be completing this on the 7 April 2016.

Staff were receiving regular supervision and appraisals were planned for all staff for June 2016. Supervision and appraisals are important as they help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. Supervision was sometimes held in a group and used to discuss particular issues such as incidents that might have occurred or topics such as safeguarding. Others were one to one sessions. The provider had undertaken reflective supervisions with staff when areas for improvement in their practice had been identified. One staff member told us they had regular supervision, they said, "We talk about training, anything I need to improve, anything I think could improve about the home, I did a quiz in my last one, it's useful". The staff we spoke with all felt well supported in their roles and were confident they could approach the provider with any concerns or issues they might have.

New staff completed an induction during which they learnt about their role and responsibilities, read policies and procedures and became acquainted with the environment and people using the service. A new member of staff had been enrolled on the Care Certificate and was completing workbooks relating to standards not covered by their existing qualifications and experience. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate and should ideally be completed within the first 12 weeks of employment.

People were positive about the food and comments included; "It's Excellent" and "We've always had good food". One person told us that if they didn't like what was offered they could "Just say and have something else". A relative said, "The food is always home cooked, even the cakes in the afternoon". Each day people were offered a choice of cereal and toast, fruit and juices for breakfast. One main course option was prepared at lunch, but an alternative was made available if a person did not like this. At supper, people were given a choice of a range of lighter meals such as sandwiches, jacket potato or egg on toast. Home baked cakes were offered in the afternoon and people were offered regular hot and cold drinks throughout the day. People were able to choose where they ate their meals and were encouraged to have friends or family join them for a meal. No-one needed assistance to eat or drink but plate guards and specialist drinking cups were available and used when necessary to support people's independence.

The chef had information about people's likes and dislikes in relation to food and they were able to tell us that one person disliked pork and another rice and so they were offered alternatives when these foods were on the menu. We observed the lunch time meal on the first day of our inspection. People were sat at the dining table where they had access to a variety of condiments, a gravy boat and a jug of squash. Dessert was

rice pudding with jam which people seemed to enjoy. There was very little food wastage and each person appeared to eat well. The lunchtime experience was quiet, there was little interaction between people, but staff did chat with people asking them if they were enjoying their lunch, or had had enough. Staff were well informed about whether people had been assessed to be nutritionally at risk or were losing weight. One staff member said, "The food is lovely, they all eat well, their weights are good, we only have one person on weekly weights at the moment, no one needs to be on food charts, but we put charts back in place if needed".

Where necessary a range of healthcare professionals including GP's and community mental health nurses had been involved in supporting people to maintain good health. Staff maintained clear records which demonstrated that prompt medical advice was sought when they suspected people might be suffering with a urine infection, for example. Staff had arranged for short term care plans to be put in place when people were being treated for acute conditions. This helped to ensure that staff could effectively monitor the person's recovery. Staff had liaised well with the community mental health team for one person who was undergoing changes to their medicines. Staff had been proactive in reporting that the change of medicine was resulting in unwanted side effects which led to further changes being made, This helped to ensure that people received co-ordinated care, effective treatment and support.

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring. One person said, "All of them are wonderful, wonderful people". Another said, "I've been here a long time, they [the staff] are very good". We overheard one person chatting to the person next to them, they said, "They are very good people here aren't they, very nice". Relatives were also positive about the kind nature of the staff. One relative said, "It's very caring, the warmth of care is there". A healthcare professional told us, "The staff are always welcoming".

Staff had good relationships with people and chatted with them about every day matters such as the food or the news. We observed that staff spoke to people kindly, respectfully and cheerfully. Staff were sensitive to people's needs. We saw staff gently wake one person to offer them a cup of tea and sensitively explaining to another person that their friend and fellow resident was unwell. The member of staff was very supportive, they told us, "I keep reassuring [the person] as they are very close and she worries". Throughout the inspection we observed that staff were patient and did not hurry people, but completed tasks slowly and in a person centred manner.

Care plans showed that people, where able, and their relatives had been involved in discussions about how they would like their care and support to be provided. Care plans were kept in people's rooms so that they were available for the person to read at any time. Care plans contained information about people's preferred daily routines, where they preferred to eat breakfast or their favoured night cap. People had signed to confirm their consent to have their photograph taken. Where people had appointed a legal representative to make decisions on their behalf copies of these were available in the persons care plan. Some people had an end of life care plan which had been drafted with the person and their relatives and described the person's wishes in relation to how they would like their care and environment to be managed in their final days. Each person now had a 'relative involvement' sheet in their care plans. These demonstrated that relatives were updated promptly when people's needs changed or if they were unwell. All of the relatives we spoke with felt they were kept informed about their loved ones care and that their views and ideas were valued and acted upon. People's relatives and friends were able to visit without restrictions, and we observed relatives visiting throughout the day and sharing in aspects of their loved ones care, but also interacting with other people using the service too. A staff member told us, "Yes I like it here, it's very homely, the residents and relatives all speak with one another, it's more like a family, the residents laugh at us too"!

