

Care UK Community Partnerships Ltd

Foxbridge House

Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

This inspection took place on 24 and 25 September 2015 and was unannounced. Foxbridge House provides residential and nursing care for up to 84 older people. The home is located in Orpington Kent and is a large purpose-built care home. At the time of our inspection there were 54 people living at the home and there was a registered manager in post. 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.

We had previously carried out an unannounced comprehensive inspection of the service on 9 and 10 March 2015 when we found nine breaches of the Health and Social Care Act 2008. Breaches found at the inspection in March 2015 included risks to people were not always assessed and managed appropriately, staff

Summary of findings

recruitment processes were not safe, staffing levels were not always adequate to meet people's needs, processes were not in place to assess people's capacity to make decisions in line with the Mental Capacity Act 2005 (MCA 2005), records were not always accurate and contemporaneous and the provider did not have effective systems in place to regularly assess and monitor the quality of service. We served the provider with three warning notices and conducted a focused inspection on 24 June 2015 to check that the warning notices we served at the March inspection had been met. The provider sent us an action plan detailing the action they would take to meet the other outstanding legal requirements.

We carried out this inspection to check the action plan had been completed and outstanding breaches had been met and also to provide a review of the rating for the service. Following the inspection in March 2015 the provider imposed a voluntary suspension of new placements until actions were taken to address the concerns and breaches we found. The provider lifted the voluntary suspension after our inspection in June 2015 when we had identified that the provider had met the three warning notices we had served.

At this inspection we found that improvements had been made, however we were unable to assess the full effectiveness of some of the systems and processes that were implemented to address the areas of concern as these had not been applied consistently over time. For example the implementation and completion of action plans developed to address areas of concern as a result of audits conducted.

There were sufficient numbers of suitably qualified and skilled staff deployed throughout the home to meet people's needs appropriately. There were safe and robust staff recruitment procedures in place to ensure staff were suitable for their roles.

Medicines were stored and administered safely, however medicine training records showed that some staff had not completed the provider's medicines foundation training. We were told that training had been booked for the end of the month. Risks to the health and safety of people using the service were identified, assessed and reviewed in line with the provider's policy.

There were arrangements in place to deal with foreseeable emergencies. There were safeguarding adult's policies and procedures in place to ensure that people using the service were kept safe. Incidents and accidents involving the safety of people using the service were recorded and acted on appropriately. Systems and process were in place to regularly monitor the safety of premises and equipment used within the home.

People told us they were involved in the decisions about their care and were able to voice their preferences to staff. Staff demonstrated a clear understanding of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). Care plans contained mental capacity assessments where appropriate and applications for DoLS were made in accordance with the MCA 2005. The MCA 2005 protects people who may lack capacity to make decisions in relation to consent or refusal of care and treatment. DoLS protects people when they are being cared for or treated in ways that deprives them of their liberty for their own safety.

People's nutritional needs and preferences were met and nutritional needs assessments and swallowing risk assessments had been completed and were contained within people's care plans where appropriate.

Staff received an induction into the home before they started work and regular up to date training, frequent and appropriate support, supervision and appraisals which enabled them to carry out their duties.

People had access to health and social care professionals when required. Care plans and records demonstrated that people were involved in making decisions about their care and lifestyle choices and people's preferences and end of life care needs were assessed and reviewed in line with the provider's policy.

Staff were knowledgeable about people's needs and preferences and how to maintain people's privacy and dignity. We observed staff treating people in a respectful and dignified manner. People were assessed to receive care and treatment that met their needs and care plans were reviewed on a regular basis to ensure this. Care plans were organised and easy to read and care plans and records stored on the home's computer system were easy to access.

Summary of findings

The home provided a range of activities that met people's needs and reflected their interests. People and their relatives told us they were aware of how to raise a concern and felt confident their concerns would be listened to.

There was a registered manager in post at the time of our inspection and people and their relatives told us the registered manager had made many improvements to the home since our last inspection and they thought the home was well led. There were systems in place to

monitor the quality of the service provided and we saw recent internal and external quality assurance audits that were conducted for all areas of care and services provided. Accurate and contemporaneous records were kept and maintained both on the home's computer system and in people's paper files in relation to the care and treatment people received. There were processes in place to ensure people, their relatives and staff were provided with opportunities to provide feedback about the service.

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?

The service was mostly safe.

There were sufficient numbers of suitably qualified and skilled staff deployed throughout the home to meet people's needs. There were safe and robust staff recruitment procedures in place to ensure staff were suitable for their roles.

Medicines were stored and administered safely; however, medicine training was not always up to date. We were told that training had been booked for the end of the month.

Risks to the health and safety of people using the service were identified, assessed and reviewed in line with the provider's policy. There were safeguarding adult's policies and procedures in place to ensure that people using the service were kept safe.

Incidents and accidents involving the safety of people using the service were recorded and acted on appropriately and there were processes in place to ensure the home environment was safe and appropriately maintained.

Requires improvement



Is the service effective?

The service was mostly effective.

Staff demonstrated a clear understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Care plans contained mental capacity assessments where appropriate and applications for DoLS were made in accordance with the MCA 2005.

People's nutritional needs and preferences were met.

Staff completed an induction programme when they started work and they received appropriate training to support people with their care needs.

The majority of staff received regular supervision and appraisals in line with the provider's policy.

