Tamaris (South East) Limited

Lydfords Care Home

Inspection report

23 High Street
East Hoathly
Lewes
East Sussex
BN8 6DR

Tel: 01825840259
Website: www.fshc.co.uk

Date of inspection visit:
15 September 2016
16 September 2016

Date of publication:
14 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Lydfords Care Home on the 15 and 16 September 2016. Lydfords Care Home provides accommodation and nursing care for up to 46 people who have nursing needs, including poor mobility or diabetes, as well as those living with dementia. On the days of our inspection, there were 46 people living at the home. The home is a large property, spread over three floors, with a communal lounge, dining room and large gardens. It is situated in East Hoathly, East Sussex. Lydfords Care Home belongs to the large corporate organisation called Four Seasons. Four Seasons provide nursing care services across England and have several nursing homes within the local area.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

The CQC is required by law to monitor the operation of Deprivation of Liberty Safeguards (DoLs) which applies to care homes. Applications to restrict people's freedom had been submitted to the appropriate DoLS office and checklists were in place to determine whether people's rights were being restricted. Staff had received training; however, staff were not consistently aware who was subject to a DoLS and what that meant for that individual. Conditions attached to DoLS were not consistently being met. We have made a recommendation for improvement.

People's nutritional needs were met. They were provided with a wide range of food options and individual dietary requirements were catered for. People's choking risk had been assessed and measures implemented to mitigate the risk of choking. However, improvements are required to enhance people's dining experience. Further work was required to ensure food and fluid charts were completed correctly. We have made a recommendation for improvement.

Appropriate recruitment checks took place before staff started work. Staffing levels were based on the individual needs of people and staff and people felt staffing levels were sufficient. Observations throughout the inspection found that the call bell constantly rang. An audit of call bell response times found that people had occasionally had to wait in excess of twenty minutes for staff to respond. The management team were responsive to this feedback and took action immediately. We have made a recommendation for improvement.

People's privacy respected and their right to confidentiality was maintained. People were involved in their care and decisions that related to this. Care plan reviews, as well as residents' meetings, enabled people to make their thoughts and suggestions known. People's right to make a complaint or comment was welcomed and acknowledged and action had been taken in response to people's concerns.

People, staff and relatives were complimentary about the leadership and management of the home and of

the approachable nature of the management team. One relative told us, "The manager is very bright and fair but will not let anything go. She is also a good nurse, if there is a gap she wears her nurse's uniform and works the shift." There were quality assurance processes in place to ensure that the systems and processes were effective and people's needs were being met.

Positive relationships had been developed between people as well as between people and staff. There was a friendly, caring, warm and relaxed atmosphere within the home and people were encouraged to maintain relationships with family and friends. People and their relatives were complimentary about the caring nature of staff, one relative told us, "The most important thing is they are very nice to her, they treat her like a human being and do not talk down to her."

People's safety was maintained as they were cared for by staff that had undertaken training in safeguarding adults at risk and who knew what to do if they had any concerns over people's safety. Risk assessments ensured that risks were managed and people were able to maintain their independence. There were safe systems in place for the storage, administration and disposal of medicines. People told us that they received their medicines on time and records and our observations confirmed this.

Staff were kind and sensitive to people when they were providing support and people had their privacy and dignity considered. Staff had a good understanding of people's needs and were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs. The provider had a training plan in place and staff had received regular supervision. People were supported to maintain relationships that were important to them.

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

Lydfords Care Home was safe.

People told us they felt safe living at Lydfords Care Home and staff were aware of the measures to keep people safe. People and staff felt staffing levels were sufficient. An audit of the call bell response time found on a few occasions people had to wait in excess of twenty minutes. We have a made a recommendation for improvement.

Staff had a good understanding about how to recognise and report safeguarding concerns. Medicines were stored, administered and disposed of safely. The environment and equipment was well maintained to ensure safety.

Appropriate checks where undertaken to ensure suitable staff were employed to work at the service.

Is the service effective?

