Fairburn Mews Health Care Limited

Fairburn Mews

Inspection report

Wheldon Road
Castleford
West Yorkshire
WF10 2PY
Tel: 01977521784
Website: www.example.com

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 17 March 2015 and was unannounced. At the last inspection in October 2013 and at this inspection we found the provider was meeting the regulations we looked at.

Fairburn Mews is a purpose built facility offering nursing and residential care for up to 20 people. There are two units of ten beds, one for people with Huntington's Disease and the other for people with mental health needs. The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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.

At this inspection we found the provider had systems in place to protect people from the risk of harm. Staff understood how to keep people safe and knew the people they were supporting well. Overall we found

Summary of findings

people were protected against the risks associated with medicines but staff competency was not checked in line with the provider's policy and some guidance was out of date.

Staff demonstrated they knew people well and had a good understanding of their support requirements. People's needs were assessed and care and support was planned and delivered in line with their individual care needs. The service met the requirements of the Deprivation of Liberty safeguards.

People enjoyed a range of social activities and had good experiences at mealtimes. People received good support that ensured their health care needs were met.

There were enough staff to keep people safe. Robust recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service. The provider had a programme of training and supervision, and staff felt supported. However, the service provided specialist care but staff had not received specialist training. This could result in people's specialist needs being overlooked. The provider took prompt action and arranged training following the inspection.

The service had good management and leadership. Effective systems were in place that ensured people received safe quality care. Complaints were investigated and responded to appropriately.

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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 safe.

People were protected against potential abuse. People we spoke with told us they felt safe and could keep their belongings safe.

Systems were in place to identify, manage and monitor risk, and for dealing with emergencies.

There were enough staff to keep people safe. The recruitment process was robust this helped make sure staff were safe to work with vulnerable people.

Overall we found there were appropriate arrangements for the safe handling of medicines.

Good

Is the service effective?
The service was not always effective.

In the main, staff received training and support that gave them the knowledge and skills to provide good care to people although some annual training was overdue. Staff had not received training to help understand how to provide specialist care. The provider took prompt action after the inspection to address this.

People were asked to give their consent to their care, treatment and support.

People were offered a varied and well balanced diet, and received good support at meal times.

People received appropriate support with their healthcare and a range of other professionals were involved to help make sure people stayed healthy.

Requires Improvement

Is the service caring?
The service was caring.

People looked well cared for and were comfortable in their home. Staff knew people well and had a good understanding of their individual needs and preferences.

Staff understood how to treat people with dignity and respect and were confident people received good care.

Good

Is the service responsive?
The service was responsive to people needs.

People received consistent, person centred care and support. People's care and support needs were assessed and plans identified how care should be delivered.

Good

Summary of findings

There was opportunity for people to be involved in a range of activities within the home and the local community.

Complaints were responded to appropriately and people were given information on how to make a complaint.

Is the service well-led?

Good

The service was consistently well led.

Staff told us the home was well managed.

Systems for monitoring quality were effective. Where improvements were needed, these were addressed and followed up to ensure continuous improvement.

Accidents and incidents were monitored to ensure any trends were identified and acted upon.

Fairburn Mews

Detailed findings

Background to this inspection

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

This inspection took place on 17 March 2015 and was unannounced. Two adult social care inspectors, a specialist advisor in Huntington's Disease and an expert-by-experience visited. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert had experience in mental health services.

Before this inspection we reviewed all the information we held about the service. This included any statutory notifications that had been sent to us. We contacted health professionals, the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

When we visited the service, we spoke with four people living at Fairburn Mews, a visiting health professional, 15 staff which included care workers, nurses, ancillary staff, administrator, clinical nurse manager and registered manager. We observed how care and support was provided to people. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records, policies and procedures, and quality audits. We looked at seven care plan records.

Good

Is the service safe?