People using the service were able to see health care professionals when they needed.

Requires improvement



Is the service caring?

The service was caring.

People were encouraged to make decisions and choices relating to their care. Care plans and records demonstrated that people were involved in making decisions about their care and lifestyle choices.

Staff treated people in a respectful and dignified manner and the atmosphere in communal areas was calm and friendly.

Good



Summary of findings

Staff were knowledgeable about people's needs and preferences and how to maintain people's privacy and dignity.

Is the service responsive?

The service was responsive.

People were assessed to receive care and treatment that met their needs and care plans were reviewed on a regular basis to ensure this.

Care plans documented guidance for staff on how people's physical and mental health needs should be met.

The home provided a range of activities that met people's needs and reflected their interests.

People's concerns were responded to and addressed in a timely manner.

Good



Is the service well-led?

The service was mostly well-led.

There was a manager in post at the time of our inspection. People and their relatives told us improvements to the home had been made and they thought the home was well led. Staff within the home were positive about the changes made and the support provided by the registered manager.

There were systems in place to monitor the quality of the service provided, however we were unable to assess the full effectiveness of some of the systems and processes that were implemented to address the areas of concern as these had not been applied consistently over time.

Accurate and contemporaneous records were kept and maintained in relation to the care and treatment people received. There were systems in place to ensure people, their relatives and staff were provided with opportunities to provide feedback about the service.

Requires improvement



Foxbridge House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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.

We undertook this comprehensive inspection on the 24 and 25 September 2015 to check if improvements had been made to meet the legal requirements for six of the breaches in regulations we found at our inspection in March 2015. Warning notices we served after our inspection in March 2015 were followed up and had been met at our inspection in June 2015.

Prior to the inspection we reviewed information we held about the service. This included reviewing the provider's action plan from the previous inspection and looking at statutory notifications and enquiries. A notification is information about important events which the provider is required by law to send us. We also asked the local authority commissioning the service and the safeguarding team for their views of the service.

The inspection team consisted of three inspectors and two specialist advisors on the first day. There were three inspectors, two specialist advisors and an expert by experience on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

There were 54 people using the service on both days of our inspection. We spoke with 24 people using the service and 11 visiting relatives. We looked at the care plans and records for 15 people using the service and 16 staff records. We spoke with 15 members of staff including the regional director, registered manager, team leaders, care staff, chef and domestic workers. We also spoke with four visiting health and social care professionals.

Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) to observe people's experiences throughout the inspection. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection we looked at records and reviewed information given to us by the registered manager and members of staff. We looked at records relating to the management of the service and also looked at areas of the building including communal areas and outside grounds.

Is the service safe?

Our findings

At our last inspection in March 2015 we found there were not always enough staff to meet people's needs safely. People told us they waited long periods for staff to offer support and staff told us there were problems with staffing levels and high usage of agency workers.

At this inspection we found there were sufficient numbers of suitably qualified and skilled staff deployed throughout the home to meet people's needs appropriately. The majority of people we spoke with told us there was enough staff available to support them when requested. One person said "Staff are very good and I don't seem to wait very long for help." Another person commented "There is always someone around to help." Visiting relatives told us they felt there was enough staff most of the time and staffing levels had improved. One relative said "On the odd occasion, they are understaffed, but on the whole everyone is always very willing to help." Another relative told us "There are a lot of new carers now, the others all left." A third relative commented "There was a period of agency staff, but it seems better now with more permanent staff."

During a tour of the premises we noted that call bells were placed in each room and throughout communal areas and were within reach for people. On both days of the inspection we observed call bells were responded to promptly by staff. Call bell alarms were displayed on screens throughout the home and were visible highlighting the room number and the duration of the call. We looked at records of call bell response times which showed the majority of call bells were answered by staff within 3 minutes. The registered manager told us that they monitored call bell response times on a regular basis to ensure people's needs and requests were met in a timely manner.

Staff told us there were enough staff on duty to meet people's needs and people using the service were safe. However nursing staff told us that on occasions they could be 'stretched'. One nurse commented "Sometimes it can be a bit stretched in terms of the clinical work that needs to be done." A team leader told us they felt there was enough staff and when they are stretched it was only in the event of staff going sick at short notice. Care staff told us that staffing levels were much better and they were able to meet people's needs. One care staff said "I think we have an adequate level of staff. We all know what we are doing

and get on with it." We looked at the staff rotas which showed that the use of agency staff had significantly declined since our last inspection and throughout our inspection we observed there were adequate numbers of staff deployed throughout the home. However the home had lifted their voluntary suspension on admissions and were admitting new people into the home at the time of our inspection which could impact on the levels of staff required. We spoke with the registered manager who showed us a staffing level dependency tool which was used to ensure that staffing levels were safe and people's needs were met. We also looked at the home's admission plan which was developed to ensure staffing levels were reviewed when people were admitted into the home.

There was an up to date and appropriate medicines policy in place. The medicines policy provided guidance for staff and included areas of medicines management such as safe administration, supply, storage and disposal of medicines. Medicines were stored and administered safely. Medicines were locked in secure medicines trolleys in locked medicine rooms that only authorised staff had access to. Controlled drugs were safely kept in locked cupboards within locked medicine rooms that only trained staff had access to. We looked at the controlled drugs register and noted it was completed correctly. Medicines which required refrigeration were kept in lockable refrigerators in medicine rooms and temperatures of refrigerators and rooms were monitored to ensure medicines were safe to use. Medicines were disposed of appropriately and collected monthly by an external company.

