SHC Clemsfold Group Limited

Kingsmead Care Centre

Inspection report

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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

Overall summary

The inspection took place on 18 and 19 August 2015 and was an unannounced inspection.

Kingsmead Care Centre provides accommodation and nursing care for up to 34 people. The service consists of two parts. The main part of the service caters for 25 older people whilst Haven supports nine people with physical and/or learning disabilities. The service is managed as one but staff tended to focus in one or other part of the service. Activities were mostly organised separately to cater for people's different interests and abilities. At the time of our visit, there were 29 people in residence.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We identified issues in how risks to people's safety were assessed and mitigated. Information for staff on how to mitigate risks was not always available or consistent. Furthermore, when additional steps to keep people safe were identified, these were not promptly updated in people's records. This lack of clear guidance for staff could lead to people receiving inconsistent or unsafe care.

There was a system in place to assess and monitor the quality of the services provided. This included audits and checks at both service and provider level. The provider also commissioned external audits of the service. The registered manager had taken action in response to audits and there was clear evidence of improvement in the service. We noted, however, that some actions had not been marked as completed and were not carried forward. We discussed this with the registered manager with a view to ensuring that the systems in place were used effectively.

People, relatives and staff spoke highly of the service and staff. In relatives' comments to a survey conducted by the provider we read, 'I cannot fault the care my Mum is receiving at Kingsmead. All the staff are very caring and try very hard to keep the residents happy'. A card of thanks read,

'We will always remember your dedication, your wisdom and your compassion'. The home was staffed by a regular staff team who knew people well and understood how they liked to be supported. Staff were able to communicate effectively with people, including those who had limited verbal communication.

Staff understood how people's capacity should be considered and had taken steps to ensure that their rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People were supported to be as independent as they were able and to make decisions relating to their care and treatment. People received their medicines safely.

People were happy with the choice of food on offer at the service. Staff offered alternatives and made sure that people were eating and drinking enough to meet their needs. If concerns, such as weight loss, were identified, referrals were made to the GP or other healthcare professionals. Professionals involved with the service told us that they followed their advice and worked effectively to meet people's needs.

Staff had received recent training in line with their responsibilities and had attended supervision meetings with their managers to discuss their work and professional development. New staff received support and training which included shadowing experienced staff as they got to know people.

There was a relaxed and happy atmosphere at the home. People felt safe and were able to speak up if they had concerns. People, staff and relatives told us that they were able to approach the registered manager or provider if they had suggestions to make. They felt confident that they would be listened to. There were regular meetings for residents and surveys were used to gather feedback, including from relatives.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

Summary of findings

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 safe in all areas.

Risk assessments were in place but people may not be protected from harm as their care records did not always contain consistent information. They were not always updated promptly when gaps in the guidance for staff were identified.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

There were enough staff to meet people's needs and keep them safe.

Medicines were stored, administered and disposed of safely.

Is the service effective?

Good

The service was effective.

Staff received training to carry out their roles and received regular support from their managers. They were encouraged and supported to pursue further professional development.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People enjoyed the meals served and were offered a choice of nutritious food and drink.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them. People were involved in planning their care and staff demonstrated skill in understanding people's non-verbal communication methods.

People were involved in making decisions relating to their care and encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People received personalised care in line with their preferences.

Activities and outings were tailored to people's individual needs and interests.

Summary of findings

People were able to share their experiences and were confident they would receive a quick response to any concerns.

Is the service well-led?

Requires improvement

The service was not consistently well-led

The registered manager and provider used a series of checks and audits to monitor the delivery of care that people received. These delivered results but had not identified some missing documentation and were not robust in ensuring that all actions were completed.

The culture of the service was generally open and inclusive but we identified that relatives of one person had not been informed about an incident in a timely way.

People and staff felt involved in the running of the service and able to share ideas or concerns with the management.

Staff were clear on their responsibilities and told us they were listened to and valued.

Kingsmead Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 19 August 2015 and was unannounced.

Three inspectors undertook this inspection.

Prior to our visit we reviewed notifications received from the registered manager, including details of a recent safeguarding incident which prompted our visit. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We observed care and spoke with people, their relatives and staff. 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. We looked at care records for ten people, medication administration records (MAR), monitoring records such as of people's behaviour or weight, accident and incident and activity records. We also looked at 12 staff files, staff training and supervision records, staff handover records, agency induction records, staff rotas, staff communication books, quality feedback surveys, audits, equipment maintenance checks and minutes of meetings.