Our findings

People were protected against potential abuse. People we spoke with told us on the whole they felt safe and could keep their belongings safe. One person said although they had not been harmed they sometimes didn't feel safe if another person they lived with got angry. Staff had received safeguarding training. They were able to demonstrate a good understanding of safeguarding issues and how they would identify abuse. Staff knew the principles of whistleblowing and assured us they would make use of whistleblowing procedures if necessary. They told us the management team had an open approach and were confident that any concerns would be dealt with promptly and appropriately. The registered manager told us they had no on-going safeguarding cases at the time of our inspection.

Systems were in place to manage risk so people felt safe and also had the most freedom possible. Risk assessments had been carried out to cover activities and health and safety issues. For example one person had a history of aggression when they were mentally unwell. An assessment had been completed and guidance was in place so staff could recognise early signs of adverse behaviour and triggers. De-escalation techniques and protecting others was also covered.

Staff used preventative measures to avoid unnecessary harm. For example, dressings were in place as a protective measure and pressure area checks were carried out to ensure any potential pressure sores were identified at the earliest opportunity. Staff had a good understanding of individual risk assessments and were able to describe to us the actions they would take in certain circumstances. We observed an incident where one person fell to the floor; staff were quick to respond and provided appropriate assistance.

We looked at systems for moving and transferring people and found these ensured people were safe. Staff had a good understanding of moving and handling practices. People's care records contained clear guidance so everyone understood how to assist people and meet their individual needs. People had personal emergency evacuation plans which identified how to support people to move in the event of an emergency. These documents along with 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) records were kept in the middle of people's care file so in the event of an emergency might be difficult to locate. The registered manager agreed to review this and place at the front of each file.

People lived in a safe and clean environment. We completed a tour of the premises as part of our inspection which included viewing some of the en-suite bedrooms and communal living spaces. All radiators were of a cool panel design, to protect vulnerable people from the risk of injury. Fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. Upstairs windows all had opening restrictors in place to comply with the Health and Safety Executive guidance in relation to falls from windows. All floor coverings were of good quality and properly fitted to ensure no trip hazards existed. People could call for assistance when in their bedroom because call bells were accessible. We reviewed environmental risk assessments, fire safety records and maintenance certificates for the premises and found them to be compliant and within date.

The management team had a health and safety calendar to follow; this identified what areas needed to be covered and when. For example, in March the bedrail policy had to be displayed. We saw this was displayed in the staff room alongside other health and safety information, which helped ensure staff were familiar with health and safety practices and their responsibilities.

We saw guidance documentation which enabled staff to effectively deal with common clinical emergencies. Staff showed us the emergency resuscitation box which contained airways, suction equipment, manual breathing equipment and a blood pressure monitor. Staff told us they were trained in the use of the equipment and records confirmed this. We saw the equipment was regularly checked to ensure it would be fit for purpose at the time of an emergency.

There were enough competent staff on duty to keep people safe. We observed that people received appropriate support and did not have to wait for assistance. Staff spent time with people and did not have to rush. One person became distressed and staff sat with them until they settled. The staff we spoke with also told us there were

Good

Is the service safe?

enough staff to keep people safe at all times although some comments were made that staffing levels were lower on a weekend and it was sometimes difficult to plan activities.

The registered manager discussed the staffing arrangements and said the staffing ratios and skill mix were appropriate. He acknowledged that, occasionally, there had been lower staffing some weekend days but was confident safe staffing levels were maintained at all times. We looked at four weeks of staff duty rotas; these showed staffing levels were being maintained and monitored. Sometimes there were less qualified staff in the building on a weekend and on three weekend days there were only eight care staff rather between eight to ten care staff which was usual. We concluded there had been sufficient staff to keep people safe at all times.