Staff were mindful of people's privacy and dignity. They spoke with people in a polite and respectful manner. Staff knocked on people's doors before entering their room and doors were kept closed when staff attended to people in their rooms. A recent infection control audit had identified that action was required to ensure that people were always wearing clean footwear. This demonstrated an understanding of how supporting people with their appearance helps to ensure that people receive dignified care. People were encouraged to remain as independent as possible. Staff explained how they encouraged people to care for themselves even if this was by completing a small task. One staff member said, "I give them choices, ask, would you like to wash your face and hands, I say, you can do it and I'll check afterwards".

Good

Is the service responsive?

Our findings

Relatives told us that people's changing care needs were identified promptly and action taken to address these. One relative said, "They [staff] get onto things straight away". Health and social care professionals were also complimentary about how responsive the service was and about the person centred nature of the care plans. For example, one healthcare professional told us, "They [the staff] know their patients well". A social care professional had commented to the service, "The care plans are clear and very easy to read and fully reflective of [the person's] needs whilst being personalised".

Since our previous inspections in January and June 2015, the provider and staff team had redesigned people's care plans to ensure that they provided a more detailed and person centred record of the person's needs. The care plans we viewed were written in a manner that helped to make sure people received care that was centred on them as an individual and met their needs. For example, one person had a communication care plan which described their sensory impairments and how this impacted upon them being able to express their choices. People had eating and drinking plans which described the size of portion the person liked to have, the level of help they needed at mealtimes and their food likes and dislikes. People had sleeping plans and night time assessments. These had been written by the night staff who knew the person's night time care needs best. Another person had a care plan to support staff to manage behaviour which others might find challenging. Staff provided consistent responses when asked how they supported the person and deescalated any behaviours the person might display.

The person or their relatives were asked to provide information about the person's life before coming to Freegrove Care Home and about their likes and dislikes. Some people had scrap books. These had been completed by their relatives and provided information about the person's family, friends, trips and holidays and interests. Staff told us about one person who had been in the RAF and loved planes, and another who had been in the merchant navy and therefore enjoyed talking about and looking at pictures of boats. The plans reflected people's needs, choices and preferences. They were thorough and detailed. Staff told us that the care plans were useful. One staff member said, "The new care plans are very easy to understand, everything you need to know is there".

Care plans were regularly reviewed and any changes were fully documented. Key workers had been given responsibility for arranging reviews with people and their relatives. Handover meetings were conducted daily during which staff shared information about any new risks or concerns about a person's health. Staff had developed a handover sheet which recorded whether anyone needed increased observations or had been involved in an incident or accident. This helped to ensure changes to people's needs were effectively communicated to those who needed to know.

We received mixed feedback about whether people received sufficient meaningful interaction and stimulation. One person told us they were "Quite content" with the activities, whereas another said, "I don't seem to do anything". During the inspection, we saw staff using a reminiscence newspaper to provoke stimulating discussion. Visitors engaged people in card games which they seemed to enjoy. Some people went with their families on trips out for lunch whilst another was taken out to the local Alzheimer's group

meeting. Staff told us, "We've done a quiz this morning, in the afternoon we have Music for Health once a fortnight and Interact UK once a fortnight, we have a cupboard with quizzes and bingo which we do, sometimes, we have a quiet afternoon, we do nail care and feet care soaking the resident's feet in a bowl of water". Some relatives felt more could be done to ensure that staff provided people with increased opportunities for meaningful interaction. We did observe that people spent periods of time in the lounge sitting passively or sleeping as staff were not present. When staff were in the room, they engaged nicely with people and were attentive and supportive. A relative told us, "They [the staff] try very hard with special occasions, but I feel [people] need a bit more stimulation". Another relative commented that perhaps more could be done with regards to activities, but they understood that not everyone wanted to join in which made it extremely hard for staff. The provider told us they were keen to ensure that people were able to take part in a range of social activities. They explained that in the build up to Christmas they had held an activity each week, involving relatives, such as making bread, biscuits and crafts. A craft and plant sale held by the service had raised money for the Alzheimer's Society and a 'high tea' was planned for Mother's Day and a garden party for the summer.

People knew how to complain and information about the complaints procedure was available within the home. People and relatives were confident they could raise concerns or complaints and these would be dealt with. One complaint had been received since our last inspection, this had been responded to promptly and fully. The provider encouraged people and their relatives to give feedback about the service. They had arranged for a 'Suggestions Box' to be made available. A relative told us they had used the box to propose an improvement which they said had been promptly acted upon. Another relative told us they were confident that the provider would act on comments or concerns. They said, "Absolutely she would do something, she is very open to talking, we feel very at ease calling the home".

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and the staff team were positive about the management of the home. Our observations indicated that the provider had a good rapport with people using the service. Relatives told us the provider 'listened' to what they had to say and 'sorted things out' if there were any problems. Staff said the provider was approachable and supportive. One staff member said, "Everyone knows her, I feel very comfortable going to her, all the residents know who she is, she is there if they need her". During the inspection, we observed that people, relatives and staff approached the provider whenever they wanted to. The provider stopped what they were doing and spent time engaging with the person or relative in a friendly and positive manner, answering any questions they might have or reassuring them about a matter. A relative told us, "Whenever I come, [the provider] is cheerful, smiling and kind to [their relative] and the other residents".