Requires Improvement

Lydfords Care Home was not consistently effective.

People were asked for their consent. Mental Capacity Assessments (MCA 2005) had been completed in line with legal requirements and where people were deprived of their liberty, applications for DoLS had been made. However, staff were not consistently aware who was subject to a DoLS and the conditions attached to DoLS were not consistently met.

People were happy with the food provided and were able to choose what they had to eat and drink. However, improvements could be made to the dining experience for some people and food and fluid charts were not consistently completed.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being

Is the service caring?

Good

Lydfords Care Home was caring.

Staff were kind and knew people well. People and their relatives were involved in decisions about their care.

People had built caring relationships with staff. Staff treated people with respect and recognised people's needs for privacy.

People's records and information about them was stored securely and confidentially.

Is the service responsive?

Good

Lydfords Care Home was responsive.

People and their relatives told us they felt staff listened to them and they had good relationships with them. People and their relatives knew about the home's complaints procedure and said they were confident their complaints would be fully investigated and action taken if necessary.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Staff supported people to engage in a range of activities within the service.

Is the service well-led?

Good

Lydfords Care Home was well-led.

People and staff were very positive about the leadership and management of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement. The management team were committed to the continually improving the service.

People were treated as individuals and their opinions and wishes were taken into consideration in relation to the running of the home.

Lydfords 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.

This inspection took place on 15 and 16 September 2016 and was unannounced. The inspection team consisted of two inspectors', a specialist nurse advisor and an Expert by Experience in older people's care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the home. We considered information we held about the service. This included safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Prior to the inspection the provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make.

We last inspected Lydfords Care Home in July 2013 where we had no concerns.

During this inspection we spoke with nine people, ten people's relatives, six members of staff, the chef, activity coordinator, deputy manager and regional manager. We spoke with the registered manager via email after the inspection, as they were not available to be present during the inspection. We reviewed a range of records about people's care and how the home was managed. These included the individual care records for eight people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support in the communal lounge and dining area and spent time observing the lunchtime experience for people and activities in the lounge.

Good

Is the service safe?

Our findings

People told us they felt safe living at Lydfords Care Home. One person told us, "There are always people coming in and out so you are never really alone, that's why I feel safe." People's relatives also confirmed they felt confident leaving their loved ones in the care of Lydfords Care Home. One person's relative told us, "I feel so much better knowing she is safe and secure here. They have worked out all the risks, she is using a frame and they have dealt with her incontinence problems."

Staffing levels were assessed and reviewed dependant on people's nursing and care needs. Each person had an individual care needs assessment. This was inputted on the provider's electronic care system, which would then determine the number of staff required on each shift. Staff, people and relatives felt staffing levels were sufficient. Our observations demonstrated that people's needs were met in a timely manner. One staff member told us, "I feel there are enough staff." Throughout the inspection, we observed that the call bell system was ringing constantly. People told us on a few occasions they had to wait for their call bell to be answered, but this was not a common occurrence and caused them no distress. A member of the management team told us, "It's not the same person calling and often it is because staff have forgotten to turn the call bell off." This was demonstrated to us by a member of the management team. A staff member was supporting someone out of the toilet but had forgotten to turn off the call bell. Staff also felt there were various reasons why people rang their call bell so frequently. One staff member told us, "Some residents ring the bell while you are in the room with them. I think some people are lonely and want company. Some people ring a lot but don't always need something."

We conducted an audit of call bell response times and found call bells were usually answered promptly but on a few occasions people were waiting over 20 minutes. For example on the 13 September, the call bell print out sheet demonstrated that a person pressed their call bell at 12:22 and it was answered at 13:08. On the same day, a call bell was pressed at 19:58 and answered at 20:47. We brought our concerns to the attention of the management team who considered why this may be. The provider had not completed a formal audit of call bell response times but was responsive to our concerns and took action immediately. Subsequent to the inspection, the provider sent us a formal call bell audit with actions they had started to implement.