The provider was employing effective staff recruitment and selection systems which complied with their own policy. We reviewed staff files and saw there was a clear process that ensured appropriate checks were carried out before staff began work. These checks helped the service to make sure that job applicants were suitable to work with vulnerable people. Staff told us the recruitment process was thorough. They told us they had to complete an application form, supply three references and attend an interview. We saw that the registered manager had secured photographic identification in the form of either a driving licence or passport and that checks had been made to ensure staff were legally entitled to work. Care workers reported they received a good induction and had worked alongside more experienced staff until they were confident and competent to care for people on their own.

We looked at the systems in place for managing medicines in the home and found there were appropriate arrangements for the safe handling of medicines. Medicines were administered to people by trained nursing staff. We looked at medicine administration records (MAR) and reviewed records for the receipt, administration and disposal of medicines. We found records were complete and people had received the medication they had been prescribed. We found people's medicines were available at the home to administer when they needed them. We conducted a sample audit of medicines to check their quantity and found these were correct. The staff maintained records for medication which was not taken and the reasons why, for example, if the person had refused to take it, or had dropped it on the floor.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. The registered nurse demonstrated a good understanding of the protocol. People were assessed as to their ability to self-medicate. Whilst no people were self-medicating at the time of the inspection, the process demonstrated the provider was attempting to maximise people's independence.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation. These medicines are called controlled medicines. At the time of our inspection a number of people were receiving controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded.

We looked at one person's medicine administration record (MAR) sheet who had been prescribed warfarin. The appropriate dosage of warfarin was dependent on the outcome of a monthly blood clotting test. The outcome of the test indicated the dose of warfarin to be given over the coming month. We saw the manager had introduced a protocol to follow to ensure the blood results were accurately recorded and the correct dose of warfarin dispensed. This meant the provider was taking appropriate and measured action to protect people from receiving unsafe care.

We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and storage room temperatures were checked and recorded daily to ensure that medicines were being stored at the required temperatures.

We saw the administration of medicines was underpinned by a written procedure. However we noted the document made reference to outdated guidance from the Royal

Good

Is the service safe?

Pharmaceutical Society and did not make reference to the current National Institute for Health and Care Excellence (NICE) document 'Managing medicines in care homes guideline (March 2014)' We looked at the provider's current guidance with regard to administering non-prescription and over-the-counter products (homely remedies). Whilst the procedure was clear it did not make reference to current NICE guidance. Furthermore we did not find there to be a common understanding of how the procedure would operate in practice. We discussed our findings with the registered manager who agreed to review the policy and ensure homely remedies and up to date guidance was included.

We discussed the safe handling of medicines with two of the registered nurses on duty; they demonstrated medicines were given safely and in a competent manner. The provider's medication policy stated that staff competency should be assessed annually, however, we noted this had not been carried out consistently. We discussed this with the registered manager and clinical nurse manager who agreed to ensure competency was assessed with all staff who administered medicines and annually thereafter.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with said they felt well supported. One member of staff said, "We get really good support from the managers and the team." Another member of staff said, "I've had really good support and know others feel the same." Staff said they had received enough training so they could do their job well. One member of staff said, "We have face to face training sessions so get chance to go through everything. We can also check things out with the trainer anytime." We spoke with a member of staff who provided a number of training sessions. They confirmed they had completed relevant training that equipped them with the skills and knowledge to provide training to staff.

We looked at the training records and saw staff had received a range of training including fire safety, food safety, nutrition and hydration, safeguarding adults and NAPPI (non-abusive psychological and physical intervention). The provider had introduced some additional annual training topics which staff had started to complete. These sessions were equality, diversity, inclusion bullying and harassment, data protection and confidentiality, customer care and communication, person centred support.

The training matrix we looked at had some gaps which indicated some refresher training was overdue; the registered manager said training updates were planned and we saw records that confirmed this. We also looked at a supervision and appraisal matrix, which showed there were systems in place to support staff. The registered manager had already identified some sessions were overdue and was ensuring these were brought up to date.

