The Holmes Care Limited

Cranham Court Nursing Home

Inspection report

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Upminster
Essex
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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place took place on 24 and 25 October 2017.

Cranham Court Nursing Home is a care home located in Upminster, Essex. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Cranham Court Nursing Home is registered to provide nursing care to older people, some of whom have dementia or palliative care needs. The service accommodates 68 people across two separate units, each of which have separate adapted facilities. The Main and Extension unit is a nursing and residential facility and the Woodlands unit, specialises in providing care to people living with dementia.

On the day of our inspection, 61 people were using the service in total.

The service had 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.

Each unit was managed by a registered nurse. They were supported by the the registered manager, who was also known as Matron.

At our last comprehensive inspection on 1 November 2016, we found the provider did not meet legal requirements to ensure the service was safe or well led. This was because care and treatment was not provided to people in a safe way and the provider did not always operate effective systems to monitor risks to people's health, welfare and safety.

The provider wrote to us to let us know what action they were taking to meet these requirements.

We visited the service again on 4 May 2017 to look at the progress of their action plan and found there were still some improvements required as there was a continuing breach of health and social care regulations. We wrote to the provider and sent them a Warning Notice to be compliant by 4 August 2017.

At this inspection, we found that the service was compliant and was now meeting legal requirements.

We saw that improvements had been made and the service was now safe. People told us they felt safe living at Cranham Court Nursing Home.

Medicines were managed safely and administered by staff who were trained to do so.

The premises were safe, clean and regularly maintained. There were enough staff on duty. However, the provider was currently relying on agency staff to fill in for staff on leave, vacancies or any sickness absences. The provider was in the process of trying to recruit more permanent staff. The provider had safe recruitment procedures in place and carried out checks on new employees.

Risks to people were identified to ensure they remained safe. It was not always clear how the risks were managed and we have recommended that these are more clearly set out.

Staff had received training on safeguarding adults and were able to describe the actions they would take if they had any concerns about possible abuse. The provider also had a whistleblowing policy, which staff were aware of and they knew how to report any concerns they had.

Staff were supported with regular training, meetings and supervision. Staff work performance was reviewed on a yearly basis and they were encouraged to develop their skills.

The provider had systems in place to support people who lacked capacity to make decisions for themselves. Staff received training in the Mental Capacity Act 2005 and were knowledgeable about the processes involved in assessing people's capacity.

Staff ensured people had access to appropriate healthcare, when needed and people's nutritional needs were met.

Staff were aware of people's preferences, likes and dislikes. People were treated with dignity and their choices were respected, although we found that some people's personal health information was displayed inappropriately. We have made a recommendation about this.

People were involved in the planning of their care and received care and support to ensure their individual needs were met. Some people's care plans were incomplete with regards to their personal histories, thoughts and preferences. We have recommended that efforts are made by the provider to ensure they are completed more thoroughly to ensure they remain person centred.

People were encouraged to participate in activities and remain as independent as possible. However, the activities programme was not always sufficient and no activities took place during our two day inspection. We have made a recommendation about reviewing the structure of activities to ensure a more stimulating environment.

People and their relatives were able to make complaints and the registered manager investigated these.

Staff felt supported by the management team. Their responsibilities and requirements when providing care were discussed in staff meetings.

The registered manager had systems in place to monitor the quality of the service provided to people and made further improvements when required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the steps to take to report any concerns about abuse.

Risks were assessed to keep people safe. However, we have made a recommendation about risk management guidance.

Medicines were managed safely and staff who were trained, administered them to people on time.

The provider had a safe recruitment procedure. There were enough staff to meet people's needs.

Is the service effective?

Good

The service was effective. Staff had good knowledge and understanding of the Mental Capacity Act (2005).

People were supported to eat a balanced diet and their nutritional needs were met.

Healthcare professionals treated people when required and people's health was monitored.

Staff were supported with training and received supervision and appraisals to monitor their performance.

Is the service caring?

Good

The service was caring. Staff knew people well and provided care with dignity and kindness.

People were able to express their views about how they wished to be cared for.

People were treated with respect and were supported to be as independent as possible.

Staff supported people with end of life care sensitively and respectfully.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans contained information about their preferences, personal history and interests but not all care plans were up to date, to ensure they were person centred.