During our inspection, we spoke with nine people using the service, the registered manager, the deputy manager, three team leaders, two care staff, the physio assistant, the activity coordinator, the chef manager and two representatives of the provider. We also spoke with a GP and an aromatherapist who were visiting people at the service. Following the inspection, we contacted two relatives to ask for their views and experiences.

This was the first inspection of Kingsmead Care Centre since there had been a change in the provider's registration in October 2014.

Requires improvement

Is the service safe?

Our findings

People felt safe living at the service. One told us, "I'm as safe as I could be, it's a great place". A relative said, "(Name of their relative) is cared for and feels secure". Staff felt confident that any concerns they raised would be listened to. They were able to speak about the different types of abuse and described the action they would take to protect people if they suspected they had been harmed or were at risk of harm. The latest multi-agency safeguarding procedures were available to staff and contact numbers for the safeguarding team were displayed. One staff member said, "I would report everything to the nurse and the manager. They would listen, they are helpful". Another told us, "I'd immediately speak to the nurse and ultimately the manager. If I really had to I'd raise safeguarding myself". Staff had attended training in safeguarding adults at risk and had discussed the procedures during staff meetings.

Prior to our visit, the registered manager had notified us of an incident which resulted in a person being injured. The service had also notified the local safeguarding team and a representative of the provider was carrying out an investigation. In response to the incident, staff had been updated and initial learning was shared with the team to minimise the risk of any future incidents. Supplementary moving and handling training was being rolled out to all staff. At the time of our visit approximately 40 percent of staff had updated their knowledge through a one to one session with the home's moving and handling trainer.

Risks to people's health and safety were assessed prior to admission and were regularly reviewed. We found however that some records did not contain sufficient detail to direct staff in how to minimise the risk to people. Some people were at risk of constipation and monitoring charts were in place to record their bowel movements. We checked the charts for seven people starting in June 2015 and found that three contained gaps of four or five days. We looked in the care plans of these three people for guidance. There was no information on when staff should take action if the person did not have regular bowel movements or on what they should do. One staff member told us, "The worry gap is only two days maximum I think", when follow-up action should be taken. In the daily records of care provided, we could not find any evidence of a concern being raised or action taken in response to the gap. There was a risk that people may not receive appropriate support to mitigate the risk of constipation.

Risk assessments were reviewed but changes were not always reflected in the person's care records. In one review we noted that the person had changed from using a medium hoist sling to a large one. This was noted in the risk assessment but had not been updated in the care plan or handling assessment. In another person's record we found that different sections of their care plan referred to different slings, without clear guidance on which sling should be used for which transfer. A third person had an updated enteral feeding regime in place (this is when nutritional fluid is given via a gastrostomy tube into the stomach) following an appointment with the Dietician in March 2015 but this had not been amended in their hospital passport. Monthly reviews of risk assessments were often recorded as, 'Reviewed. No changes made'. In two cases the person's risk score relating to skin integrity using a recognised scale had increased. One of these people had been referred to the GP as they had lost weight. There was a note to, 'Fortify snacks'. These changes had not been reflected in the review or on the person's eating and drinking care plan. There was a risk that actions agreed to mitigate risk may not be consistently implemented as they were not accurately documented.

Following a recent incident, one person's risk assessment had been updated to include additional detail for staff on how to keep them safe. We checked the risk assessments for other people where this information was directly applicable to their safe care and treatment. The update had not been made. The registered manager told us, "We are going to reflect it in everybody's plan. Staff have been made aware". We found that the service had not taken all practicable action to mitigate the risk because one month after the risk was identified, written guidance for staff on how to keep people safe had not been updated.

There was a risk that people may not receive safe care because the information on how to mitigate risks was inconsistent and additional detail was not promptly added to people's records.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service safe?

Risk assessments relating to other aspects of people's care were detailed. There was clear information for staff on how to support people with epilepsy. This included the action staff should take if the initial treatment described was not effective. Monitoring charts were in place and there were records of regular night checks to promote people's safety. Where people had specific nursing needs such as gastrostomy care, suctioning to clear their airways or oxygen administration, risk assessments and care plans were in place. If accidents or incidents occurred these were documented. Body maps were used to indicate any injuries sustained and information was shared within the service and with the provider. One staff member said, 'We complete them (incident records) at the time and review them each day as part of handover'. In the staff communication book we read, 'Please ensure to check the equipment before using it to ensure that the equipment is in good working order especially side rails, lap belts, harness and hoist. This is to minimise the risk of accidents'. This helped to share learning amongst the staff team and make them aware of any immediate changes in people's condition or support needs.