The service provides a specialist service to people with Huntington's Disease. Some staff said they would benefit from more training and guidance to help them understand the condition. We found there was very little information available and staff had not received specific training. We discussed this with the registered manager and clinical nurse manager who agreed they would provide some specific training and would look into gathering information and making it available on the unit. After the inspection we received written confirmation that specialist training was being arranged.

Throughout our inspection we saw that people who used the service were able, individually or through their relatives, to express their views and make decisions about their care and support. For example one person had an advanced directive, which outlined their wishes in relation to inserting feed tubes (PEG) and not wishing to die in hospital. The person's wishes were being respected. We saw staff seeking consent to help people with their needs. Our discussions with staff, people using the service and observed documentation showed consent was sought and was appropriately used to deliver care.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that if restrictions are in place they are appropriate and the least restrictive. Three people at the home were subject to DoLS with one of the authorisations containing conditions. With regard to the conditions being attached to one person's DoLS authorisation we checked with care plans to ensure the conditions were being met. We found the care plans reflected the conditions and the daily activity record demonstrated they were delivered consistently. Discussion with members of the management team demonstrated a good understanding of the legal framework in which the home had to operate to secure a valid DoLS authorisation.

Our observations of the environment and people's care plans suggested that the provider utilised a number of methods which may constitute a deprivation of liberty. The front door was locked. The exit doors from each floor were locked and people were under constant supervision. Whilst each element of restrictions may not constitute a deprivation of liberty, it may be the case that an accumulation of restrictions being experienced by some people may amount to an unauthorised deprivation of their liberty. We judged that the provider may be exercising control over people's care and movements. We spoke with the registered manager about our findings and were assured as they shared our views and confirmed additional DoLS authorisations would be applied for.

We spoke with staff about restraint practices. Whilst physical, mechanical means of restraint and restricting people's choice was not a feature of care at the home, staff had a good understanding of the issue. We saw the service had incorporated de-escalation and restraint avoidance assessments in people's care plans. We spoke with a nurse about the use of restraint. They were able to demonstrate their knowledge and knew the difference between lawful

and unlawful restraint practices. Whilst bed-rails were not a common feature of the service we spoke with the nurse about their potential use. Answers we received demonstrated that when people had capacity they were consulted on the use of bed-rails and understood the action was proportionate to the potential harm. Where there was a lack of capacity or the person's capacity fluctuated, relevant others such as relatives were consulted before bed-rails were used.

We got a mixed response when we spoke with people about the meals. One person talked to us about some difficulties they had experienced in the past with their lifestyle. They told us they chose healthy options from the menu, had lost weight and felt much better. They said, "Now I'm in control." One person said they would like more food options for people with diabetes. One person said they didn't enjoy the food. We asked the cook about options for people who were diabetic and they confirmed appropriate desserts were provided. The registered manager agreed to ensure this was promoted so everyone knew diabetic options were available.

We observed lunch in both units, which was a relaxing and well organised experience for people. People were offered a choice of liver or cottage pie. There was plenty of staff to support people throughout the meal period. Staff assisted people to eat and drink were patient and responsive to the needs of the person they were supporting. One person was on a pureed diet and received one to one support throughout the meal. The member of staff spent time taking to the person, explained what the food was and ensured they could eat at their own pace. One person asked for a small portion but a large portion was served. The person only ate a very small amount of their meal. We shared our findings with the registered manager who agreed to remind staff that they must ensure they respected people's wishes.

We spoke with the cook who explained that menus took into account people's preferences and were changed twice a year. They said there was always a good supply of provisions which included fresh fruit and vegetables. The cook had a good understanding of healthy eating and how to ensure they met people's individual needs.

Staff we spoke with said meal times were consistently good and they were confident people ate healthily and had balanced diets. The home had a four week rolling menu which was varied and offered choice to people at meal times. People could choose from two options at lunch and evening meal. On the day of the inspection meal options were displayed on the table but these did not correspond with the food served. The cook explained this was because the menus had been changed and the displayed version was not up to date. The registered manager agreed to ensure menus displayed were up to date so people are informed of the meals provided.