People were encouraged to participate in activities of their choice but some people did not feel there were enough activities. We have made a recommendation about the activities programme.

People and relatives' complaints and concerns were investigated by the registered manager and they were notified of the outcomes.

Is the service well-led?

Good

The service was well led.

People and relatives were encouraged to provide their feedback about the service.

Quality assurance audits took place regularly to ensure the service was safe and people's needs were being met.

The registered manager was committed to making improvements to the service.

Cranham Court Nursing Home

Detailed findings

Background to this inspection

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

This unannounced comprehensive inspection took place on 24 and 25 October 2017 and was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed all the information we held on the service, such as previous inspection reports and notifications. A notification is information about events that by law, the registered persons should tell us about, such as safeguarding alerts and serious incidents. We also obtained feedback from the local authority and the local Healthwatch, for their views on the service.

During our inspection, we spoke with six people and with six relatives. We made observations of care being provided. We spoke with two nursing staff, two care staff, the registered manager, the training administrator, three care staff and an activity coordinator.

We looked at 12 care plans and other records relating to people's care, such as fluid charts and medicine administration records. We also looked at six staff files, accident and incident records, training records, quality assurance audits, health and safety procedures and other records kept in the service.

Good

Is the service safe?

Our findings

Most people and relatives told us they felt safe living in the service. One person said, "Yes, I am looked after. It's nice." Another person told us, "Oh yes it is safe." Other comments from people included, "Nice beds, I sleep well. It's a nice place here" and "I can't fault anything. It's fine."

At our focussed inspection in May 2017, we found that improvements had been made to ensure peoples' medicines were managed safely on all units. This was following our last comprehensive inspection in November 2016, when we identified that a number of people had not been administered their medicines for two days. However, at our focussed inspection, we still had concerns that people did not always receive their medicines in a timely manner. We made further recommendations about this and for staff to be provided with additional training in administering certain treatments such as eye drops, creams and ointments.

At this inspection, we noted that these issues had been addressed. Only nursing staff were permitted to handle medicines and one staff member told us, "As the nurse, we check all the MAR (medicine administration records) charts and administer people's medicines and if they are not sure what it is, we spend time with them and explain what the medication is for." Staff had received training before they were able to administer medicines to make sure they knew the procedures to follow to keep people safe. This meant medicines were managed safely by staff who were trained and competent. Additional training had been provided to all staff who were required to apply topical treatments such as creams, gels and eye drops.

We looked at medicine records and found people had received their medicines on time and as prescribed. All people had MAR charts, which contained the medicines they were prescribed and the time they needed to have them. If people needed to have their medicines covertly with food, we saw that the appropriate procedures were followed and the person's doctor had authorised staff to be able to do this. Covert medicines are usually crushed into people's food or drink without the person knowing. If a person refused to take their medicine, staff recorded this and notified the person's doctor to review the medicines they were required to take. One person said, "My medication is regular as clockwork. If anything is changed, staff always explain why to me."

Medicines were stored securely in a locked room and appropriate measures were in place to make sure medicines were kept at the manufacturer's recommended temperatures. Any controlled drugs were stored safely and checked to prevent any misuse. For people that were prescribed medicines on an "as required" basis (PRN), there was guidance in place for staff to follow, on when to administer such medicines. This helped to ensure staff administered medicines to people safely. Nursing staff carried out checks to see if people had received their medicines as prescribed and to identify any gaps in the MAR records. This helped the management team to monitor that all medicines had been administered safely. There were records for when medicines had been received from the pharmacy and when they were returned for disposal.

Risks to people's health were assessed, although the guidance in place on how to manage these, was not always clearly set out. People's care plans contained specific sections on their health care needs that

included any risks and included a dependency score to indicate the level of risk to the person. There was a risk checklist against each health care need such as with the person's mobility, personal hygiene, nutrition or any skin conditions. Staff were required to tick the risk if they were relevant or state whether there were 'other' risks that were not specified. However, for some people, these risks were not selected at all and neither was the option to state 'other'. If there was no risk to the person, it was not stated on the form to clarify why none of the boxes were ticked. For example, one person had occasional incontinence. Staff had written that the person required a catheter and staff were to assist them to the toilet. However, the checklist was not ticked to state what the possible risk or impact of their incontinence was, such as whether it could lead to an infection. The option to tick 'other' was not used either and there was no written information to state if there were no risks. Another person needed support with their personal care and sometimes needed one staff and other times needed two staff to support them with their mobility. It was not clear in what situations the person would require one staff or two staff.