From talking to staff and people, staffing levels were sufficient and people received care in a timely manner, however, we recommend that the provider seeks guidance on how to safely assess, monitor and review call bell response times on a regular basis.

Staff had the knowledge and confidence to identify safeguarding concerns and were aware of their responsibilities in reporting any concerns. Records confirmed that staff had received training in safeguarding. Staff were able to tell us what may constitute abuse, signs which may alert them to concerns and reporting procedures. One staff member told us, "Abuse can be neglect, emotional, mental, physical, sexual, and financial. People may become withdrawn, family might only visit when their pensions is due, a person might have unexplained bruises. I would report my concerns straight away to the manager." There were whistle blowing procedures for staff to raise concerns and guidance was displayed prominently as a

reminder to staff.

There were robust systems to ensure people received their medicines safely. Policies and procedures were in place to support the safe administration and management of medicines. This included covert medicines (giving of medicines in a disguised form) and people taking responsibility for their own medicines. Registered nurses completed training updates when required and their competence was assessed to ensure medicines were continued to be given safely. Medicines were regularly audited to ensure that they were maintained to a safe standard. Medicine Administration Records (MAR) charts were checked to ensure that all documentation had been completed correctly. We observed medicines being given to people and saw that this was done following best practice procedures. People and their relatives confirmed they received their medicines when required. One person told us, "I have the usual pills, but no more antibiotics." A visiting relative told us, "They give her painkillers through a patch on a regular basis; it's nice to know she isn't in pain." Medicines and topical creams were stored and disposed of safely. Medicines were labelled, dated on opening and stored tidily within the trolley. Medicine fridge and medicine room temperatures were monitored daily to ensure they remained within safe levels. Medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of following safe procedures.

People living with dementia, communication difficulties or people receiving end of life care may not be able to verbalise whether they are in pain or discomfort. Pain assessment charts were in place which explored the 'resident's own description of pain' (if able to verbalise this), what makes the pain better and what makes the pain worse. Where people were unable to verbalise, they considered body language, change in behaviour and facial expressions to monitor for any pain. This demonstrated that steps were taken to mitigate the risk of people experiencing any pain or being in discomfort.

People were cared for by staff that the registered manager had deemed safe to work with them. Before staff started work identity and security checks had been completed, and their employment history gained. In addition to this their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers' make safer recruitment decisions and helps prevent unsuitable people from working with adults at risk. Documentation confirmed that registered nurses all had current registration with the Nursing and Midwifery Council (NMC).

The risk of people receiving unsafe care and treatment had been assessed and actions implemented to mitigate any such risks. The provider had consulted nationally recognised guidance such as the 'Health and Safety Executive (HSE)' and the 'National Institute for Health and Care Excellence (NICE).' There were individual risk assessments in place which supported people to stay safe, whilst encouraging them to be independent. Some people were supported to undertake positive risks. We observed some people, who had been assessed as being at risk of falling, walking independently around the home using their mobility aids. Steps had been taken to minimise the risk of people suffering harm if they did fall. For example, one person was identified at very high risk of falling. To mitigate the risk of harm, a low profile bed and crash mat had been given to them. . Where people required the assistance of two staff members to move and transfer along with a mobility aid (hoist), risk assessments considered the equipment required, handling constraints and other factors which may prevent a safe transfer.

Management of pressure damage is an integral element of providing safe care to people living in nursing homes. Pressure damage is often preventable and requires on-going monitoring and nursing care input. We looked at the management of pressure damage throughout the home. Risk assessments were in place which calculated people's risk of skin break down (Waterlow score). Where people were assessed at high risk, actions were implemented to reduce these risks. These included the implementation of air flow mattresses, regular re-positioning and application of barrier creams. Input had been sought from the Tissue

Viability Nurse where the person's skin integrity had broken down and nursing staff followed specialised wound care management plans. Documentation reflected that people's dressings were changed in line with the frequency recorded in their wound care management plan. Care staff had a good awareness of the basic principles to prevent the development of pressure damage. One staff member told us, "I learned to look for red skin, I would check to see if it blanches and then inform the nurse."