During our inspection we saw medicines were administered to people safely. People's medicines were stored in individual trays which had people's names clearly printed along with the name and dosage of the medicine to ensure people were administered the correct medicines. We looked at 12 people's medication administration records (MAR) which listed people's medicines and doses along with space to record when doses had been given by staff. MAR charts we looked at had been completed correctly. We noted photographs were kept on people's MAR records to identify them to new staff to help ensure medicines would be administered to the right person. Records of allergies were recorded on people's MAR charts to prevent the risk that people could receive medicines they were allergic or have an adverse reaction to.

Is the service safe?

Staff administering medicines told us they had received training and competency checks relating to the management of medicines. Records confirmed staff had received competency assessments within the last year. However, medicine training record showed that some staff had not completed the provider's medicines foundation training. We spoke with the registered manager who showed us records which demonstrated that the majority of staff had completed the training and those who had not were to complete it by the end of the month.

There were safe appropriate processes in place for people who receive their medicines covertly. Covert administration of medicine occurs when medicine which needs to be administered in people's best interest is deliberately disguised, usually in food or drink. We found the correct procedure had been undertaken by the home according to the provider's medicine policy. We noted the GP had signed and dated records of decision forms and mental capacity assessments were completed along with best interest decisions for the administration of covert medicines. Records showed involvement from staff, people's relatives, the registered manager, GP and pharmacists. We found the use of covert administration had been documented in people's care plans and in people's medication administration records.

People who were safe to do so were supported to manage and administer their own medicines. The clinical manager told us some people preferred to take their own medicines rather than have them administered by staff. However we spoke with two people who self-administered medicines and found that people were not always being monitored effectively by staff in line with the provider's medicine policy. We brought this to the attention of the registered manager who took immediate action to ensure systems were in place whereby people who self-administer medicines were reviewed on a weekly basis and in line with the provider's policy.

There were appropriate processes in place to report and record medicine errors. However we noted there had been three medicine errors since our last inspection and saw that the most recent medicine error had not been documented correctly using a medicine incident form in line with the provider's policy. We spoke with the registered manager who told us that medicines errors were recorded on the computer system however there was not a robust

process in place to record and learn from medicine errors. The registered manager took immediate action to ensure that all staff followed the provider's medicines policy and recorded medicine error's appropriately.

At our last inspection in March 2015 we found that risks to people's health and well-being were not always assessed, documented or managed appropriately and staff recruitment procedures were not safe. We served the provider with three warning notices. At our focused inspection in June 2015 we found that the provider had addressed the breaches of regulations and were compliant with the warning notices we served.

Risks to the health and safety of people using the service were identified, assessed and reviewed in line with the provider's policy. Risk assessments formed part of people's agreed care plan and covered risks that staff needed to be aware of to help keep people safe. Staff showed an understanding of the risks people faced. For example one staff member explained how they checked the general environment daily for trip hazards. We saw that people's care plans included risk assessments with information for staff on how to support people appropriately in order to minimise the risk to them. Risk assessments were reviewed on a regular basis by staff and included areas such as falls, eating and drinking, moving and handling, nutritional needs, skin integrity and night time support. For example, where people were assessed at risk of malnutrition there were plans in place to support them with eating and drinking.

People's skin integrity was regularly assessed and risk assessments were documented in people's care plans. We saw that where a person required support with wound care there was guidance for staff to follow and records of appointments with a tissue viability nurse. There were photographs of the wound at various stages of improvement and staff were required to report any deterioration to the wound nurse. We noted where a person had been scored as medium risk of pressure sores, their care plan reflected this and staff we spoke with could explain to us how they manage and monitored this. In another care plan we saw that the person's manual handling risk assessment documented clearly the level of staff support and type of equipment required to ensure the person's safety when mobilising. People at risk of falling were observed by staff when mobilising. One member of staff told us, "We try to make sure people are safe and don't

Is the service safe?

have any falls.” We observed a member of staff who responded quickly to one person who had attempted to get out of their wheelchair and became unsteady thus preventing a fall.

There were arrangements in place to deal with foreseeable emergencies. People had individual emergency evacuation plans in place which highlighted the level of support they would need to evacuate the building safely. We also noted a red dot placed on peoples doors where they required assistance in the event of an emergency. There was a fire evacuation plan in place to ensure people’s safety in the event of an emergency and staff had received up to date fire training and knew how to respond in the event of a fire. Records confirmed that staff participated in frequent fire alarm tests and checks on fire equipment within the home were conducted to ensure they were in working order. Fire signage and exit points were clearly displayed and we observed that fire exits were clear and free from hazards.

There were safe staff recruitment procedures in place. Staff records showed that the provider had safe systems in place for the recruitment and selection of staff. Thorough recruitment checks were carried out before staff started working at the home. We looked at the personnel files of 11 staff who worked at the home and saw completed application forms which included references to their previous health and social care experience, their qualifications, their employment history and explanations for any breaks in employment. Each file included evidence that criminal record checks had been carried out, two employment references, and proof of identification. In addition, records contained evidence of the right to work in the UK and an occupational health assessment which cleared the person fit for work. All records relating to nursing staff were maintained and included their up to date PIN number which confirmed their professional registration with the Nursing and Midwifery Council (NMC).