This showed that risk assessments were not always thorough about what the risks were and what strategies were used to minimise these risks. We saw that information on what actions staff were required to take to support the person and manage the risk was hand written in an assessment and evaluation section, below the risk assessment. These were checked regularly and signed by staff. The registered manager said, "The risk management guidelines for staff are the actions that we take and write down. It is written out by staff as they support the person."

Risks to people were highlighted and a dependency score was calculated. We were satisfied that risks to people were identified and strategies were in place. However, they needed to be more clearly set out because it was not immediately apparent what the checklist was used for and that the hand written information showed how the risks were managed and reduced. This information would be necessary for new staff or agency staff who may not know the person well.

We recommend that the provider seeks best practice guidance on reviewing people's risk assessments and setting out the actions required to minimise and manage risks.

The provider had an effective recruitment and selection process in place. We looked at six staff files, which detailed their employment history, qualifications and previous experience. A number of checks were undertaken before staff started working at the service. This included obtaining references, checking if they had any criminal records and seeing proof of their identification and immigration status, to check if they were legally allowed to work in the United Kingdom.

There were enough staff to ensure people received the care and support they needed. Each unit was managed by a registered nurse. There was a nurse's station or office in each unit and we saw that staff were available. People and relatives had mixed views about the staffing levels. One person said, "Yes plenty of staff. Too many." Another person told us, "Staff say, 'I'll be with you in a minute' but it feels like hours. Some of them are over worked and say, 'I'm doing something'. It's OK today." Another person said, "Yes but sometimes not enough." The registered manager told us they were recruiting staff for permanent positions. When the service was short of staff, processes were in place for cover staff to be called. This included agency care staff and nursing staff.

On the two days of our inspection, both unit managers, who were registered nurses, were on leave and agency staff were in place to provide care to people. Another senior member of staff was also on leave on the first day. We saw there were care staff and nursing staff on duty to respond to the needs of people living in the units. We viewed staffing rotas and saw staff were available on each shift and showed if additional staff were required on particular days in the forthcoming weeks. Staff told us they did not have concerns

about a lack of staff cover. Staff who worked for the provider on a permanent basis knew people well and covered sickness or leave to ensure people's needs were met. The registered manager explained that they made sure agency staff had worked at the service previously and were familiar with people and other staff. However, they told us the recruitment of permanent staff was an issue due to the location and accessibility of the service. There was a reliance on agency staff because of this, which meant that a more stable group of staff was still to be put in place and was in progress.

The provider had policies and procedures in place for staff to refer to, if they had any concerns about people's safety. Staff recognised and responded to any allegations of abuse and this helped to ensure people were safe. They were aware of different types of abuse people may experience and the actions they would take to protect people from harm. They had an understanding of their responsibilities and said they would report abuse if they were concerned about a person. They were also aware of the whistle blowing procedures. A whistleblower is an employee who raises concerns about the practice of an organisation, to external organisations, such as the local authority or the CQC. All staff had received safeguarding training, which was refreshed annually. New staff received the training as part of their induction. One member of staff said they would report concerns to their managers and they felt confident they would be listened to and action would be taken to keep people safe.

Staff were aware of people's preferences and mobility support needs. We observed staff assisting people appropriately, such as when transferring them using equipment or helping them remain comfortable in their beds.

The premises were mostly clean to prevent any risks of infection spreading. Staff received training in infection control. They followed infection control procedures and used Personal Protective Equipment (PPE) such as anti-bacterial gels, gloves and aprons when carrying out their work. The premises were regularly maintained. Records were available to ensure water, refrigerator and freezer temperatures were kept at suitably safe settings. Equipment, such as hoists and wheelchairs were maintained and serviced as per the manufacturer's recommendations. We saw checks were carried out on fire safety equipment on a regular basis to make sure they were within recommended usage levels. People had individual evacuation plans for staff to follow in the event of a fire. Gas and electrical systems were serviced annually or when they were due.

The premises had an outdoor area which meant there was space for people to sit outside in suitable weather. One person told us, "The gardens are beautiful. I sit out there nearly all day every day."