There were enough staff to meet people's needs. We observed that staff supported people in a relaxed manner and that they took time to engage with them. Each part of the service was staffed by a nurse, three or four carers and an activity coordinator. When we were with one person in their room they rang the call bell and staff responded promptly. Another person said, "Staff come quickly". A relative told us, "I feel there is enough staff now, they seem well trained". The registered manager had bank staff that they called upon to cover shifts if needed. They also used agency staff on occasion. One staff member told us, "Last year we had quite a lot of agency, this year we haven't". We found that people were supported by a regular staff team who understood their preferences and were able to meet their needs.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers. This helped to ensure that new staff were safe to work with adults at risk.

People received their medicines safely. Medicines were administered by registered nurses. We observed as medicines were administered in both parts of the service. The nurse explained to people the medicines that were being given and what they were for. We heard them remind one person who was taking a course of antibiotics of their purpose. We saw that people were asked and assessed by the nurse to see if they were in any discomfort. The nurse was able to tell us about each person and describe whether they were able to express if they were in pain and ask for pain relief. Medicines were administered safely and with kindness. We observed that the nurse adjusted one person's position before giving the medicine to minimise the risk of them choking. Another person was offered water after using their inhaler as the nurse was concerned their mouth might feel dry. The nurse stayed with each person until they had safely taken their medicines.

Medicines were stored in locked trolleys. The temperature of the storage areas was checked to ensure that it was within recommended limits. Bottled medicines and topical creams were dated on opening. These measures help to ensure that medicine remains effective. Medication Administration Records (MAR) were up-to-date. They provided a clear record of the medicines prescribed and administered, along with any allergies the person had. Where medicine had been prescribed on an 'as needed' (PRN) basis guidance was in place. This described when to use the medicine, the dose and the expected effect which helped to ensure that PRN medicine was administered consistently and not used as a long term treatment. Controlled drugs (drugs which are liable to abuse and misuse and are controlled by legislation), were stored securely in a separate locked cupboard fixed to the wall and were accurately recorded. Surplus or discarded medicine was clearly documented and was stored safely ready for collection by the pharmacy.

Good

Is the service effective?

Our findings

People spoke highly of the staff who supported them. One said, "I'm very satisfied with the care". Another told us, "The nurses are really good here, you couldn't get better". The GP who was visiting told us, "They have excellent knowledge of patients. They're always well prepared when I visit. They will have everything to hand". The provider had an in-house training academy which offered a wide range of training opportunities for staff. Training made mandatory by the provider included moving and handling, safeguarding adults, fire safety, infection control and first aid. Some staff had completed additional training, such as in making mealtimes safe. The registered manager told us that training in epilepsy was scheduled later in the month and that staff were due to follow specific training in supporting people with a learning disability.

Staff were enthusiastic about the training on offer. One said, "I find it (the job) easy because of the training". Another told us, "The training offer is very good". Staff were able to undertake qualifications in health and social care and were supported by the provider to pursue further professional development. One member of the therapy team was going to start a Master's degree while another staff member told us that they were due to begin nurse training. They said, "I'm very happy for this opportunity. I want to stay here and be a nurse". New staff were supported via a programme of induction which included classroom based training and shadowing of more experienced staff. Two staff at the service had been trained as mentors and were responsible for inducting new staff. Where the home used agency staff, profiles detailing their skills and experience were received. They then received an induction to the home to ensure that they were aware of procedures including for fire and other emergencies. In one card received by the service we read, 'Thank you so much for the attention you have given me since I have been here. I really feel I have had the very best treatment I could have had'

Staff felt supported. One said, "The best thing here is staff morale. If there is any issue it is dealt with straight away. We are really supported by (named managers)". Records of supervision meetings showed that a range of topics were discussed. This included people's support needs, the home's policies and procedures, the staff member's learning and development needs and their goals. Action points were agreed and these were reviewed at the subsequent meeting. One staff member said, "We have three supervisions and an appraisal. They are usually bang on time".