The registered manager showed us a separate file which contained all agency staff records and included the profiles of agency nurses and care workers. We looked at 10 profiles

including nursing staff and care workers and found all relevant information, including their photograph, training details and NMC registration where appropriate for nursing staff.

There were safeguarding adult’s policies and procedures in place to ensure that people using the service were kept safe. Staff demonstrated a clear understanding of the types of abuse that could occur. They told us the signs they would look for, what they would do if they thought someone was at risk of abuse, and who they would report any safeguarding concerns to. One member of staff said, “I have had all my training on safeguarding, which gives me confidence. If I thought someone was being abused I would always report it to the manager.” Staff told us they had received training on safeguarding adults from abuse and were aware of the organisation’s whistle-blowing procedure and how to use it should they need to.

Incidents and accidents involving the safety of people using the service were recorded and acted on appropriately. We looked at the home’s accident and incident file which recorded all incidents and accidents that had occurred for people using the service. This included the detail of the incidents or accident, i.e. what happened, what action was taken, for example risk assessment reviewed or if medical advice and support was sought. The registered manager and regional director also showed us the electronic system for reporting and monitoring incidents and accidents. These were recorded on the home’s computer system which flagged up any trends, patterns or queries. These would then be flagged up with the registered manager during a senior manager bi-weekly meeting so they could address any concerns.

Systems and process were in place to regularly monitor the safety of premises and equipment used within the home. We saw that equipment was maintained and checked regularly for example, laundry and domestic equipment, sanitary fittings, lifts, fire alarms and emergency lighting, wheel chairs, beds, hoists and hand rails. Legionella and portable appliance electrical testing checks were carried out and records we looked at were up to date. We saw that the premises were kept clean and people’s rooms and communal areas were tidy and free from odours.

Is the service effective?

Our findings

At our last inspection in March 2015 we found the provider did not have appropriate processes in place to assess and consider people's capacity and rights to make decisions about their care in line with the Mental Capacity Act 2005 (MCA 2005).

At this inspection people told us they were involved in the decisions about their care and were able to voice their preferences to staff. One person said "They [staff] talk to me and ask me how I want things to be done." Another person told us "I do feel involved; they always tell me what's happening." A visiting relative said "We were always kept informed, nothing was overlooked. I was so involved; I knew everything and learnt so much from all the staff."

Staff we spoke with demonstrated a clear understanding of the MCA and the Deprivation of Liberty Safeguards (DoLS). They told us that most people using the service had capacity to make some decisions about their care and treatment and we saw consent to treatment forms within people's care plans which were signed by people to show they were part of the care plan process and agreed to their plan of care. One staff member said, "When people move here we must assume they have capacity to make decisions for themselves. If we think they don't have capacity to make decisions about specific issues the manager makes sure capacity assessments are carried out. After that other people such as health care professionals can meet to make decisions in the person's best interests."

Care plans contained mental capacity assessments where appropriate and applications for DoLS were made in accordance with the MCA 2005. The MCA 2005 protects people who may lack capacity to make decisions in relation to consent or refusal of care and treatment. DoLS protects people when they are being cared for or treated in ways that deprives them of their liberty for their own safety. We saw that appropriate referrals were made to local authorities so that people's freedom was not unduly restricted. We saw that DoLS authorisations followed guidance and conditions that were in place. Staff understood the importance of seeking consent before they offered support and records confirmed that staff had received up to date training on the MCA and DoLS.

At our last inspection in March 2015 we found people's nutritional needs and preferences were not always met. At

this inspection people told us they enjoyed the food on offer and were given choices. One person said "I am quite happy. There is always plenty of fresh fruit about, you can help yourself. It is mostly good quality food." Another person told us "I am finicky about food and if there was something I didn't like, they [staff] would get me something else." Visiting relatives also spoke positively about the food. One relative said "The food has got better; they seem to have upped their game slightly." Another relative told us "Her eating and drinking has improved no end since she came to live here."

We saw that nutritional needs assessments and swallowing risk assessments had been completed and were contained within people's care plans where appropriate. Where people were at high risk of malnutrition or swallowing, risk assessments indicated they were at risk of choking and referrals were made to speech and language therapists (SALT) for advice, support and guidance. There were SALT guidelines in place advising staff on people's nutritional needs and how they should be supported with food and fluids. For example one person's care plan recorded that they needed to be alert and seated in an upright position to eat safely. We observed staff provided care as directed by recorded guidance. Where people were diabetic and required a special diet this was also highlighted in their care plan. We noted that care plans documented people's nutritional needs in detail and were completed on a weekly basis to ensure people's needs were up to date and catered for appropriately.

Accurate records of people's dietary requirements were available to the chef and kitchen staff to ensure people's needs were met. We saw a white board displayed in the kitchen and a dietary record book that was kept to document the dietary requirements and preferences of all the people using the service. For example, any food allergies, if a person was diabetic, the type and texture of meals, whether vegetarian, soft diet or pureed foods were required. We noted that one person preferred a no red meat diet and another preferred no curry or spicy dishes. We also saw that one person using the service had recently been seen by the SALT and required a normal diet with pureed meat. This had been communicated to the chef by the SALT and was recorded on the whiteboard and in the dietary record book to ensure people's needs were catered for. We spoke with the chef who told us that the speech and

Is the service effective?

language therapist contacted them directly after reviewing people's nutritional needs and advised them of any changes. This information was then recorded on the white board and the dietary record book.