We saw that some areas of the premises required some minor maintenance and the registered manager took steps to ask the maintenance team to look into it. The registered manager said, "We have a new handyman team who are always here to check and fix anything when needed." However, we noticed a bathroom was being refurbished in the main unit but the door to it was left unlocked. A lock was later fitted and a sign put up to show that the room was not in current use. One person told us the light had gone out in their bathroom. We saw that this was logged and a new light bulb was fitted the following day. Another person said, "The odd job man comes round if you call him."

Good

Is the service effective?

Our findings

People told us staff understood their needs and they performed their jobs well. One person told us "They are marvellous and treat me well. Everybody is very, very good to me." Other comments about the staff and the service included, "The staff are busy and don't come to bother you" and "The food is lovely."

Staff were knowledgeable about people's different needs and had received the relevant training to help them meet these needs. Staff told us they were able to access the training they needed for their roles. They undertook regular refresher training sessions to keep themselves updated with the latest guidance and practice. We viewed a training schedule and saw staff had completed a number of training courses in areas such as dementia awareness, safeguarding adults, challenging behaviour, infection control, medicine management, end of life care and catheter care. Some staff had achieved diplomas in Health and Social Care to become qualified in certain skills. Skills for Care standards were tailored into the training. Skills for Care are nationally recognised learning standards and assessments for health and workers. This meant that staff were provided with relevant and up to date training.

Staff told us the training was helpful and provided them with the necessary skills and knowledge they needed to carry out their role. One member of staff said, "The training is very good and helpful." New staff received an induction when they started working in the service. One staff member told us, "Yes I had an induction when I started. It was for two weeks. I have had practical training and online training."

Staff felt supported by the registered manager and other members of the management team. Staff received regular supervision and we saw records of supervision meetings between staff and their line managers. They discussed topics such as any concerns they had, their work performance and training needs. This meant people were supported by staff who had received guidance and support to carry out their roles effectively.

The provider had policies and procedures in relation to the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

The registered manager and the deputy manager demonstrated a good understanding of the MCA and DoLS. We saw they had made applications for people, where there were indications they may be deprived of their liberty for their own safety. This meant people were not being restricted without the required authorisation. We found staff had received training and were knowledgeable of the MCA (2005) and DoLS. They respected people's ability to make their own decisions. Staff knew what action to take when this was not the case, such as involving relatives or other health professionals to make a decision in their 'best

interest,' as required by the legislation. We saw records of capacity assessments and when decisions were taken in people's best interest. People were involved as far as they were able to, in decisions about their care and support needs. Staff always made sure they sought people's consent before providing care and support.

People's weight was monitored and any risk of malnutrition or dehydration was assessed to make sure they maintained their health. People's food and fluid intake was recorded to show how much people ate and drank, so their nutrition and hydration could be monitored. We noted that staff were able to state the appropriate dosages of food and fluid provided to people following procedures that were set out by the management team. Some people required PEG (percutaneous endoscopic gastrostomy) feeding, for which a tube is passed into their stomach when they required to intake food and fluids. Records showed they were supported to maintain their nutrition and hydration. If staff had any concerns about a person who was at risk of malnutrition, they sought advice from relevant health professionals, such as dieticians.

The staff supported people to have sufficient amounts to eat and drink in order to maintain a balanced diet. People were able to choose what they wanted from the menu and there was a four-weekly menu in place for them. If people did not want what was on the menu, they were able to request a different meal.

A copy of the menu for the day was displayed in the front entrance of the building, in the dining rooms on each unit and near the rear exits. We noted that the displays were not always consistent and showed menus for different weeks. For example, there was one display for Week Two and another in a different location for Week Three. One person was provided with lunch and told us they were expecting a different meal based on what they viewed on one of the menu boards that were on display. We addressed this with the registered manager who told us the menus were supposed to be representative of Week Three and that large whiteboards within the service had also displayed the lunchtime meal. The registered manager assured us they would make sure all menu notices were correct when put on display, in order to avoid any confusion about what people expected to have for their main meal.

We observed a lunchtime service on both days of our inspection. The main dining room had round tables with chairs around each and we saw people sitting at them whilst being served. People that required wheelchairs were provided with enough room to sit at the table. There was music playing in the background, which helped to provide a comfortable atmosphere. Staff were observed being friendly, patient and attentive. They assisted people with their food if necessary and asked if they wanted more food. One person told us, "The food here is lovely. They've got a super cook and the food's gorgeous. It's delicious, and you always have a choice, and if you don't want either of them they cook you something else."