Staff spoke with people and gained their consent before providing support or assistance. Staff explained that if people were unable to communicate their wishes verbally they used facial expression and gesture to understand their views. They told us that if someone refused their assistance they would respect their decision but would return later and offer support again. One relative told us, "They're ok if she wants to stay in bed a bit longer, if she doesn't want to get dressed they will leave her". A staff member said, "You have to respect their wishes".

Staff understood how people's capacity should be considered and had taken steps to ensure that their rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The requirements under this legislation had been discussed in staff meetings and guidance had been shared with the team. Where people lacked capacity to make particular decisions, best interest decisions involving relevant professionals and the person's relatives had been arranged. Examples included decisions regarding health and care needs, treatment by the physiotherapist and wishes relating to end of life care. One staff member said, "It's all about choices, making sure they've got as much choice as possible. If we feel they are making a choice that is unsafe we would look into it further. We would involve the GP, best interest meetings and discuss with the service user and their family. We need to make sure everyone is involved".

Two DoLS applications had been authorised and others were awaiting decision. DoLS protects the rights of people by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. This included the use of specialised wheelchairs, harnesses and padded bed rails, as well as those under continuous supervision due to risk factors such as epilepsy.

People were enthusiastic about the food service at the home. One said, "You couldn't ask for better they're good, good service". Another told us, "There is always plenty of food". We observed as lunch was served in both parts of the home. There was a relaxed atmosphere. People received the support they needed to choose their meal and were assisted, if necessary, to eat it. Once served, people were

Good

Is the service effective?

offered condiments and sauces to accompany their food. Comments during the mealtime demonstrated that people enjoyed the food. One said, "It's lovely, real tasty". When one person looked disappointed with their meal, staff quickly arranged for them to have an alternative. Another person did not eat much of their main course but were offered other options and then enjoyed a plate of cheese and biscuits. Staff encouraged people to eat and offered top ups of drinks throughout the mealtime. They were aware of people's individual needs and were seen assisting people to sit upright, cutting food into bite-sized pieces and monitoring those at risk of choking. One staff member said, "You have to take your time to feed (name of person) because she might aspirate or choke".

The chef had clear information about people's dietary needs, including those who required special diets such as soft, pureed, gluten-free or diabetic. Staff recorded people's weight on at least a monthly basis and reviewed the overall loss or gain each quarter. This provided an initial action plan, for example if a person had lost less than five percent of their initial weight, staff were directed to, 'Continue to monitor'. If the weight loss was more significant referrals had been made to the GP and/or other healthcare professionals. Staff were able to tell us the people who were at risk of malnutrition or who needed a fortified diet to help them maintain or gain weight. As dessert was served people were offered cream and ice cream, which can be used to boost the calorific value of the meal. We noted that following intervention some people had gradually gained weight. The GP told us, "Patients' weights are well maintained and I am told if there is deterioration". Fluid charts were used to ensure that people received enough to drink. For those who were at risk of dehydration, a target daily intake volume was set. Staff had totalled the drinks they consumed during the day to check that people had enough fluid to meet their needs.

People had access to healthcare professionals to ensure that their health needs were met. One told us, "I can see a doctor ever so quick". People's care plans provided guidance about their health needs and medical history. Each person had a section of their care plan which focused on health needs and the action that had been taken to assess and monitor them. This included people's skin care, eye care, dental care, foot care and specific medical needs. We noted that one person had been referred to an osteoporosis assessment service and that staff had sought guidance from the in-house physiotherapist regarding how best to support another person with their mobility. A record was made of all health care appointments including why the person needed the healthcare visit, the outcome and any recommendations. Professionals told us that staff took note of their recommendations. The GP said, "(The Registered Manager) is approachable and easy to speak to. She will take any concerns forward".

Good

Is the service caring?

Our findings

People enjoyed the company of staff. One said, "It's good fun, lots of laughter goes on". Another told us, "They're so good to you. I'm perfectly happy and contented". A relative said, "They're always friendly. They don't act like people that are paid, they like Mum". Staff knew people well and understood how they liked to be supported. People's care plans included information on their preferences and life experiences. Staff told us that they had time to get to know people. One said,

"We chat with them. We have a lot of time in the lounge with the service users". They supported people to maintain contact with family and friends by assisting them to send cards, speak on the phone and arrange visits. One relative told us, "The staff are always caring with every single service user". A visiting professional said, "They seem to understand them really well".