We observed how people were supported and cared for during lunchtime in two of the three dining rooms. Some people required support with eating and drinking and some people ate independently. The atmosphere in the dining rooms was relaxed and not rushed and there were appropriate levels of staff to assist people when required. For example one person using a wheelchair tried to get up out of their chair. A member of staff acted quickly and reminded them they need to sit down to eat their meal safely. We observed another member of staff helping one person walking with a purpose to find their seat and supported them to cut their food. Some people ate their meals in their rooms and we saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day and these were available on each floor and in the café located near reception.

At our last inspection in March 2015 we found that staff did not receive regular up to date training, frequent and appropriate support, supervision and appraisals to enable them to carry out their duties. This was a breach of legal requirements and we took enforcement action and served a warning notice on the provider requiring them to become compliant with the legal requirement. At our focused inspection in June 2015 we found that the provider had addressed the breaches of regulations and were compliant with the warning notice we served.

At this inspection staff told us they had completed an induction programme when they started work. One member of staff said "My induction into the home was good. I had a work book and opportunities to observe how other staff did their jobs." Staff induction records included the provider's new induction pack which covered mandatory care topics and operation policies and procedures. We saw the new induction pack was comprehensive and specific to the designation of staff for example registered nurse would be given a clinical induction. Induction booklets were signed off by senior staff which confirmed that individual staff members had

been assessed and were competent in specific areas. Registered nursing staff induction booklets also covered clinical topics, record keeping and documentation relevant to their role.

People using the service were supported by staff with appropriate skills and experience. One person told us, "You get everything you need here as if you were at home; the staff seem to know their stuff." We observed that staff understood people's care and support needs and knew people well. One staff member told us, "I always make sure to read the daily notes so that I know if there is any change I need to be aware of. For example, if a person has had a bad night, then they will be quite fragile the next day and may need more of an eye kept on them."

Staff told us they felt they had received appropriate training to support people with their care needs. One staff member told us, "I find the training quite good and I am well up to date. We are reminded when something is due to be refreshed." Another member of staff said "I have done all of my mandatory training. I have also received training on dementia. This has really enlightened me on the different stages of dementia and on how I need to support people. This has given me even more confidence to do my job." We saw the provider's mandatory training included safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards, dementia awareness, moving and handling, food safety and fire safety. We saw that training provided was delivered either in a classroom environment or by an electronic learning system. There was an electronic training record which enabled the registered manager to monitor staff training and ensure staff were kept up to date. Certificates of completed training which were not stored on the provider's computer system were held on individual staff files. For example staff training in catheterisation, venepuncture, tissue viability and continence awareness. Training records demonstrated that staff were up to date in all areas of training provided.

People were supported by staff that were appropriately supported to deliver care and treatment effectively. Staff told us they received regular supervision and appraisals in line with the provider's policy. One staff member said "I have supervision regularly. It is very helpful because I get to discuss how things are with my work and my supervisor makes helpful suggestions." Another member of staff told us "My supervision is very regular. You get to discuss both the positives and the negatives and get guidance on how to

Is the service effective?

go forward.” The provider’s supervision matrix showed that staff generally received supervision on a regular basis and in line with their policy. However, we noted there was no supervision recorded for one senior staff member who was appointed in June 2015 and we also saw gaps in the frequency of supervision given to bank staff. We spoke with the registered manager who told us the senior staff member had received supervision but acknowledged there was no written record of this. They advised us this would be remedied. We were told that the gaps found in supervision records for bank staff was the responsibility of individual bank workers. The regional director told us that bank staff were responsible for booking their own supervision but acknowledged that despite this, there needed to be a better management oversight of all staff’s supervision needs.

Staff told us they had received an appraisal of their performance and felt supported by the registered manager. One staff member said “I get supervision and have had an appraisal which I didn’t use to get. There have been a lot of improvements since the new manager arrived.” However records we looked at showed that not all members of staff had received an annual appraisal. The registered manager told us that they were currently working through people’s annual appraisals and we saw evidence of this from the provider’s supervision matrix.

People using the service were able to see health care professionals when they needed. One person said “When I want to see a doctor, I just ask and you can. If you are ill, they [staff] send for one straight away.” Another person told

us “Today I have had the St Christopher Nurse visit me, it’s the doctor soon. The staff seem to know how to look after me.” Visiting relatives told us their loved one’s had access to health care professionals when required. One relative said “My loved one was given six months of life. I asked for the Hospice Team to visit just in case anything had been missed. They said that nothing had and the nurses here were just fantastic!” Another relative told us “They’ve [staff] done a really good job with my mother’s legs. They have sorted them out here with the doctor’s help, they were so swollen and now they’re not.”

GP and healthcare professional’s appointments and visits were recorded within people’s care plans to ensure people received the appropriate care and treatment when required. Care plans we looked at reflected advice and guidance issued by healthcare professionals. For example we saw one person’s care plan reflected advice given by a specialist respiratory nurse and specialist nurse in palliative care. We spoke with the visiting general practitioner who confirmed they worked collaboratively with the staff at the home in order to provide safe and effective care. The GP attended to people on a regular basis, visiting twice every week. On the second day of our inspection the GP, clinical lead and specialist nurse in palliative care met to discuss the changing care needs of people who used the service. We spoke with the specialist nurse in palliative care who confirmed they worked alongside staff at the home on a regular basis in order to help provide safe, effective end of life care.