Records showed people were supported to maintain good health. Their health care needs were checked daily and referrals were made to healthcare professionals, if people became unwell or had sustained any injuries through falls or pressure sores. One person said, "I see a chiropodist. They come to see me." Staff had a good knowledge of people's health conditions and communicated with health professionals. Outcomes of appointments or treatments and any advice given was recorded. The registered manager said that all people were registered with the GP, whose surgery had a long standing arrangement with the service. This helped maintain a relationship between the staff, people and the GP, who knew each other well. We spoke with the GP who visited the service weekly and checked on the health of people living there. They told us, "The staff are very helpful. When I do a weekly ward round the nurse comes with me and provides an update. There is always constant communication between us."

Good

Is the service caring?

Our findings

People and relatives told us staff treated them with dignity and respect and that they were caring. One person said, "The carers are nice. They clean me up and help me OK." Another person said, "Yes, they are most certainly caring."

Relatives were mostly satisfied with the level of care received by their family members. One relative said, "I have no worries about [family member] here. They are very friendly, approachable and obliging." Another relative told us, "Yes, as far as I can see, it's good." Some relatives were not entirely happy with the approach of staff and one said, "A couple of the carers are a bit abrupt with my [family member] like when [family member] needs to go to the toilet. I'm not happy with them." Another said, "For some carers here, English is not their first language, which leads to some misunderstandings."

We observed caring interaction between people and staff and one member of staff told us, "We try to make people as comfortable as possible. I communicate properly with people and look at their body language to try to understand their needs. We don't argue with people and have to show them respect." We saw that people were appropriately dressed during the day and they were free to spend time in their rooms, outside or in the communal areas. People's relatives visited them and we noted a relaxed atmosphere throughout the service. Staff were friendly and knew people well, including their likes, dislikes, preferences and care needs. One person said, "I'm made to feel like royalty. The carers are a good group and they all know about my hat that I have to wear. They remind me."

Staff knocked on people's doors before entering their rooms and spoke to them politely, addressing them by their first names. They ensured people's privacy was protected when providing personal care. Staff treated people as individuals, respected their human rights and ability to make decisions for themselves. They understood how to treat people equally regardless of their race, religion or gender. They were respectful of people's cultures, beliefs and backgrounds. However, we noted that people's dietary needs were displayed in dining rooms for kitchen staff to understand people's food preferences and whether they had conditions such as diabetes or any allergies. While these details were important, it was available for all people and visitors to see other people's personal information.

We recommend that people's personal health care needs are respected and not displayed in communal areas.

Staff were patient and considerate when supporting people, such as when assisting them to eat their meals. One staff member responded to a specific request for fruit and told the person they would try to find some. They returned with the item and we noted this was positive interaction between staff and people. After the lunchtime service, staff chatted to people as they pushed them in their wheelchairs out of the dining room. One person told us, "I'm well happy and well treated."

People and their relatives felt comfortable around staff and knew who the senior staff were. A relative of a person staying in the service told us, "[Family member] has a wash everyday and their nightie is changed

everyday. The sheets are always clean."

People and staff engaged in positive, kind, caring and respectful interaction. Staff were attentive and did not wait too long before checking to see what help a person required. People could call for assistance by pressing a call bell attached to their beds. One person told us, "They come when I call, or within a minute. You have the odd day when you buzz and have to wait to get something – 30 minutes." We saw that care and nursing staff attended to people promptly after they called for assistance.

People's care files contained individual care plans. They were supported to remain independent as much as possible or according to their health needs. People and relatives told us they were involved in developing and reviewing the care plans and we saw they were completed with their help. The plans outlined people's choices, preferences and needs. They were reviewed and updated monthly or when people's needs changed. People and their relatives were involved in discussions about the care they received. A relative said, "If we have concerns we have a meeting. We've had quite a lot of them."