Some people in one of the units used feeding tubes (PEG) so did not eat meals prepared at the home. Appropriate assessments and guidance were in place for PEG feeding. Other specialist health professionals were involved in people's care which helped ensure people's individual needs were monitored and met. We saw from records people accessed speech and language therapists, dieticians, palliative care team, dentist, opticians, GPs, chiropody and tissue viability had been consulted. Some people had reached an age when bowel and breast cancer screening was appropriate. We saw that when people were invited to take part in the screening care staff helped people to make their choices.

We were told by one person they were having difficulties managing their medical appliance. We looked at the person's care plan which documented the current difficulties. We saw the staff had requested guidance from specialist nurses who had visited and made suggestions. Whilst the advice of the specialist nurses had been adhered to we noted a suitable solution was yet to be found. We spoke with a nurse who assured us all solutions had not yet been tried and they would persist until a solution was found.

Some people at the home were diagnosed with mental health illness, and their care was coordinated using a multidisciplinary approach. We saw multidisciplinary involvement in assessing, planning and reviewing people's mental health care needs. Meetings took place at the home with all relevant health and social care professional in attendance. A health professional told us, "They appear to arrange treatment changes via the GP quickly whenever I had advised changes to treatment."

One person's care plan identified the need for a new wheelchair with specific adaptations. On the day of our visit the person attended the wheelchair fitting centre to take

Requires Improvement

Is the service effective?

delivery of their new wheelchair. On arrival back at the home we spoke with the person. They described the significant benefits of the new chair and praised staff for helping them secure it.

Good

Is the service caring?

Our findings

We observed interaction between staff and people living at the home on the day of our visit and saw people received good care. Staff spoke gently, were attentive and helped people relax. We saw that people responded positively to staff with smiles when they spoke with them. One person started to get anxious and staff spent time with them, offered them reassurance and checked the person was settled before they left them. Another person said they wanted to sit in a chair and again staff offered reassurance. One person said, "I chose to come here, I could have come next door, but no I wanted to come here." A health professional said, "I have always found the staff to be courteous and pleasant."

Staff enabled people to be independent. One person was reluctant to go on a pre-planned event. Three different members of staff spent time with the person and were encouraging and enthusiastic. The person decided to attend the event. When they returned we asked of it was ok and they replied, "Yeah it was alright." Ancillary staff asked people's permission to enter their room and also checked what support they wanted with their laundry.

Some people who used the service were unable or chose not to tell us about their experience of living at Fairburn Mews. We saw staff interacting with people in a kind and compassionate manner. One person was severely agitated and experiencing delusional thoughts. We observed staff caring for this person over the full day of our inspection. Care given was effective which allowed the individual to have significant periods of calm behaviour which on some occasions turned to visible happiness. Staff clearly demonstrated they knew people well and had a good understanding of their support requirements, and likes and dislikes. Staff had knowledge of people's background and future goals which helped them understand the person and how to respond when offering support. We saw that people's care records contained details of their life history.

People looked well cared for. They were tidy and clean in their appearance which is achieved through good standards of care. We saw people appeared at ease and relaxed in their environment. We observed that staff included people in conversations about what they wanted to do and explained any activity prior to it taking place.

We found that some people at the home had no, or very little, support other than their care workers at the home. The provider sought to make advocates available for any person who needed help in presenting their views. An advocate is a person who represents and works with a person or group of people who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld. We saw three people were benefiting from advocacy involvement.

All the staff we spoke with were confident people received good care. A member of staff said, "We look after people well and make sure they get everything they need. We listen to health professionals so we know we are doing things right." Another member of staff told us, "The standard is high. We 're a good service and try to do our best for everyone." Staff were able to explain and give examples of how they maintained people's dignity and privacy.