Is the service caring?

Our findings

At our last inspection in March 2015 we found people were not always enabled to make or participate in making decisions and choices relating to their care and treatment and there were no effective systems in place to assess and record people's end of life care needs and wishes.

At this inspection people told us they were encouraged to make decisions and choices relating to their care and staff were kind and supportive. One person said "Staff are very nice, very helpful. They help me to put my makeup on and do my nails just how I like them." Another person told us "The staff are very good and they look in at me during the night just to make sure I'm ok which I like." A third person said "All the staff are lovely here. Wonderful. There's not one you dread seeing." A fourth person told us "Staff are very helpful and kind and support me with things I'm not able to do but want to do." Relatives spoke positively about the care provided and the staff. One relative said, "I cannot speak highly enough of the care here. She settled in really quickly, they are all so compassionate and lovely." Another relative commented "All the care he receives is very good. I cannot speak highly enough of the carers themselves." A third relative told us "The care is good. They [staff] all interact with her and with us as well."

Care plans and records we looked at demonstrated that people were involved in making decisions about their care and lifestyle choices. For example one care plan contained photographs of the person and documented involvement from their relatives with their agreement in regard to their care and treatment and personal choices made. Another care plan recorded the person's choice of sleeping patterns and how staff should support them during the night. Care plans were signed and dated by individuals or their representatives where appropriate to show their involvement and agreement with their plan of care. People's spiritual needs were assessed and recorded within their care plans. One person told us "There's a service for those who wish to attend which I quite enjoy." We saw that services held in the home were displayed on the activities sheets in communal areas for everyone to see and attend if they chose.

Care plans also contained assessments of people's end of life care needs and wishes ensuring these were respected. We saw 'coordinate my care' documents within care plans which are sent to 'out of hour's services' providing doctors

and health care professionals with information about people's last days of life wishes. We spoke with a visiting palliative care nurse who told us "The home has completed and faxed 'coordinate my care documents' for those people at the end of their life. We have also seen a 'supportive care register' in place on two floors of the home which assesses and codes the end of life care needs of each person using the service. This is very helpful. The new clinical lead nurse has a good understanding of end of life care and is up to speed with setting things in place. The manager has started sending staff on end of life care training. Things have improved recently however there is still more work to do. They have come a long way from where they were last year."

Throughout the course of our inspection we observed staff treating people in a respectful and dignified manner. The atmosphere in communal areas throughout the home was calm and friendly and we saw staff took their time and gave people encouragement whilst supporting them. Staff respected people's choice for privacy as some people preferred to remain in their own rooms. One person told us "I am quite happy not doing a lot, my family visit and staff come in regularly and have a chat with me." We saw staff sitting with people engaged in meaningful conversations while others were participating in organised group activities. We noted that one main lounge was playing quiet classical music which provided a relaxing background for people to enjoy but also enabled them to converse with one another.

Staff were knowledgeable about people's needs and preferences and how to maintain people's privacy and dignity. Where people needed support with personal care staff ensured their privacy by drawing curtains and shutting doors. One person told us "Staff always close doors if they are helping me. They never just do something, they always ask first." Staff told us they tried to maintain people's independence as much as possible by supporting them to manage as many aspects of their care that they could. One staff member told us "There is good information in people's care files so we know what their needs are and what we need to do to care for them." Another member of staff said, "I constantly explain what I am about to do and ask permission first. I always encourage people to do as much as possible for themselves, no matter how small." Staff addressed people by their preferred names, explained what they were doing and sought permission to carry out personal care tasks. They told us they offered people

Is the service caring?

choices, for example, with the clothes they wanted to wear or the food they wanted to eat. One member of staff said, "We always provide same sex personal care. That's important. I put a towel over people when I am giving them personal care. I always explain what I am doing for them; I think this is very reassuring for them." Another member of staff said, "I like to tell people what I am doing for them. I call them by their preferred name. I take my time when I help people. It's never good to rush things."

People were supported to maintain relationships with their relatives and friends and visitors were seen coming and going throughout the course of our inspection with no restrictions placed upon them. One relative said, "Everybody knows me already. Staff are always happy to see you." Another relative commented "We can come and go as we please." A third relative told us "One of us is here all the time. They [staff] come to see us whenever we come in, which is nice."

Is the service responsive?

Our findings

At our last inspection in March 2015 we found people's care was not always assessed and reviewed in response to people's needs, guidance on how to meet people's needs was not always recorded or followed and people's preferences were not always documented.

At this inspection people told us they received care and support that was responsive to their needs. One person said "I like to have breakfast in bed and staff do this for me." Another person told us "I like to have a shower every day. They [staff] come to help me." A third person said "I hate to stay in bed, so I get up early." Relatives also commented positively about the responsiveness of staff and care received. One relative said "They [staff] don't mind that she gets up very early, she likes to and she can. They were concerned at first but once I said that it was normal for her, they were fine and they have her with them in the office." Another relative told us "Towards the end, she did not want to go to bed at all, so they kept her with them at all times of the day. It gave me a sense of security, knowing this. She did not want her light out and that was fine."