People's wishes for end of life care were respected. These were expressed in their care plans and staff ensured people were comfortable and any pain was managed sensitively and carefully. When required, advice and support was provided to people, relatives and staff on pain management for those on end of life care. Some people had DNAR (Do Not Attempt to Resuscitate) forms where applicable, which meant that they confirmed they did not wish to be resuscitated should they fall into cardiopulmonary arrest. Support was received from health professionals and St Francis Hospice, who provided advice to staff on managing people's end of life care sensitively and in accordance with their wishes. The provider followed end of life care guidance from the NHS and they were looking to implement the Gold Standards Framework which provides accredited training in end of life care for frontline staff.

Requires Improvement

Is the service responsive?

Our findings

Most people and relatives told us the service was responsive to their needs. People received care from staff that were aware of their individual care and support requirements. Comments from people included, "Everybody is very, very good to me" and "At any time you can say what you think. Several times staff pop their heads round and ask me if I'm happy." Another comment was, "My family are happy with it here."

We found that there was a lack of stimulation within the service for people to take part in regular activities. People and relatives had mixed views about the activity programme. A relative told us, "Because [family member] is blind they don't do a lot with [family member]. I don't know what they could do but they get bored." Another person said, "I've been here too long. There's nothing to do, especially today. Bored." During our two day inspection, we did not observe any group activities take place despite notices and posters on display boards. An activity poster stated that "all activities are tailored to the individual" and included activities such as bingo, painting, quizzes, crafts, modelling, baking and ball games. However, there was no structure evident to show what days these activities would take place.

The provider employed two activity coordinators and we spoke with one of them who told us, "We have one to one and group activities. I visit everyone individually and find out if they are interested in anything or what sort activities they want to do. We don't have a timetable because we find people don't stick to it." Although two coordinators worked in the service at various times during the week, no activities took place in either unit on any of the two days we inspected. The second activity coordinator was unavailable on both days and the first coordinator told us they were assisting a person to an appointment in the afternoon. This meant people were left with nothing to stimulate or engage them for two consecutive days. There were notices for staff to guide them on creating "an empowering dementia environment" and included instructions to "develop purposeful activities as negative behaviour is a result of boredom." However, some comments from people did not reflect a purposeful environment. One person said, "It's an old place with nothing going on at all." Another person told us, "As far as I'm aware activities are virtually non-existent. I can still knit and sew and do puzzles. Staff bring me puzzles and books but there's no group activities." A relative said, "They had a group called Bangers and Mash and they had a nice sing song. I've seen some dogs in here as well, which is nice."

We saw records of group activities and one to one meetings that had taken place and they included what the activity was and the names of people that had taken part. For example, there was a recent quiz in the Woodlands unit that was described as a "very good session, very talkative" with six people.

However, we recommend the provider reviews its activity programme to ensure people have an opportunity to participate in daily activities more regularly.

Each person had their own room with and had the required adaptations in place according to their needs. People's rooms were tidy, clean and had been personalised with their pictures and belongings. When a person started to use the service, a personalised care plan was developed to meet their individual needs. It included information such as their background, what their needs were, their likes, dislikes, interests and how

they preferred to be supported. For example, people were able to complete a form called Life Story which enabled them to write down all aspects of their lives such as their favourite place, time of year, what they were most proud of and what makes them happy or sad. For example, one person said they were "proud of owning their own business, enjoy trips down memory lane and reading about politics." This information was important because it enabled people to have a voice so that staff could get to know them.

Care plans were reviewed and evaluated every month, although we found that not all people had a Life Story section in their care plan because they were incomplete or left entirely blank. This was brought to the attention of the registered manager who told us people and relatives did not provide the information for the Life Story section and it was not usually followed up. We required more assurance that personalised care plans would be completed.

We recommend that the provider seeks best practice guidance on ensuring care plans are completed to ensure they remain person centred.

Staff completed daily records of what care and support people had received and there was a handover of important information between each shift. Staff completed turn charts to record when they changed the position of people who were unable to do so by themselves and needed support. The staff responded to people's requests and assisted them when they wanted to go to the bathroom. They spent time helping people in and out of wheelchairs and hoists when requested. A key worker system was recently reintroduced where people were allocated a member of staff, who took responsibility for arranging their care needs and preferences.

The provider had a complaints procedure in place for people and relatives to make formal complaints if they wished. There was an effective system in place for receiving and responding to complaints. The registered manager investigated all complaints. We saw that complaints were acknowledged and responded to in detail and with explanations by the registered manager. One person said, "I haven't complained, I manage. But my bed is very uncomfortable." A relative said, "I have no complaints but I know what to do. I make sure I go to the top if I have a complaint."