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of electrics, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare. There was a business continuity plan. This instructed staff on what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property. People's ability to safely evacuate the home had been considered within a bedroom risk assessment. For example, it confirmed if they would require assistance, but personalised evacuation plans were not in place. Subsequent to the inspection, the registered manager sent us evidence that personalised evacuation plans were now in place.

Requires Improvement

Is the service effective?

Our findings

People and their relatives had confidence in the skills and abilities of the staff employed at Lydfords Care Home. One person told, "I very much trust the staff, they are very good." Another person told us, "I would say the staff are very competent." Despite people's high praise for staff, we found care and support was not always delivered effectively.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. Staff confirmed they had received training on DoLS and training records confirmed this. Despite training in place, staff were not consistently aware of who was subject to a DoLS and what that authorisation meant for individuals. Some people had conditions applied to their DoLS authorisations. One person condition noted 'that the DoLS authorisation forms part of the care plan and staff to be aware of its implications.' We asked staff if they could tell us whether this person was subject to a DoLS authorisation. Staff were unaware that this person was subject to a DoLS. Another person had a condition applied to their DoLS which noted, 'they should be encouraged to practice their Church of England faith.' We asked a member of the management team to demonstrate how this condition was being met. They were unable to demonstrate how this condition was being met. However, they were responsive to our concerns and started taking action to address the concerns.

Although DoLS authorisations were in place, people's rights were not consistently protected as staff were not fully aware who was under a DoLS, what it meant for those individuals and what conditions may be attached to their DoLS authorisations. From our observations, we could see that the provider had recognised where people were deprived of their liberty. However, we have identified this as an area of practice that needs improvement.

We recommend that the provider seeks guidance from a reputable source about to how embed DoLS training.

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. Staff were able to confidently describe the main principles of the legislation. One staff member told us, "It is to protect people's independence, it is about if a person is able to make a decision for their health and wellbeing. People have different levels of capacity and it can fluctuate. People can have capacity for some decisions, but not others." Decision specific mental capacity assessments had been completed. Capacity assessments covered a wide range of decisions, such as care plans, bed rails, low profile bed and

crash mats.

Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' On both days of the inspection, we observed the mid-day meal. Tables were neatly decorated and laid and people were asked where they would like to sit. Menus were on display and people were offered a wide variety of meal options. People spoke highly of the food provided. One person told us, "The food is excellent." Another person told us, "Good choices and alternatives." One relative told us, "I have lunch with my loved one every day. They always ask me what I would like and never charge me." People were encouraged to be as independent as possible. For example, plate guards were available to enable people to eat independently.

Despite people's positive feedback, we observed elements of care which did not consistently uphold people's dignity during meal time. Mealtimes can be a significant event in people's lives and supporting people with engagement can enhance their experience. On the second day of the inspection, we observed a staff member call out loudly in the dining room, 'Is (person) being fed?' This interaction did not uphold that individual's dignity. Due to some people's care needs, they required support with eating and drinking in their bedroom. Staff had brought up a tray of soup to a corridor of the home. The tray had been placed on top of a radiator and one person's soup had been placed in front of them. This individual called out to the Inspector, "Help, I can't eat this myself, can you help me?" A staff member shortly arrived and assisted them to eat, leaving the other soups in the corridor to get cold. Contact between the person and staff member was functional, there was little interaction as they stood over the person whilst supporting them to eat and drink. However, this was not consistent throughout all interactions. On the other day and throughout the rest of the inspection, we saw staff supported people in an appropriate way which did uphold people's dignity, this included a member of staff taking time to talk with people and engage them in conversation, as well as explaining what was for lunch, and the options.

We recommend that the provider seeks guidance on embedding a lunchtime experience that enhances people's wellbeing.