People were assessed to receive care and treatment that met their needs and care plans were reviewed on a regular basis to ensure this. People's care plans showed that before they moved into the home their needs were assessed through a pre-assessment and admissions process. This ensured that people's individual needs could be met by the home. People were allocated a keyworker to coordinate their care and ensure their preferences were respected and met. One member of staff told us "We try to match a care worker to a resident. If they have mutual interests then this helps a good relationship to develop." They told us how the keyworker had oversight of a person's room; including maintaining their clothes and ensuring they had adequate toiletries. They linked with family members and communicated with them on a regular basis.

Care plans we looked at were organised and easy to read and care plans and records stored on the home's computer system were easy to access. Care needs assessments included assessments for example on moving and handling, mobility, nutrition, communication, sleeping, night care, activities, medicines, continence and end of life care. Care plans were developed using the assessment information and the expressed preferences by individuals and their relatives where appropriate. Care plans included

detailed information which described people's daily living activities, their communication methods, mobility needs and support they required with, for example, eating and drinking and personal and nursing care. We noted that care plans were reviewed each month in line with the provider's policy. People told us they were involved in their care plan reviews and relatives we spoke with also confirmed their involvement where appropriate. One relative told us "I requested to see the care plan quarterly rather than monthly as we are confident about the care and that any changes would be relayed to us." Another relative said "I see the care plan every month and everything is all recorded."

Care plans documented clear guidance for staff on how people's physical and mental health needs should be met. We saw care plans contained where appropriate guidance and recommendations for health and social care professionals, notes from meetings held with health care professionals, mental capacity assessments, records of best interest's decisions and Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms. A member of staff told us the home had a 'resident of the day' scheme which ensured people's care plans were monitored and reviewed on a regular basis. Daily notes documented within care plans recorded the care and support delivered to people throughout the course of a day.

Care plans documented people's preferences and contained information entitled 'All about me' which was completed by the person and their relatives. Information such as how people would like to be addressed, their likes and dislikes, details about their personal history, their hobbies, pastimes and interests and their religious, cultural and social needs was considered when planning people's care. Care plans described the support people required from staff, for example, with their communication methods, mobility needs and support required for social interactions.

The home provided a range of activities that met people's needs and reflected their interests. Activities were provided seven days a week and there were three activities staff employed. We spoke with one of the activity staff who told us they had completed an activities course which enabled them to plan activities that met people's needs. They told us how they incorporate five main areas into the activities programme which includes physical, emotional, social, cognitive and spiritual needs. Activities were planned around these areas and in line with people's abilities and

Is the service responsive?

preferences. Activities offered included therapy sessions, religious services, cinema, quizzes, games and links with the local community and schools. The home has access to a mini bus which was used to take people out on day trips. Recent trips had included a trip to a local shopping mall and a visit to a local historical site. One activity staff member told us that they had requested more activity equipment for people with dementia which included rummage boxes and tactile objects to stimulate memories. We observed there were fiddle boards in some communal areas which allowed people to touch and stimulate the senses. We visited the outside garden which was pleasant and allowed for people to walk safely and in view of staff. We were told that there were plans to develop more raised flower beds which would allow for residents to attend to, although we noted indoor potting of plants was an activity some people already enjoyed.

On the first day of our inspection we saw one person running a mobile shop in the reception area. They told us “I do this weekly and really enjoy doing it. I don’t do any of the setting up or heavy work I only sell snacks and treats to whoever wants them.” On the second day of our inspection a charity coffee morning was held in the café area and was well attended by people and relatives. People their relatives and staff told us they had made cakes to sell to raise money for the cause.

People and their relatives told us they were aware of how to raise a concern and felt confident their concerns would be listened to. One person said “I would go to the office if I had any concerns.” Another person told us “I’d just tell any staff member. They would always help.” A relative told us “The ward staff are very good, they are efficient.” Another relative said “Most staff are very approachable and the manager is also usually around.”

People’s concerns were responded to and addressed in a timely manner. The registered manager showed us the complaints file which included a copy of the provider’s complaints policy and procedure. We tracked four recent complaints and found these had been appropriately investigated. The registered manager responded by e-mail to all four complainants within a matter of days. Two of the complaints were resolved within one week and where the other two were more complicated in nature, we saw there were clear and concise progress updates communicated to the complainants on a regular basis. The home had a complaints policy which provided people with details on expected timeframes for responses and listed people and organisations to contact if people were unhappy with the response to their complaint. In addition there was information displayed in the entrance hall on how to make a complaint.

Is the service well-led?

Our findings

At our last inspection in March 2015 we found there was instability in the management and leadership at the home and a new manager had been appointed and was registering with the CQC. We also found that the provider did not have effective systems in place to assess and monitor the quality of service and there was a failing to ensure accurate and appropriate records were kept and maintained in relation to the care and treatment people received.

At this inspection we found the home had made improvements and was well led, however we were unable to assess the full effectiveness of some of the systems and processes that had been implemented to address the areas of concern as these had not been applied consistently over time. For example staff and residents meetings were not frequently held and action plans that were implemented to address areas of concern from meetings held were not implemented or completed. Internal audits that were conducted highlighted areas of concern and action plans were developed, however we found highlighted actions had not been implemented or completed as required.