People were involved in decisions relating to their care and daily routines. One said, "You can go to bed anytime you like. I'm not an early to bed, I'm a late sleeper". Another said, "They don't force you up. I get my breakfast in bed". Most people were aware of the information contained in their care plan and had been involved in reviewing it. Some had signed to demonstrate their agreement. Staff demonstrated skill in communicating with people who had limited or no verbal communication. From our observations, it was clear that staff knew people's likes and dislikes extremely well. A member of staff told us how they supported people in reviews. They told us, "Every person has a detailed communication passport, certain eye movements, body language and verbal communication that helps us understand their choices and decisions". The passports included how to recognise a person's feelings, such as when they were happy, sad, anxious, thirsty, angry or in pain. For example, 'I look upwards and have a smiling face for 'yes' and I look downwards and have a sad face for 'no'' and, 'I shout and shake my body when I am distressed, unhappy or if I am in pain'. Some people expressed themselves through signing and knew the signs for 'food', 'toilet' and 'pain'. We observed as staff communicated using Makaton or short phrases. Makaton uses speech with signs (gestures) and symbols (pictures) to help people communicate.

Staff supported people to be as independent as they were able. We noted that some care plans included guidance for staff on how to maximise the person's independence, for example in eating and drinking. One staff member told us, "This morning she (person using the service) was holding the spoon so I put the table in front of her. She wanted to do it on her own. They need help but if they want to do it, give them the freedom to do it. I just waited for her to finish". At lunchtime, we observed as a staff member gave hand over hand support to one person as they ate their meal. This continued until the person indicated vocally that they wanted more support. Another staff member explained, "We prompt and encourage them to stay mobile and exercise. We try to get them to help themselves. It's not easy to be just depending on people. You don't want to feel useless. It boosts their self-esteem"

People's care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. When staff spoke about people they focused on their personality and strengths, describing how they enjoyed supporting them. They were respectful in the way that they provided support. We heard a staff member ask, "Can I move you forward" to a person in a wheelchair as they wished to pass behind. One staff member told us, "I make sure I communicate what I am doing and why". Another told us, "If people have visitors in their room or garden we will let them have privacy and close the doors".

Good

Is the service responsive?

Our findings

When a person moved to the home they and their relatives were asked for information about their experiences and interests. This was added to by staff as they got to know people better. A staff member explained, "Before someone is admitted (the Registered Manager) would do a pre-admission assessment to determine if their needs can be met. We would do a draft care plan and get family to have a look at it and put in any additional information about likes and dislikes, social aspects; maybe they like the theatre of have a certain religion". We saw that care plans included information on what people enjoyed doing, what was important to them, things they liked and did not like. We read, 'Likes eating sweet food, such as ice cream, pureed banana and hot chocolate' and, 'Loves to go out shopping and out for day trips'. One staff member said, "If you need more information you can get it straight away (from the care plan). It's also about what the service user wants. It's a good way of getting to know them".

The care and support provided to people was reviewed monthly by the nurses to determine if it was still meeting their needs. Insofar as they were able, people and, if they wished, their relatives were involved in these reviews. A full review was carried out annually. This included reports from the nursing, care, therapy and activity teams, along with input from external healthcare professionals such as the GP and social workers as appropriate. One relative told us, "They invited us to a yearly review with the social worker". Another said, "Staff always contact me, they always involve me".

People told us that staff responded quickly when they needed assistance. A staff member explained, "We have an observational checklist so we check every hour if they need anything and make sure their call bell is close-by in case they need something". People's health needs were monitored. One person had a hypoglycaemia protocol in place and had achieved improvements in their blood sugar levels through changes in their diet. Another person had a wound on their shin following discharge from hospital. This had been closely monitored by staff and it was starting to heal.

Where people had been assessed as displaying behaviours that might challenge themselves or others, guidance was in place for staff. This included the specific behaviours the person may exhibit, what the trigger might be and how staff should respond to prevent these behaviours from escalating. Staff demonstrated that they understood and followed this guidance. We observed that two people became upset and appeared angry. Staff responded quickly. Their actions matched the guidance detailed in the care plan. We saw that people's moods and behaviours were observed and recorded, together with any lessons learnt from incidents that could inform future ways of supporting the person.