Good

Is the service well-led?

Our findings

At our last inspection in May 2017, we found that the provider was still in breach of the regulation for providers to have effective systems and processes to assess, monitor and mitigate the risks to the health, safety and welfare of people in the service. This was following our last comprehensive inspection in November 2016, when the original breach of Regulation 17 was found. This was because we saw that there were on going issues with the service obtaining people's medicines on time. For one person, their medicines were not obtained immediately after they moved into the service. Further action by staff to order them was delayed, without reason and until almost a week after the person was admitted. We wrote to the provider and issued a Warning Notice for them to be compliant by August 2017 because we were concerned that this could have a negative impact on people's health.

At this inspection, we saw that the service was now compliant. The issues had been addressed and staff had learnt from previous mistakes. Since the last inspection, there had not been any further incidents and staff took action to obtain people's medicines as soon as a new person moved into the service. The registered manager supported staff by carrying out an evaluation exercise. We saw records to show how staff had learnt from the experience. One member of staff wrote that they would "monitor discharges from hospital and meds received and act immediately" in future. Another staff member had written, "If there is a similar incident, I would call the hospital first and get them to send the missing items." We saw that these actions were being followed.

Staff told us they felt supported by the registered manager. They were aware of their roles and responsibilities and told us they were happy working in the service. One staff member told us, "The manager is very supportive." Another said, "Everything is fine. The managers are very helpful." People and relatives were mostly happy with the management of the service. One person said, "The manager is marvellous and stops and chats to me." Another person told us, "Matron [registered manager] comes in and asks if everything's OK and fine. She's caring." Other people also told us that the registered manager visited them to check on their welfare. A relative said, "The Matron's a lovely lady. The Matron says anything [family member] wants, they can have." Another comment was, "The staff are good. They always let me know if my family member has a fall or something."

People and relatives were also complimentary about the unit managers of the Main and Woodlands units. One relative said, "It has got a lot better since the new manager of Woodlands has been here. They will phone me if I haven't seen them to catch up. That didn't happen before." Another relative said, "We said we didn't like [family member] being on their own. So now there is someone with them when we arrive, even when they don't know we are coming."

Staff felt they worked well as a team and meetings were held regularly. The management team and staff shared learning and best practice, so they understood what was expected of them and what their responsibilities were. Topics of discussion included recording of nutrition and hydration, updating repositioning charts, meal times and medicine management. The nursing staff who worked in both units also met monthly to discuss new admissions of people, care plans, training and supporting staff. During our

observations, we did note that staff did not always notice other people wandering around and visitors had to help direct them to where they wanted to go. We spoke to the registered manager about good practice and they assured us that they addressed and discussed issues such as poor practice or behaviour with staff, to ensure continuous learning. We saw that disciplinary action was taken, when necessary, by the management team.

The service also held 'residents and relatives' meetings where participants were able to express their views about the service, air any concerns and provide feedback. We noted that people's requests or suggestions were responded to. For example, action was taken to replace or repair old garden furniture upon request. Another person complained about noises at night time and the registered manager spoke to night staff to resolve this issue. They also spoke to people individually who were unable to attend meetings. This meant that the provider took action to ensure all people were satisfied with the service to make further improvements. Annual questionnaire surveys were sent to people and other stakeholders, such as relatives. We looked at the results from the most recent survey and noted comments were mainly positive. The registered manager told us, "We are always happy to receive feedback and make improvements. We want to learn from mistakes and make sure they don't happen again."

The provider had systems in place to monitor the quality of the service. Health and safety spot checks were carried out monthly. Audits were carried out by the registered manager to check records, including those for accidents, incidents, PEG feeds, catheter care and pressure sores. Medicine audits, including checks on controlled drugs were carried out daily and weekly, in accordance with a checklist set out by the pharmacy. This helped to ensure that people were safe and appropriate care was being provided. Policies and procedures for various aspects of delivering nursing care and support were in place and were reviewed annually.

The management team monitored the service through observations and discussions with people, staff and relatives. Compliments received from people and relatives included, "Thank you for your kindness and support in caring for [family member" and "[family member] was in good hands. You gave love and care to them until the end."