At this inspection people and their relatives told us the registered manager had made many improvements to the home since our last inspection and they thought the home was well led. One person said, "We have met the manager and she is always available for us." A relative told us "It is a well-run home and the manager is approachable. She has to set the rules and she is good at her job. She has a presence." Another relative told us "The way it is all run is very slick, nothing is overlooked, everything is photographed and logged. That is down to the management. It is good to see the staff moving around, good for their own ideas and skills." A third relative described the manager as "Very active and out on the floor, which is good."

Staff within the home were also positive about the changes made and the support provided by the registered manager. One staff member told us "Having the same manager for a period of time has made such a difference. I feel we are heading in the right direction and are working together as a team to achieve this. The place feels much calmer and safer now. I hope she stays." Another member of staff said "Over the last 6 months there has been better leadership. The manager is very proactive and hands on. She regularly

walks around to check on residents and staff to make sure everything is running smoothly. We are giving residents more choices now and we are making sure they have a good quality of life." A third member of staff told us "I really enjoy working here. I feel really good doing this job. I get good training, which has enhanced my skills and given me confidence on how to work with people. Things have really improved in the last 6 months. We have a steady manager, we get supervision and training and we work together as a team."

The registered manager told us how their values and rationale was 'to work as a team and assist wherever I am needed'. This was confirmed by staff we spoke with who were able to give us examples of where the manager had worked alongside staff to assist in the day to day running of the home. One staff member also told us that "Communication is better since the manager came; there is more transparency and team work." The registered manager had identified several areas where improvements were needed and had worked to address these since our last inspection. For example the recruitment of staff and volunteers. Staff told us that staff meetings took place on a regular basis and records confirmed this. Meetings were held for the various disciplines in the home for example for care staff, registered nurse as well as a combined staff meeting including domestic staff. Minutes of meeting held showed that topics related to their working practice and conduct for example annual leave, the organisation, handover formats, care plans and training needs. In addition there was a clinical meeting held monthly where issues such as wound care, medicines and cream applications were discussed. We also saw that the activities staff held meetings to discuss issues such as the development of a resident's newsletter, recruitment of volunteers and increase in activities and outings.

There were systems in place to monitor the quality of the service provided and we saw recent internal and external quality assurance audits were conducted for all areas of care and services provided. For example medicines management, records, infection prevention and control, fire risk assessments, accident and incidents, nutrition, tissue viability and staff supervision and support. We saw there was a clear line of responsibility in undertaking regular checks and audits on the quality of the service. For example the monitoring and auditing of the home was conducted by the registered manager on a monthly basis and the regional director undertook monitoring visit which

Is the service well-led?

were conducted on a two weekly basis. The clinical lead monitored medicines and the nursing staff, registered nurses and senior care staff monitored people's care plans and records and the provider produced regular reports on the home's general performance against CQC's five domains.

We spoke with the assistant director of governance who showed us the home's computer 'Quick View' data base. This was a dashboard for the organisation and highlighted any concerns that had been raised about the home's performance. We saw evidence and statistics that indicated 0.8% use of agency staff which was a vast improvement since our last inspection, care records and reviews were calculated at 91% completed and accidents and incidents trends were being monitored by the regional director and discussed at monthly visits with the registered manager and clinical lead. We saw recent governance officer's reports which were mock inspections completed by governance officers. They covered the CQC's domains of safe, effective, caring, responsive and well led. These included an action plan which was incorporated into the home's 'service improvement plan' and was monitored on a monthly basis by the regional director. We also saw that the home's computer system which the registered manager had access to monitored falls, pressure sores, infections, safeguarding, care reviews, assessments, agency use and complaints received. This ensured that where issues or concerns were present the registered manager would be alerted and able to take appropriate action.

Accurate and contemporaneous records were kept and maintained both on the home's computer system and in people's paper files in relation to the care and treatment people received. The provider used a computer based records system and a paper file system to ensure records were accessed by staff should the computer system fail. We saw that paper files and records on the computer system were accurately maintained, updated and reviewed in line with the provider's policy to ensure people received the appropriate care and support to meet their needs.

There were systems in place to ensure people, their relatives and staff were provided with opportunities to provide feedback about the service. We looked at the findings of a recent staff survey that had been conducted in 2015 and had a 58% response rate. Response statistics were generally positive with the exception of staff satisfaction with benefits received. Other results showed that 85% of respondents felt customers were cared for well and 78% of staff would go the extra mile for residents. We also looked at the results for the relative's survey that was conducted in June 2015 and which included a telephone questionnaire and a paper form being sent out of which 19 people responded. The overall findings were positive in relation to staff and the care people received and responses to call bells indicated they were answered promptly. Areas for improvement included for example an increase in activities on offer and dining menu's needed to be on display so people could see what was on offer. We saw that where issues had been highlighted these had been addressed for example menus were displayed within dining rooms and a review of the home's activities had been undertaken.

We saw there were several means for people to provide feedback about the service including a comments and suggestions box which was located in the entrance hall. We looked at the compliments and comments folder from the most recent compliments recorded. Comments included "My relative was always treated with courtesy and great dignity." "The staff demonstrated great patience, care and compassion," and "Facing my relative's dementia wasn't easy, however due to your support we are taking away many positives."

People and their relatives told us that residents and relatives meetings were held on a regular basis and we saw notices displayed throughout the home for forthcoming meetings and events. These included an open forum discussion with the provider's dementia specialist where relatives could attend and raise any issues, make suggestions or ask questions.