Promotion of hydration in older people can assist in the management of diabetes and help prevent pressure ulcers, constipation, incontinence, falls, poor oral health, skin conditions and many other illnesses. People were regularly assessed for nutritional and dehydration risk. Where people were assessed as being at risk, a care plan was put in place to identify how their risk was to be reduced. Staff monitored people's dietary and fluid intake to ensure they received the nutrition they needed and drank enough. However, there was a lack of consistency in some areas, which required improvement. For example, food charts consistently reflected that after 17:30 people had nothing to eat and drink until the following morning. A member of the management team told us, "I can confidently say that this is not true, but acknowledge our recording needs to reflect this." People also confirmed they were offered snacks and regular drinks throughout the evening. People's daily fluid intake was not calculated to ascertain if they met their daily fluid intake target or if staff needed to push fluids the following day. For example, we calculated the fluid intake for one person on the 6 September 2016 as 475mls. Guidance produced by the Royal College of Nursing advises that people with a low fluid intake (less than 2400mls a day) are at heightened risk of urinary tract infections. We asked the management team, what strategic oversight was in place in the absence of formally calculating people's fluid intake. They told us, "We review the fluid charts at the end of the day and would share information at handover if people were at risk." However, we queried how this information could be shared without formally calculating the person's fluid intake. A member of the management team told us this was done informally, but agreed formal calculation would be helpful.

We recommend that the provider seeks guidance from a reputable source about effective oversight of

people's hydration needs.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support the needs of people living at Lydfords Care Home. For new staff an induction programme was in place to ensure new starters received the appropriate training, support and guidance to enable them to provide safe and effective care to meet people's needs. New staff were able to shadow a current staff member until they were deemed competent and confident to provide care. There was a full and intensive programme of training which included essential training for staff. Training included, moving and handling, infection control and safeguarding. Registered nurses received on-going clinical training which also maintained their continuing professional development. Clinical training included catheterization, PEG (percutaneous endoscopic gastrostomy), venepuncture (puncture of a vein), diabetes and wound care management. One staff member told us, "The manager is very supportive at ensuring we have regular training. Our competency is then assessed also."

Mechanisms were in place to support staff to develop their skills and improve the way they cared for people. Staff received regular supervision. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they felt supported within their roles and felt able to approach the registered nurses and management team with any queries, concerns or questions.

People received effective care that meet their nursing and care needs. Effective management of people's healthcare needs means people can live long healthy, autonomous and fulfilling lives. People's changing health needs were reviewed on a regular basis and referrals were regularly made to healthcare professionals. Each person had a multi-disciplinary care record which included information when dieticians, SALT (speech and language therapist) and other healthcare professionals had visited and provided guidance and support. People and their relatives felt confident their healthcare needs were effectively managed and monitored. One relative told us, "The personal supervision is excellent. My loved one has had two strokes and she never comes to any harm here. They cannot eat and the PEG was not successful. They are now on RIG (Radio Induced Gastric). The care home monitors it. They change my loved one's position. Nurses and carers talk to them and I take them into the garden for 20 minutes. They have special creams called dermol and double based gel for showering, moisturising and dry skin. They take my loved one's temperature regularly."

Good

Is the service caring?

Our findings

There was a friendly, homely atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that they were well cared for. One person told us, "The staff are kind and compassionate."

People were treated with kindness and compassion, as individuals, and it was clear from our observations that staff knew people very well. Staff made eye to eye contact as they spoke quietly with people; they used their preferred names and took time to listen to them. One person had become distressed and was walking along a corridor without footwear on. Staff sensitively approached them and queried if they were ok. The staff member then gently linked arms with the person asking if they would like a cup of tea and their favourite biscuit. They then slowly walked to the person's bedroom talking about the day ahead.