People were involved in activities that interested them. One person said, "The lady that does the activities, she's the best". Another said, "They have their own mini bus. They take us out for meals; we go out in it about once or twice a month. During our visit people were involved in a range of activities. In Haven this included music form an external entertainer, a sensory and passive movement session, games with staff and manicures. Staff supported people and encouraged their participation. One person went out shopping with a staff member and another went to another of the provider's services to use the computer room, equipped with eye-gaze technology (this enables people who may have physical difficulty using a computer to operate software with their eyes). Staff spoke with us about people's individual interests. They told us that one person enjoyed going fishing, another liked to go shopping to buy materials for knitting and to visit a garden centre and a third liked to go to the pub. The activity coordinator said, "I speak to people every day and will rearrange activities. It's their choice, they can change their minds". There were photographs displayed in the service depicting events that had taken place. Relatives had written cards thanking staff for a recent barbeque. One wrote, 'It was a wonderful party, the service users really enjoyed it'.

In the main part of the service, the activity coordinator was on leave. One person said, "She's (the activity coordinator) away this week so you notice it". There was a weekly timetable which included a quiz, sing-along, reminiscence session, baking and cinema afternoon. A staff member said, "She ensures they go out and we have a programme. If someone wants to do something else the care staff are there to help as well". We observed care staff chatting with people, in one case about history which the person specifically enjoyed. We asked staff how they ensured that people who opted to spend time in their rooms or were unable to come down and join in activities were supported. One staff member said, "Care staff spend time with people in their rooms but sometimes they are busy". We saw that

Good

Is the service responsive?

between half an hour to one hour of one to one time was included on the activity programme twice weekly. One person said, "Staff are busy, I'm not the only one here. They don't have time to chat". We discussed this with the registered manager as feedback we received suggested that some people would appreciate more social interaction. One staff member told us that they had suggested increasing the activity support to allow for more one to one time and that this had been raised with the registered manager. We asked for records of the one to one time provided in recent weeks but the records were not provided.

People were supported to practice their cultural or religious beliefs. Two people were helped by staff who understood their faith and who had worked with the person's family to make arrangements. This included weekly visits to church and a monthly communion which was on the days chosen by the person.

People were encouraged to share their views with staff. There were regular resident meetings, arranged separately for the different parts of the service. These included a discussion of activities and people's preferences for outings. People were invited to complete questionnaires focussing on their experience of living at the home; if they felt well cared for, if their privacy was respected, if they had choice over how they spent their time, if they felt safe and whether they knew who to speak to if unhappy. The responses were largely positive. There was also a specific catering feedback form which had resulted in changes on the menu. Some dishes had been removed following poor feedback, others dishes had been requested and added to the menu. During our visit one person voiced some concerns to the registered manager. The registered manager listened carefully to what this person had to say and outlined the action they would take. The person appeared satisfied with the response that they received.

Staff told us that if a person told them something was upsetting them, they would try and resolve it straight away. If they could not do so, they would report it to the registered manager. Staff explained that some people could not verbalise their concerns, but that changes in their behaviour would alert them that something was not right and that further investigation might be needed.

People understood how to make a complaint. One person said, "If I was unhappy I would make a complaint and they'd cover it immediately, I would speak to the nurse". Another told us, "I always make complaints, they like it. It keeps them going!" To aid people's understanding, the complaints procedure was displayed in both written and Makaton versions. The registered manager kept a record of complaints, including those made verbally. Some were around the time taken to respond to call bells or were from relatives waiting to be let in at the front door. One person had complained about the wait to use a wheelchair on one occasion when they wished to go to the hairdresser. Staff had discussed this with them and asked if they would like a referral to the wheelchair service to have their own chair. They declined this but understood that they may have to wait on occasion. In each case action had been taken and response given to the complainant. One person told us, "I can't really fault them".

Requires improvement

Is the service well-led?

Our findings

There was a welcoming and inclusive atmosphere at the home. One person said, "They make my family feel welcome". The registered manager said, "I love my work; my staff are here always to support me. The staff are willing to work. They work beyond the call of duty. We're like a family here". The registered manager described the vision for the service as, "To improve and provide the best possible care".