Staff were seen respecting the privacy and dignity of the people who were using this service. For example, by knocking on bedroom doors before entering and allowing people time to respond. Each room visited showed signs of individual choice and personal touches such as photographs, prized possessions and personal furniture. One person's favourite colour was pink, which was reflected in the décor. Another person enjoyed rock music and motorbikes, which again was reflected in the décor. One person told us they had asked to have the colour of their wall changed which was done by the handyman and were waiting for some shelves to be put up. They described the handyman as, "Good and helpful." One person told us the furniture in the communal lounge was not comfortable. We shared this view with the registered manager.

Good

Is the service responsive?

Our findings

People talked to us about activities they did within the home and the community. One person said, "I do lots of things with the garden. I have planted flowers for the hanging baskets, tomatoes, onions, sweetcorn, potatoes, carrots and pumpkins. We have two apple trees and a pear tree. We will be able to eat the food we grow." Another person talked about skills they had developed to help their independence when in the community. They said, "I have been taught how to use the cashpoint to use my bank card and my number. I never thought I would be able to do it. I had seen other people using the cashpoint and I didn't understand it. Now I am proud that I can do it." The home had two activity co-ordinators who facilitated individual and group activities. One of the activity workers said, "We plan activities using a person centred approach. We also organise lots of events that everyone can enjoy." There were photos around the home showing people had taken part in past events. A 'tea party' was being arranged the day after the inspection. People told us their relatives could visit anytime.

From observations, discussions and a review of care records we concluded people received consistent, person centred care and support. A visiting professional said, "It's nice to come somewhere, where they know what's happening. They were able to provide good information, it was a good experience." Another health professional said, "The key workers appear interested in the welfare of the patients under their care. They appear to be able to offer activities on and off the unit more compared to other local care homes. The care home certainly seems to be responsive to the patients' needs; although they are not able to offer everything that the patient may benefit from e.g. kitchen assessment due to health and safety considerations." Another health professional who had visited the service on one occasion told us the person they visited was receiving appropriate care, and an assessment and care plan was in place and staff were following this. They said, "All the staff were very friendly. This residents care plans and risk assessments were up to date."

We received some suggestions about how care and care planning could improve from people who used the service. One person told us their bed was too hard and would like a more supportive mattress. Another person said they "wanted to be left alone" when they were "irate". They also said they would like a key for their room. Another person said they would like to have a telephone in their room so they could ring their relatives. We discussed these suggestions with the registered manager who agreed to discuss them with the people involved. The person who requested the key said they had not asked for this before and was given a key to their room on the day of the inspection.

People's care and support needs were assessed and plans identified how care should be delivered. The outcome of risk assessments at the point of admission to the service were used as the foundation to create a safe care plan covering, mobilisation, toileting, nutrition, communications, mood, night care and personal hygiene. We saw that staff recorded on a daily basis; outcomes of the care plan and took steps to modify the plan in light of people's experiences or changing health care needs.

Care plans recorded what the person could do for themselves and identified areas where the person required support. The care plans had sufficient detail to ensure staff were able to provide care consistently. There was good correlation between what the care plan required and the care given. We saw staff were able to easily access any aspect of defined care need through clearly presented files. Each person had a short profile which provided an overview of their care needs. This could be used to give important information quickly. One person who used the service said they would like to have access to their care records which were kept in the office. We discussed accessibility of files with the registered manager who agreed to look at how they could improve the current arrangements.

We saw from assessments and care plans one person had been identified as being at risk of self-harm and had in the past managed to harm themselves. The care plan identified the likely scenarios when the person may be of greatest risk and identified when sharp objects may be available. Throughout our inspection we saw staff were diligent in ensuring risks were being kept to a minimum. Some people had sensors to help warn staff when people were at risk. For example, if they rolled out of bed staff would be alerted. We saw some people were on 15 minute observations; care plans, daily records and observation charts were completed.