People were treated with respect and were able to independently choose how they spent their time. They were cared for by staff that knew them and their needs well. People were encouraged to maintain relationships with their family and friends and received visits throughout the day. Staff told us people's relatives and friends were able to visit them without any unnecessary restriction. Information on visiting was in the guide for people who used the service. Throughout the inspection, we spent time with one person who was enjoying the warm sunshine outside. They told us how staff supported them outside and helped them to sit in a position in the shade and made sure they had sun cream on. They had a call bell to hand, refreshments and their radio. They commented on how they enjoyed having their lunch outside and spending time with visitors outside. People were encouraged to spend time with their loved ones. One person told us how they enjoyed having lunch with their wife when they visited. On the second day of the inspection, we observed them eating lunch together and enjoying spending time together.

People's right to privacy was respected. People were assisted discreetly with their personal care needs in a way that respected their dignity. One person told us, "They knock and ask if I want to be washed or showered." People commented that they were made to feel comfortable at Lydfords Care Home to treat Lydfords Care Home as their own home. People's rooms were personalised with their belongings and memorabilia. With pride, people showed us their photographs and items of importance. One person told us how they enjoy Elvis Presley music and had pictures of Elvis on their bedroom wall. People commented that staff recognised that their bedroom was their own space and this was respected by staff.

Guidance produced by the Social Care Institute for Excellence (SCIE) advises on the importance of choice and control for older people within care homes and empowering people to retain their identify. Staff recognised the importance of supporting people to dress in accordance with their lifestyle preference and promote their identity. One staff member told us, "Where it's important for people to wear make-up, we'll support them with that. It's important to them." Staff had helped people to dress in the way their care plan said they preferred and to have belongings with them that were of importance, for example, their handbag. We spent time with one person in the communal lounge, commenting on how glamorous they looked. They told us how they enjoyed wearing jewellery and how staff supported them with choosing what jewellery to wear.

People were consulted with and encouraged to make decisions about their care. They also told us they felt listened to and able to contribute to their plan of care. One person told us, "My family know about my care plan." A visiting relative told us, "We are always consulted." Another relative told us, "They go through the care plan with me and my loved one which is nice." People were encouraged and supported to make day to day decisions about their care and how they wished to spend their day. For example, people told us they could get up and go to bed they wished. Staff members confirmed that people were supported to have a routine that suited them. One staff member told us, "Everyone has a different way, some people don't want to get up early and other's need care to make sure they are clean and comfortable."

People's equality and diversity needs were respected and staff were aware of what was important to people. People were encouraged to be themselves. For those living with dementia, relatives spoke highly of how staff supported their loved one. One visiting relative told us, "The most important thing is they are very nice to her, they treat her like a human being and do not talk down to her." Where people were not able to express their needs, their wellbeing was taken into account by staff as they were proactive in ensuring people's wellbeing. We heard staff constantly asking people if they were okay or if there was anything they needed. For those who preferred to stay in their bedroom, staff conducted regular checks of their wellbeing and safety.

Care records were stored securely in the staff offices. Information was kept confidentially and there were policies and procedures to protect people's confidentiality. Staff had a good understanding of privacy and confidentiality and had received training in this area.

Good

Is the service responsive?

Our findings

People and their relatives told us that they received personalised care which was responsive to their needs. One person's relative told us, "They all listen to me and ring me if they have any problems or anything happens. I never have to worry." Another person's relative told us, "People receive high quality care and they encourage activity."

People's individual care needs had been assessed and a care plan written to meet their identified needs. People's needs had been assessed before they moved into the home to check whether the service could accommodate these needs. A care plan was then devised based on the pre-admission assessment. These assessments gave a clear account of people's needs in relation to their medicines, communication, nutrition, continence, skin integrity, human behaviour and mobility. Care plans were detailed and included information on the individual's assessed need and expected outcome. One person's nutrition care plan identified they were at moderate risk of choking. Guidance included, 'staff to be vigilant and ask if they would like their food cut up and provide discreet supervision. This enabled staff to provide personalised and individual care to people.