People, their relatives and staff told us that there was an open atmosphere at the home. One person said, "I have no hesitation in saying if something is wrong". Relatives told us that they were contacted promptly if there were any concerns about their loved one. One said, "They notify us if there is anything we need to know about". Another told us, "If there are any issues they will contact me, they're always forthcoming". Staff had an understanding of duty of candour. One told us, "The duty of candour is really important, you have to be honest". Another said, "I have to tell the nurse because it has been an incident and the duty of candour". Following a recent incident, relatives of the person involved had not been informed until one week after the event, and only when an injury became apparent. At the time of the incident it was not apparent that the injury met the threshold for a 'notifiable safety incident' under the regulations. We found, however, that in the spirit of transparency, the registered manager could have communicated more promptly with the person's representatives.

When we visited, the registered manager was working as a nurse in Haven. We observed that people had a good relationship with her. The registered manager told us that she worked shifts in both parts of the home. She said, "Instead of just being in the office there is an advantage as well in doing shifts as a nurse". One staff member told us, "She is very fair and her main aim is to be here for the service users. She will deal with problems". Another said, "The manager always supports us". There were regular staff meetings, both for nursing staff and for all staff. This helped to share information and to address any concerns. Staff representatives also participated in the provider's employee forum and in subject specific meetings such as on infection control. We saw in the minutes that learning from these meetings had been shared with the staff team. Staff told us that their feedback was acted upon. One example was that new bed linen and towels had been purchased to replace some stained items.

The registered manager and provider used a system of audits to monitor the quality of the service. For the most part, these were effective at assessing, monitoring and mitigating risks to people's health and safety. We identified two missing risk assessments for bed rails and found that the home's Calibration Mattress Inspection was overdue. This equipment should be checked regularly to ensure that it is functioning correctly to minimise the risk of pressure injury to people's skin. The last inspection record stated that it was an annual certificate, indicating that the check was overdue by more than a year. When we raised these concerns with the registered manager they were quickly rectified. Bed rail risk assessments were completed and the check on pressure reducing mattresses and pumps was completed during August 2015 following our visit.

Other equipment checks had been carried out. There was a monthly audit of slings to check that they were safe to use. We noted that some slings had been replaced due to fraying seams or faded labels. All hoist equipment had been inspected in July 2015. Hoists, wheelchairs, standing aids, commodes and shower trolleys were clean and there was evidence of regular checks. Maintenance tasks within the home and grounds were quickly completed by the on-site team. The registered manager told us, "If the maintenance team cannot fix it they will call the supplier to come". The provider had commissioned an external audit of the home's health and safety. Over the past year, the service had improved its score from 77 percent in June 2014 to 93 percent in July 2015. Actions such as replacing the kitchen floor had contributed to this improvement. The service had also made progress in relation to fire safety. After a visit from the fire service in August 2014, actions were set. In a subsequent visit, dated January 2015 the home was assessed as meeting requirements.

The registered manager carried out a monthly medication audit. As a result of the findings, a new medication fridge with a built in thermometer had been purchased. This was because temperature fluctuations had been recorded which could impact on the effectiveness of medicines stored. Staff had also been reminded to, 'Double check MAR sheets before handing over to ensure no gaps are left'. The medicine records were in good order. Accidents and

Requires improvement

Is the service well-led?

incidents were reported to and monitored by the registered manager. Information about accidents and incidents was also sent to the provider so that patterns or trends could be identified and action could be taken to reduce the occurrence of any of these events. We noted that trends in certain types of bruising that had been identified for one person. The action taken, including a bed extension and a change of footwear, had resolved the problem. One staff member said, "I think it is well managed because the manager is always checking if everything is alright".

A representative of the provider carried out monthly checks on the service. These included reviews of a sample of care plans and staff records. It also considered the environment, accident and incident records and complaints. Following each visit an action plan was compiled. The registered manager worked to address these actions and added progress notes or completion dates to demonstrate progress. The action plans were also used to monitor areas identified for improvement in other audits, such as an external audit of compliance and the provider's own internal quality audit. The registered manager told us, "I make sure it's done because I go through it again and make sure staff are doing it. If they say on-going I'll go back and write an update". There was good evidence of progress against the actions listed. We noted that a small number of actions from previous months did not have a progress note or a completion date recorded. We discussed this with the representative of the provider and registered manager how carrying forward incomplete actions from month to month might help to ensure that nothing is missed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risks to people's health and safety had not been fully assessed or mitigated. Regulation 12 (2)(a)(b).**