We saw that care plans recorded whether someone had made an advanced decision on receiving care and

Good

Is the service responsive?

treatment. The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions. The correct form had been used and was fully completed recording the person's name, an assessment of capacity, communication with relatives and the names and positions held of the healthcare professional completing the form. We spoke with staff who knew of the DNACPR decisions and were aware that these documents must accompany people if they were to be admitted to hospital. However while the correct form had been used to record the DNACPR decision only copies of the original were available at the home. It is a recommendation of the Resuscitation Council (UK) that only the original (top) copy can be identified as a CPR decision record for clinical use, avoiding the potential danger of a copy being used to guide clinical decisions when the original may have been cancelled. We discussed this with the registered manager who agreed to review their procedure and ensure original forms were available in the relevant files.

The provider had a complaint's procedure which outlined how people could raise concerns and complaints. Staff we spoke with knew how to respond to complaints and understood the complaints procedure. The registered manager told us they had no on-going complaints. We looked at the complaint's record which showed complaints were dealt with within a reasonable timescale. They were fully investigated and resolved where possible to the person's satisfaction.

Good

Is the service well-led?

Our findings

The service had a registered manager who oversaw the care given. The registered manager, clinical nurse manager and unit managers worked alongside staff and provided support and guidance where needed. The management team had knowledge of people who used the service which enabled them to monitor service delivery. Staff working outside normal office hours were supported by senior colleagues on an on-call rota.

Staff spoke positively about the management team and were happy working at the home. One member of staff said, "They're very approachable and always checking everything is being done as it should be." Another member of staff said, "Things are well organised so we know what we should be doing." Another member of staff said, "I love working here I feel as though it is home for me, I had to go and help in another complex, and I felt I needed to come back home. "It's like being part of a family; people are really cheerful and friendly."

Staff had clear roles and responsibilities and knew what was expected of them. There was guidance to help staff understand their responsibilities. In one unit we noted there was a list of keyworkers and who they were responsible for on that shift. The nurse explained this did not mean that only these staff could complete the tasks required but that they were responsible for making sure the tasks were completed. For example, if a person required positional turning, the keyworker had to make sure the times were recorded and the staff responsible for making sure the person was turned had to record this in the daily records.

The provider had systems in place for monitoring the quality and safety of the service. Staff and the management team said regular checks were carried out to make sure the service was running smoothly. We looked at records which confirmed this. Daily checklists included cleaning schedules, cutlery checks and temperature records. The management team also carried out a range of reports that helped ensure the service was monitored. Unit managers completed a weekly report that covered visiting professional visits, any major weight loss, pressure sores, adverse events and staff cover. Medication and care profile audits were also completed. We looked at monitoring visit reports where the provider visited the service and checked everything was being carried out at the home. The last visit was carried out in December 2014. The registered manager said further visits were planned.

Accidents and incidents were monitored by the registered manager to ensure any trends were identified. Adverse event report forms contained clear information to show what had happened and any action that was required to reduce the risk of repeat events. We noted one person had an injury as a result of a cushion being placed the wrong way in a chair. The person's notes stated the incident was to be recorded on an adverse event form. When we checked this had not been completed. However, a new care plan had been written to ensure all staff knew how to do this correctly in future. The registered manager said they would follow this up and ensure a form was completed.

The provider asked the views of people using the service and others to help drive improvement. Resident meetings were held. We saw minutes which showed a range of topics were discussed which included activities, menu and keyworker role. Staff were asked to comment on the service and contribute to the running of the home. Staff said they attended daily handovers which were a good form of communication. Regular staff meetings were held where they discussed quality and safety. For example they had recently covered activities, recruitment, infection control, survey results and ideas to improve the environment. We looked at survey results from an annual staff satisfaction survey. This showed that although there had been a low response responses were generally positive. Staff were asked to comment on training and development, support from their manager, raising concerns at work, and occupational health and safety.

At the inspection we received positive feedback and observed good care being provided. We also received comments where people thought the service could further develop. We shared these ideas with the management team who were very receptive and keen to take on board any suggestions.