Personalised care planning is at the heart of health and social care. It refers to an approach aimed at enabling people to plan and formulate their own care plans and to get the services that they need. Personalised care plans consider the person's past, their life story, their wishes, goals, aspirations and what's important for them when receiving care. A recent initiative implemented at the service was the introduction of the 'my choices' booklet. These booklets had been completed in partnership with people and provided information on their life history, what was important to them, important memories and how best to support them. One person's 'my choices' booklet noted that if they were having a bad day, they wanted staff to respect their decision to stay in bed and know that it wasn't a problem.

People, relatives, staff and visitors were given regular opportunities to provide their feedback about the service, the staff, the environment, the food, activities and about the running of the service. The provider had introduced a new initiative called the 'Quality of Life Programme.' The 'Quality of Life Programme' enables feedback to be obtained from people and their relatives through the use of technology. The service had been provided with several IPads which provided staff with the ability to obtain feedback from people on a daily basis and make it easier for people to provide feedback. Feedback is then fed into the thematic resident care audit which enabled the provided to look at the individual care people received along with specific elements of care. People and their relatives confirmed they had begun providing feedback on the IPads and commented that it was relatively easy to provide their feedback.

There was a complaints procedure in place and people and their representatives told us they knew how to access and use this. People also told us they could bring up any concerns and issues at the residents meeting. People and relatives felt they would be listened to and would usually approach the registered manager or deputy manager as they were both available and approachable. We saw evidence that complaints which had occurred had been recorded and responded to appropriately. Where complaints had been received, the registered manager and identified learning from each complaint to help drive

improvement. For example, one complaint was in relation to the provision of eye care. As a result of the complaint, group supervision was held with staff reiterating the importance of eye care.

It is important that older people in nursing homes have the opportunity to take part in activities, including activities of daily living that helps to maintain or improve their health and mental wellbeing. People should be encouraged to take an active role in choosing and defining activities that are meaningful to them. The service employed dedicated activity coordinators. A wide ranging activity timetable was available. We observed a game of bingo, arts and crafts and a musical sing along. In the afternoon, the lounge came alive and many people joined in for the musical sing along with light exercise. The activity coordinator gently woke people up by calling their name to see if they wished to participate. Everyone in the lounge participated and the environment came alive with singing and dancing in chairs. Songs from old films, such as 'My Fair Lady' were playing and staff and people were singing along. The activity coordinator used a giant balloon which people passed to another one to promote light exercise. People spoke highly of the activities. One person told us, "We have bingo, music, singing and keep fit."

A large number of people preferred to spend time in their own rooms, undertaking activities of their choice, such as reading or watching television and staff respected people's rights to choose how they spent their time. One person told us, "I would rather stay in the comfort of my own room and watch TV and read my Daily Mail, the staff stop for a chat if they have time." However, we queried what mechanisms had been implemented to reduce any feelings of social isolation. Staff told us, "The activity coordinator spends one to one time with people in their bedrooms once a week." This was recorded in people's daily notes. For example, one person enjoyed one to one time with the activities coordinator talking about they use to enjoy the garden and greenhouse. Documentation reflected that one to one with people was primarily a chat, rather than offering personalised activities or supporting people to pursue their hobbies and interests. This was raised to a member of the management team who agreed that improvements could be made to ensuring people received meaningful activities in their bedrooms.

We recommend that the provider review activity provision in line with best practice guidelines.

Good

Is the service well-led?

Our findings

People, relatives and staff talked positively about the management of the service. One person told us, "The manager is very approachable and sometimes comes to my room for a chat." A relative told us, "The manager is very bright and fair but will not let anything go. She is also a good nurse, if there is a gap she wears her nurse's uniform and works the shift."

People, their relatives, staff and healthcare professionals were actively involved in developing and improving the service. Regular satisfaction surveys were sent out to people to enable them to provide feedback. The latest feedback from August 2016 to September 2016 found that 70% of respondents felt they had access to a range of social activities and events within the home while 77% of respondents felt staff were warm and friendly. Feedback from staff satisfaction surveys found that 74% of staff reported that they trusted the manager to do the best for them and the home. The regional manager told us, "We then analyse the feedback and any action points are inputted onto our action plan which I have oversight of but the manager is responsible for updating. The satisfaction surveys are a really powerful tool to give us an indication of what's working and what isn't working. We'll compare the results to other months and see what may have changed. " Following the results of recent satisfaction surveys, an action point had been the implementation of a 'you said, we did board.'