At each inspection since July 2014 we had found that the provider had failed to ensure there were arrangements in place to check and monitor the quality of the service and for identifying, assessing and managing risks to the health, safety and welfare of people. At this inspection, we found that improvements had been made. The provider now had a more robust programme of audit in place that was being used to drive and sustain improvements. A range of audits were being undertaken to monitor the effectiveness of aspects of the service including care documentation, health and safety and infection control and medicines management. Where areas requiring improvement were identified, an action plan had been drafted, for example, we reviewed the most recent action plan resulting from a care plan audit and found that the required actions had been completed and signed off by the provider. We did note that the infection control audits had not been fully effective at identifying all of the areas where improvements could be made. For example, we observed that a toilet was stained with brown marks and another was heavily stained with lime scale. A toilet roll holder was missing, meaning that the toilet roll was stored on a window sill behind the toilet making it difficult to access. Two pedal bins provided in the bathrooms were not working. We bought these areas to the attention of the provider. By the second day of our inspection, the toilets had been thoroughly cleaned, the toilet roll holder had been re-sited and the pedal bins had been replaced. The provider also revised the infection control audit tools to ensure that in future it specifically assessed these areas.

Whilst there was a much improved schedule of health and safety checks taking place. Some further improvements were needed to ensure that all of the risks associated with the environment were effectively addressed. For example, for two successive months, the temperature of water being discharged from the upstairs bath tap had been recorded as being in excess of safe limits. Whilst a quote had been obtained for remedial work to be done to address this issue this had not yet been completed. The provider told us they had not prioritised this as the bath was never used. We were, however, concerned that this could still present a risk to people. The provider has since the inspection confirmed that arrangements have been put in place to ensure people cannot now access the bathroom at all.

Each person had a personal emergency evacuation plan (PEEP) which detailed the assistance they would require for safe evacuation of the home. These were stored in a 'fire box' which also contained items that

would be useful in the event of an emergency or evacuation of the building such as torches, foil blankets and water. The provider had developed a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. Weekly checks were made of the call bell system and of the slings and hoists used for moving and transferring people to ensure equipment was fit for purpose. Monthly checks were undertaken of the fire equipment and of the first aid boxes. Annual checks were undertaken to ensure the safety of electrical equipment. Checks had been undertaken of the water system to ensure the effective control of legionella.

The provider had put in place a number of measures to ensure that continuous improvements were being made. The provider had subscribed to external agencies to assist in ensuring that their policies and procedures remained relevant and were updated when necessary. When required they also sought the support and guidance of external agencies with the implementation of health and safety processes and staffing policies. Following our inspection in June 2015. The provider arranged for a consultant to work alongside them and the staff team, advising and supporting them on meeting the legal requirements and implementing best practice. This support is still in place and is assisting the provider to sustain the improvements that have been made.

Staff were encouraged to contribute their ideas and make comments or suggestions about how the service might improve, for example, staff had developed new forms to make the handover process more effective. A member of staff told us, "The home is well led, we share information, we have whole staff meetings, any suggestions would be acted upon". The provider told us that the staff team had all contributed to the process of making improvements and that they were really proud of them for this. They said, "We have all pulled together, the relatives have been amazing, the community support has been amazing, I love coming to work". This positive culture was echoed by the staff we spoke with. For example, one said "[the provider] is here to support us, I feel a lot better, we can take ideas to her and she will listen….I am clear about my role now".

Whilst the provider and staff team had been working hard to make and sustain improvements to the quality and safety of the care provided, they had still maintained a friendly and homely culture within the home. A relative told us, "The staff are happy, this leads to happy people, we are very pleased, it's not the poshest home, but I'd far rather have the atmosphere, you see staff having a giggle, I feel they are outstanding in that way". Another told us they visited a number of homes, but found Freegrove Care Home to be the "Homeliest". A staff member told us, "I love working here, its friendly, the whole atmosphere is friendly". The provider told us that it was very important to her to maintain the small, friendly nature of the home, underpinned by family values. They said, "It's a community within a community, its warm, welcoming and friendly". The provider continued to nurture strong links with the local community. Local churches visited to share communion or to shop for people using the service. People attended tea parties and coffee mornings at local schools and at the local Alzheimer's Society group. Visitors whose family members were no longer living at the service continued to visit the home to spend time with people. This provided a way for families to continue to connect with the service and gave people more opportunities for social interaction. The provider explained that they also hoped to develop a 'Friends of Freegrove' with the aim of fund raising for a mini bus.

The provider was aware of the challenges that remained. They told us the improvements needed to continue to be embedded so that they became "Second nature". They had identified that further improvements could be made to the daily records that staff maintained to ensure that these provided a 'real time' account of the care and support provided. Throughout this inspection the provider remained open to receiving feedback. Where the inspection identified areas where improvements or actions were required,

this was acted upon promptly. For example, in relation to monitoring the safety of the environment and equipment and the effectiveness of infection control procedures. A care worker told us, "Everything has moved forward, we have done this as a team…it's like a second home here, I'm happy coming to work now".