There were systems to review the quality of service provided which included a variety of audits and checks. Audits are a quality improvement process that involves reviewing the effectiveness of practice against agreed standards. Audits help drive improvement and promote better outcomes for people who live at the home. The management team were completing regular audits of infection control, medication, topical creams, pressure care and nutrition audit. The provider's regional manager also visited the home on a monthly basis conducting internal audits regarding the governance of the home. The regional manager told us, "I complete a monthly review which considers quality assurance. Such as, has the manager been completing the daily walk around and where feedback from people has been received, how has this feedback been responded too." The service was then assessed against CQC's key lines of enquiry and scored as to how well they were measuring against each key question. Night spot checks were also undertaken by the management team which considered the competency of the night staff and the delivery of care at night. The last night visit took place in August 2016 where the manager arrived at 4am. Action points were transferred onto the service's action plan and actions included for a new medicines book to be ordered.

Documentation was in place for the recording of incidents and accidents. This included the date, time, person and staff involved, details of the incident/accident, immediate action taken and the level of harm, such as minor injury or no harm. On a monthly basis, all incidents and accidents were collated and analysed for any trends, themes or patterns whilst also considering how improvements could be made following individual accidents and incidents. The regional manager told us, "With regards to falls, we analyse falls by looking at the times people fell, how many staff were on duty and if people are falling at similar times or if there is a time when people are falling more regularly. The level of falls at Lydfords Care Home is very low, with only five falls last month. The manager also analyses incidents and accidents at a local level,

considering how many infections, skin tears or resident altercations there may have been. Action points are identified and actions are then implemented onto the action plan."

Lydfords Care Home is part of a large, corporate organisation called Four Seasons. Four Seasons provide nursing care across England and have several nursing homes within the local area. The management team consisted of a registered manager and a deputy manager. The registered provider had a philosophy of care that stated 'We are committed to providing the highest possible standards of care. Residents will be treated as individuals and cared for with respect and dignity within a safe, comfortable and homely environment which provides stimulation and encourages independence where appropriate'. There was a friendly, homely atmosphere. Staff spoke highly of the management team, commenting that they were open, friendly and operated an open door policy.

The registered manager was committed to the continuous development and improvement of the service. A service improvement plan was in place which detailed the on-going work that was required to improve the décor and environment of Lydfords Care Home. During the inspection, we identified that the service only had one wet-room to 46 residents and one operating bathroom with a ceiling hoist. In total, the service had two bathing facilities, as people's individual bedrooms were not en-suite. Meeting minutes throughout the year identified that the registered manager had raised the bathing facilities as a concern to the provider and subsequent to the inspection; the registered manager sent us confirmation that an estates surveyor would be visiting the home in October to begin the process of converting the old bathrooms into wet rooms.

The management team were open and responsive to our feedback. For example, during the inspection, we identified that a large number of people were living with dementia. A safe, well designed and caring living space is a key part of providing dementia friendly care. A dementia friendly environment can help people be as independent as possible for as long as possible. For people living with dementia, signage can help promote independence, such as signs to the toilet, or signs to the lounge and dining room. The environment at Lydfords Care Home was not specifically designed for people living with dementia and signage was not readily available. Throughout the inspection, we observed that people could independently navigate the home and find their way about. However, it is seen as good practice for care homes to be dementia friendly. The service improvement plan identified that a programme of redecoration was about to start. As part of this programme of redecoration, we queried with the registered manager their plans on the making the environment more dementia friendly. The registered manager told us, "I have started to order signs which we can implement immediately."

The registered manager was aware of their responsibility to comply with the CQC registration requirements. They had notified us of events that had occurred within the home so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken.