Care Quality Commission

Caring Homes Healthcare Group Limited

Rectory House Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 18 and 19 December 2014 and was unannounced. At the inspection held in July 2014, Warning Notices were issued under Regulation 9 – Care and welfare of service users, Regulation 14 – Meeting nutritional needs and Regulation 20 – Records. Compliance actions were set against Regulation 18 – Consent to care and treatment, Regulation 12 – Infection and cleanliness control, Regulation 22 – Staffing and Regulation 10 – Assessing and monitoring the quality of service provision. At this inspection, we found that improvements had been made and that all Warning Notices and compliance actions had been met.

Rectory House Nursing Home is a care home with nursing. The people living there are mostly older people with a range of physical and mental health needs. Some people using the service are living with dementia. The home is a historic building with a Georgian style frontage and dates back to 1785. It is set within two acres of mature landscaped gardens and located in a residential area on the outskirts of Worthing. People can furnish their rooms to their own taste and have access to two large lounges and a conservatory overlooking the garden. The home is registered to accommodate up to 48 people. At the time of our visit, there were 36 people living at the home.

Summary of findings

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.

People were safe as they were supported by staff that had been trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. There had been safeguarding concerns raised at the previous inspection. The provider had co-operated in the local authority investigation and had implemented a comprehensive action plan that addressed safety issues for individuals and for the service as a whole. Accidents and incidents had been recorded and appropriate action had been taken and recorded by the manager. There were sufficient numbers of staff in place to keep people safe and staff were recruited in line with safe recruitment practices. Medicines were ordered, administered, recorded and disposed of safely. Only registered nurses administered medicines. The environment was clean. Systems, training and equipment were in place that ensured the prevention and control of infection

People could choose what they wanted to eat from a menu that was changed every four weeks. People were asked for their views about the food and were involved in planning the menu. They were encouraged and supported to eat and drink enough to maintain a balanced diet. The service monitored people's weights and recorded how much they ate and drank to keep them healthy. Consent was sought from people with regard to the care that was delivered. Staff understood about people's capacity to consent to care and had a good understanding of the Mental Capacity Act 2005 (MCA) and associated legislation, which they put into practice. Staff were appropriately trained holding a National Vocational Qualification (NVQ) in Health and Social Care and had received all essential training. They received supervisions from their line managers. Communication was good between staff and handover meetings were held daily between shifts.

People could choose when they wanted to get up and go to bed and were cared for by kind and compassionate staff, who knew them well. If people were at risk of pain, the service had a range of tools to monitor this and treat people effectively. People were involved in making decisions about their care and their privacy and dignity were respected. As people reached the end of life, the service ensured that their wishes were fulfilled in a sensitive way and that palliative care met their needs.

Prior to admission, people were assessed by the registered manager so that care could be planned that was responsive to their needs. Care plans provided detailed information about people and were personalised to reflect how they wanted to be cared for. The service followed clinical guidance and ensured that best practice was followed in care delivery. Daily records showed how people had been cared for and what assistance had been given with their personal care. People were encouraged to stay in touch with people that mattered to them. There was a range of social activities on offer at the service, which people could participate in if they chose. The service had a complaints policy in place and a procedure that ensured people's complaints were acknowledged and investigated promptly. Lessons were learned from these complaints and action taken.

The service was well-led by the registered manager who felt supported by the provider's senior management team. A positive culture was promoted and staff had a good understanding of how to communicate with people in an accessible way. There was a range of audit tools and processes in place to monitor the care that was delivered, ensuring a high quality of care. People could be involved in developing the service if they wished, for example, helping to interview new staff. They were asked for their views about the service through questionnaires and relatives were also asked for their feedback. Encouraging and complimentary feedback had been received overall. Staff knew what was expected of them and regular team meetings were held.

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?

Good

The service was safe.

People were supported by staff who recognised the potential signs of abuse and knew what action to take. They had received safeguarding adults at risk training.

People's risks were assessed and managed appropriately. There were comprehensive risk assessments in place and staff knew how to support people. Accidents and incidents were logged and dealt with appropriately.

Staffing levels were sufficient and safe recruitment practices were followed. Medicines were managed, stored and administered safely. Systems and training were in place to ensure the prevention and control of infection

Is the service effective?

Good

The service was effective.

People could choose what they wanted to eat and had sufficient amounts to maintain a healthy, balanced diet. They were asked for their views about the food. People had access to, and visits from, a range of healthcare professionals.

People's consent to their care and treatment was assessed. Staff followed legislative requirements and had a good understanding of the Mental Capacity Act 2005 (MCA).

Staff were trained in all essential areas and new staff completed a comprehensive induction programme. Communication between staff was good and handover meetings were held between shifts.

Is the service caring?

Good

The service was caring.

Staff knew people well and friendly, caring relationships had been developed. People were encouraged to express their views and how they were feeling.

End of life care was delivered sensitively by staff who understood people's wishes. Advice and support was implemented from a range of health professionals.

Is the service responsive?

Good

The service was responsive.

People were assessed by the registered manager before admission to the service. Care plans provided detailed information about people so that staff knew how to care for them in a personalised way. Staff demonstrated that they followed current good practice.

People were supported to stay in touch with people that mattered to them. There was a range of activities available for people to engage in at the service.

Complaints were listened to, investigated and acted upon.

Summary of findings

Is the service well-led?

Good

The service was well-led.

People could be involved in interviewing new staff, if they wished. They were asked for their views about the service. Relatives were also asked for their feedback.

Care plans provided detailed information about people and were accessible to staff.

Robust quality assurance systems were in place to enable the provider to continually monitor all aspects of the service.

Rectory House 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 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.

The inspection took place on 18 and 19 December 2014 and was unannounced.

Two inspectors, a nurse specialist and an expert by experience with an understanding of older people undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people, relatives and staff. We also spent time looking at records including ten care records, three staff files, medical administration record (MAR) sheets and other records relating to the management of the service. We contacted local health and social care professionals who have involvement with the service, to ask for their views.

On the day of our inspection, we spoke with eight people using the service and four relatives. We spoke with the registered manager, the regional manager, three registered nurses, four care assistants and one member of kitchen staff.

Good

Is the service safe?

Our findings

As a result of our inspection in July 2014, a Warning Notice was issued due to serious concerns regarding the protection of service users against the risk of receiving care or treatment that was inappropriate or unsafe. The provider had not adequately assessed all the needs of people. Care and treatment was not planned and delivered to meet people's individual needs and to ensure their welfare and safety. At this inspection, we found that sufficient steps had been taken and that the Warning Notice was met.

People were safe as their health needs were identified and then acted upon. We looked at three people's care plans and risk assessments which described the care that they received and identified areas that were a priority. The care plans and assessments demonstrated that people were receiving care specific to their individual needs. For example, where people needed support with managing their skin integrity, a risk assessment had been completed. Staff knew how to deliver people's care because plans were in place that detailed the care needed and equipment required.

Accidents and incidents were recorded. These were recorded in detail and, where possible, the person's opinion was sought. The registered manager signed these documents and recorded the actions taken. For example when someone was found to have bruising the GP was consulted and confirmed that the bruising was a result of the use of aspirin not an injury. Where someone had been experiencing repeated falls these incident reports had been analysed and specific equipment sourced to minimise the risk of the person falling. This showed us that there were systems in place that accurately reflected the risks to individuals and the ways in which these were addressed.

As a result of our inspection in July 2014, a compliance action was set due to concerns regarding inadequate staffing levels at the service. There were insufficient qualified, skilled and experienced staff to meet people's needs. At this inspection, we found that steps had been taken and that the compliance action was met.

On the day of our inspection there were enough staff on duty. There were eight care staff, two nurses and the registered manager on duty. A dependency tool was in place to identify the levels of need for people living at the service and indicate the number of staff required to meet those needs. As a result of using this system staffing levels had been increased since the last inspection to reflect the needs of people living at the service. The registered manager told us that the service now had a stable group of staff in place and that they include a ten percent addition in staffing as a contingency for staff sickness. If needed the service used staff from an agency. Where possible they tried to use the same agency staff that knew the needs of the people at the service. A member of staff said there were enough staff on duty and that they had enough time to carry out their duties.

Safe recruitment processes were in place and the required checks were undertaken prior to staff starting work. This included obtaining two references, having a copy of the professional registration required for nursing staff and completion of disclosure and barring service checks for working with vulnerable adults. This ensured that people were protected against the risk of unsuitable staff being recruited to the service.

As a result of our inspection in July 2014, a compliance action was set due to concerns regarding the risk of infection. The service was not kept clean and appropriate guidance had not been followed. At this inspection, we found that sufficient steps had been taken and that the compliance action was met.

People were protected by the prevention and control of infection. The general environment at Rectory House was visibly clean and discussions with staff confirmed that they had adequate equipment, such as gloves and aprons, to provide appropriate, safe care. Clinical waste was disposed of appropriately. Night staff had a checklist of equipment that needed to be cleaned and a green sticker was applied to identify when this had been done. There was a dedicated housekeeper and a cleaner for each floor. Cleaning equipment was in accordance with current guidance in relation to colour coded equipment for use in different areas of the home. Each person's room had a deep clean every month and cleaning was audited; audit records were reviewed by the registered manager.

Staff received training in the prevention and control of infection and there was a comprehensive policy in place that included guidelines for infection outbreaks such as Clostridium difficile (C Diff), guidelines for isolation and a reporting and notification procedure for reporting Meticillin-resistant staphylococcus aureusis (MRSA).

Good

Is the service safe?

Infection prevention and control audits were undertaken every two months and had been reviewed. Where actions had been identified, plans for addressing these had been put in place. For example the cleaning of equipment had been identified in the July audit and processes for cleaning and future auditing were put in place.

People told us that they did not have concerns about their safety. A relative told us, "Staff come in regularly and keep an eye on him". People were protected from harm and abuse. We talked to the registered manager regarding the concerns that had been raised at the previous inspection about the safety of people who live at Rectory House. The registered manager told us that following the previous inspection by CQC and by working in partnership with the local authority, action plans were put in place. These plans ensured that people were safe and that the risk of incidents were minimised. Staff had been trained in safeguarding adults at risk procedures and knew how to recognise signs of abuse. There were systems in place that ensured this knowledge was checked and updated. There had been safeguarding concerns raised at the previous inspection. The provider had co-operated in the local authority investigation and had implemented a comprehensive action plan that addressed safety issues for individuals and for the service as a whole.

Medicines were stored and administered safely. Nursing staff administered medicines and were aware of what medicines needed to be taken by people. Medicines were prescribed by the GP and reviewed every two weeks. A local pharmacy dispensed medicines utilising a monitored dose system and supplied medication administration record (MAR) charts. They also collected medication for disposal. There was a protocol in place for PRN (medicines to be taken as required) and the administration of covert medication. Two medicines rounds were observed and staff washed their hands before and during the round. The staff member asked people about their pain levels and if they required analgesia. The medicines trolley was locked as each person's medicine was administered. The staff member wore a tabard to indicate that they were administering medicines and not to be disturbed. This ensured that the risk of being interrupted and making a mistake was minimised.

Controlled drugs were stored appropriately and when administered two staff members signed to indicate this. There were two recorded checks of controlled drugs daily. The local pharmacy carried out audits which ensured that there was an oversight from an external organisation to identify good practice and areas where improvements were needed. On the day of our inspection a meeting was taking place with the pharmacy to discuss their joint working protocols.

Good

Is the service effective?

Our findings

As a result of our inspection in July 2014, a Warning Notice was issued due to serious concerns in relation to the risks of inadequate nutrition and hydration. People were not provided with a choice of suitable and nutritious food and hydration in sufficient quantities to meet their needs. They were not supported to eat and drink sufficient amount for their needs. At this inspection, we found that sufficient steps had been taken and that the Warning Notice was met.

People were supported to have sufficient to eat and drink and to maintain a balanced and healthy diet. Weekly menus were planned and were rotated every four weeks. There was a good choice of food available throughout the day and the main meal, including a dessert, was served at lunchtime. For example, at the time of our inspection, the lunchtime choice on offer was fish and chips or sausage and mashed potato, vegetables, then jam sponge and custard or ice-cream. People could also choose an alternative option and special diets were catered for. One person said, "The food is very good and there's plenty of it". Another person told us, "The food is very good, a varied menu". A relative thought that their family member enjoyed the food and told us, "Oh she loves it. She was always very picky at home. Second portions are offered, she eats very well".

We observed people eating their lunch in the dining room and in the sitting room; the atmosphere was relaxed and unhurried. Staff supported people to eat their food where they were unable to eat independently. People were encouraged to eat a little more and one staff member said, "I've brought your pudding", then referred to the first course saying, "Did that go down all right?" Staff were friendly and engaged in conversations with people as they supported them to eat. Many people chose to eat their lunch in their rooms rather than eat in the communal areas and this was respected. Drinks were available to people throughout the day and night; food was available between mealtimes, if people wanted to eat at other times. A high calorie snack list showed foods equivalent to 300 calories, so that people could choose snacks that supplemented the main meals on offer.

Residents' surveys were undertaken in the spring and autumn and people were asked for their views about menus and their food preferences. Their views were taken into account. The chef told us that people's diets were discussed on a regular basis and that she was busy planning the Christmas menu.

The service used a Malnutrition Universal Screening Tool (MUST) to monitor people's nourishment and weight. MUST is a five-step screening tool that identifies adults who are malnourished or at risk of malnutrition. The tool includes guidelines which can be used to develop people's care plans. Food and fluid charts were completed for each person and these were reviewed by senior staff on a weekly basis to monitor the amounts that people ate and drank. Appropriate action was then taken. For example, some people had been identified as having problems with swallowing (dysphagia). The speech and language therapist had been contacted for advice on their diets, which was implemented. People at risk of malnourishment had their weight checked weekly. Higher calorie or protein meals were served to them on red trays so that staff could monitor how much they ate and provide them with support and encouragement to eat a little more.

At our inspection in July 2014, a compliance action was set as the provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to their care and treatment. At this inspection, we found that steps had been taken and that the compliance action was met.

Consent to people's care and treatment was sought in line with legislation and guidance. Staff had a good understanding of the Mental Capacity Act 2005 (MCA) and demonstrated their knowledge of this. One member of staff told us, "Everyone has the ability to make decisions until assessed and proven otherwise". People's capacity to consent to care or treatment was recorded in their care records; these showed that people were involved in reviewing their care on a continual basis. People were assessed on their capacity to consent in a range of areas and the registered manager had completed capacity assessments. Capacity assessments were reviewed either monthly or three monthly as required. People were able to make day-to-day choices and decisions about their care.

Where people were unable to give their consent, a best interest meeting was held. This is where staff, professionals and relatives would get together to make a decision on the person's behalf. People were also able to attend these meetings if they wished and were supported in the decision

Good

Is the service effective?

making process. For example, a best interest meeting was held for one person whose relative lived abroad and was therefore not readily available to support their family member to make decisions. Some people at the service were subject to a Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The registered manager had received advice on this from the local authority to ensure legal guidelines were followed. Some people were able to leave the premises independently, whilst others received support from their relatives or staff whilst they were out.

People received effective care from staff who had the knowledge and skills they needed to carry out their role and responsibilities. Staff had achieved National Vocational Qualification (NVQ) in Health and Social Care at Level 2 or 3 and some staff were working towards Level 4. Staff had received essential training in areas such as safeguarding adults at risk, infection control, fire procedures and mental capacity. Staff had access to e-learning training which was arranged by the provider. Nursing staff had received training to provide them with the skills for their role such as medication, diabetes, tissue viability, mental capacity and life support. They had access to advice and support and on recent guidance and practice. New staff completed a comprehensive induction programme which included a tour of the service, location of company policies and procedures and a training portfolio. The registered manager followed safe recruitment practices. Staff files showed that two references had been obtained for new staff and their identity checked. Disclosure and Barring Scheme (DBS) investigations had been undertaken to check their criminal records and that they were safe to work with adults at risk.

Staff received supervisions with their line managers every three to six months and records confirmed this. One member of staff said, “I can go to her [registered manager] at any other time if I need to discuss anything”. There was a training plan in place to ensure that staff completed their essential training and that training was refreshed as needed. For example, staff had annual updates for safeguarding adults at risk which meant they were knowledgeable about current practice and what action to take.

Handover meetings were held three times daily at the end/start of shifts. Handover meetings involved updates on individual people’s current status and any changes that had taken place. One nurse on duty explained her handover record and her written notes which identified relevant changes and updates to people’s care. Registered nurses would have handover meetings with each other between shifts and would then communicate relevant information to care staff afterwards. This ensured good communication of people’s needs between staff to ensure people received appropriate care.

People were supported to maintain good health and had access to a range of healthcare services and support. Care records showed that people received visits from their preferred GP and had access to the services of a dentist, optician or podiatrist, if required. People told us that they could see a doctor whenever it was necessary. One person said, “It’s easy to see a doctor if needed” and another person told us, “It’s arranged quickly”.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. During lunch, we observed staff supporting people to eat their meal and engaging in conversation. Staff knelt down by people who were seated so that they could communicate at eye level. Everyone we spoke with thought they were well cared for, treated with respect and dignity and their independence promoted. One person told us, "The staff are very good, very friendly, which is nice" and another said, "I find the staff are caring, very kind. The way they speak to me, never harshly or anything like that, very caring". Exchanges between people and staff were positive and respectful and there was a shared sense of humour. Relationships between people and staff were warm, friendly and sincere. Relatives knew staff by their first names and communication was cheerful. A relative whose husband had been at the service for some months was very positive about staff and the care they delivered.

People could get up at a time that suited them. A relative told us, "Most of the time she chooses not to get up. They [staff] do try and encourage her, but she's not very good at sitting up". Care records provided information about people's individual preferences, for example, what time they wanted to get up, have their meals and whether they preferred to bath or shower. Some people had expressed a preference as to whether they wished to be cared for by male or female care staff and their choices had been acted upon. People's cultural needs were respected and people had access to spiritual support and religion.

Where people were at risk of pain, there were a range of tools in place to minimise the risk and to control pain. Where people were unable to verbally communicate their needs, the service utilised an accessible pain rating scale using faces. For example, a smiling face meant that people had no pain and a sad face meant that the pain experienced was distressing or intense. People could point to the appropriate face when nurses asked whether they had any pain and were offered appropriate analgesia. Care plans confirmed this.

People were supported to express their views and be actively involved in making decisions about their care. Residents' meetings were held and their relatives could also attend these meetings if they chose. People were asked if they wished to be involved in residents' meetings and for their relatives to be invited and this was documented in their care records. People's care plans were reviewed monthly with people and their consent was sought. Where people needed independent support to review their care, then they had access to an independent advocacy service.

People's privacy and dignity were respected and promoted. One person was cared for in bed and required total nursing care. The staff demonstrated respect, ensuring the door was kept closed when attending to their needs and covering the person with a sheet whilst washing them. Staff talked to them and explained what was happening, even though the person appeared unable to understand or respond. People we spoke with found staff respectful. One person confirmed that staff treated him with respect and care. A relative referred to staff and said, "They come very close to him and tell him what they are going to do, very gently".

People were supported at the end of their life to have a private, comfortable, dignified and pain-free death. The service had links with a local hospice who provided advice and support about palliative care to care staff. Staff explained about advanced care plans and their understanding of how people wished to be cared for as they reached the end of life. One advanced care plan documented the views of the person and showed their family had been involved in discussions about power of attorney, resuscitation and whether to involve community nurses such as the palliative care team. Whilst staff had not received any specific end of life training, they were supported by specialists who had. They had training in recognising deteriorating conditions and how to monitor vital signs and administer oxygen if required. When people's care needs meant that higher levels of support or nursing input were required, their care plan was reviewed more frequently than on a monthly basis.

Good

Is the service responsive?

Our findings

As a result of our inspection in July 2014, a Warning Notice was issued due to serious concerns that people were not protected against the risks of unsafe or inappropriate care and treatment because of a lack of proper information about them. Accurate records were not maintained for people that included appropriate information and documents relating to their care and treatment. At this inspection, we found that sufficient steps had been taken and that the Warning Notice was met.

People received personalised care that was responsive to their needs. People were assessed by the registered manager prior to being admitted to the service and were involved in planning their care. The care plans followed the activities of daily living such as communication, personal hygiene, continence, moving and mobility, nutrition and hydration, breathing, pain control, sleeping, medication and mental health needs. The care plans were supported by risk assessments. These showed the extent of the risk, when the risk might occur and how to minimise the risk. For example, a Waterlow risk assessment was carried out for all people using the service. This gives an estimated risk for the development of a pressure ulcer. The assessment took account of risk factors such as nutrition, age, mobility, illness, loss of sensation and cognitive impairment. It enabled staff to assess the risks and then plan how to alleviate the risk, for example, ensuring that the correct mattress was made available to support pressure area care. A review of care plans identified that people's care and treatment was planned and delivered in a way that was intended to ensure their safety and welfare.

Care plans included people's social history, likes, dislikes, social, cultural and religious preferences and end of life plans. All care plans were reviewed and updated on a monthly basis, involving professional support where required, e.g. input from a physiotherapist or dietician and any changes to the care plan as a result of this review were recorded. People's general health was routinely monitored. One relative told us that, "Staff always monitor closely. She's fantastic now". Some people were on frequent monitoring programmes for temperature, pulse, respiration and blood pressure. Other people had routine monthly recording of these observations and care files showed that this was maintained. Everyone had their weight monitored monthly or more often, as required.

Care plans were a good reflection of individual's care needs. They demonstrated that current best practice was taken into account when planning care. People with pressure ulcers were cared for in accordance with the most recent National Institute for Clinical Excellence (NICE) guidance. Each person with a Waterlow risk score of 15 had a tissue viability/wound book identifying the ongoing care to prevent or treat a wound/pressure ulcer. Pressure ulcers are graded according to a number of factors, but in particular depth and size. Grade 3 and above pressure ulcers are reported as an incident to CQC. Professional support from a Tissue Viability Nurse (TVN) was sought for every person with a pressure ulcer grade 3 and above. There were seven people with pressure ulcers at the time of our inspection. The records for one person with complex needs identified that they required full nursing care when they were admitted with a grade 4 pressure ulcer. They had received advice and support from the TVN since admission. Body maps, photos and charts recording progress over time were completed. Improvement to the pressure ulcer could be demonstrated so that the support of the TVN was no longer required. The provider had implemented specific training for staff in relation to pressure ulcer and wound care and another training date 'Super Heals Day' was planned for February 2015.

A number of people were insulin dependent diabetics. The practice in relation to caring for diabetics in accordance with the NICE Quality Standard was delivered. The standard identifies that each service user should have a named member of staff who had been trained in the care of people with diabetes. All registered nurses at the service had been trained in diabetic care and had regular updates. Care plans showed that NICE guidance had been used as there was information about how blood sugar was monitored and a body map for people to identify where insulin was being administered. Changes to where insulin was being administered was made on a regular basis to avoid damage to people's tissue/skin. Staff were trained to administer insulin and, whilst people were encouraged to self-administer; this was not always possible due to their ability to do so.

Daily records were completed for day and night shifts and provided a satisfactory account of how people's needs had been met. For example, they showed the assistance they had been given with personal care, if the person had taken their diet and fluids well, what their mood was like and if they had taken part in any social activities.

Good

Is the service responsive?

People were encouraged and supported to develop and maintain relationships with people that mattered to them and to avoid social isolation. Relatives told us they could visit the service whenever they liked and one said, "I can eat here if I want to. It's above my expectations of nursing homes". Another relative told us that his family member was too unwell to be involved with activities and said that, "Staff know if he's in the right frame of mind, whether he wants to get up or not". An activities co-ordinator worked at the service and spent three mornings a week talking with people individually who received care in bed. Some people enjoyed going out shopping and minibus trips had been organised so people could visit a garden centre, the beach or the Bluebell steam railway. A hairdresser and manicurist visit weekly. Other activities at the service included a fortnightly visit from a Pets as Therapy (PAT) dog, a singer and his electronic keyboard and karaoke. All people were aware of the activities on offer at the service and could choose whether they wanted to participate or not.

The service routinely listened and learned from people's experiences, concerns and complaints. A relative told us that if they had a complaint they would tell the registered manager and said, "She's very approachable, very easy to talk to and I get the impression she would listen to me". This relative said he had seen how things had been improved at the service and felt the registered manager was "on top of things". Another relative felt that communication was good with staff and said, "I leave here and I feel good. I would recommend it [the service]". A noticeboard provided people with information on how to make a complaint, whistleblowing, safeguarding and related policies. The complaints policy was signed by staff to say they had read and understand the contents. Any complaints raised were dealt with in a timely fashion and lessons learned in line with the provider's policy.

Good

Is the service well-led?

Our findings

As a result of our inspection in July 2014, a compliance action was set due to concerns regarding the identification, assessment and management of risks relating to the health, welfare and safety of people and how these were monitored and analysed. At this inspection, we found that steps had been taken and that the compliance action was met.

The service demonstrated that it delivered high quality care. Information in care plans followed the provider's corporate template which was used throughout the service. Care plans were divided into sections allowing easy access to people's information as required. The care plan templates were regularly reviewed and revised. They prompted staff to assess, plan, evaluate, record and review people's care as required. The registered manager audited the care plans, including risk assessments, on a regular basis using a case tracking tool. The audits for the year, July to November, were reviewed on the day of inspection. The audit monitored completion of records and also evaluated the care delivered. The registered manager also monitored the completion of all supporting documentation such as food and fluid charts, daily bed rail checks, mattress checks, hourly observation records, hourly lounge checks and the daily plans for people. This review was carried out prior to the afternoon staff commencing duty. The feedback from the review formed part of the afternoon staff handover demonstrating that continuous review of service user records and care was evident.

A significant change to the service, and across other services of the provider, was the introduction of booklets for people in areas such as nutrition and wound management. For example, a nutrition booklet provided a template that was completed for people individually and included charts to monitor and manage their weight, a nutritional preferences checklist (people's likes and dislikes) and a nutritional care plan. There were sections that staff had completed about what people needed to meet their needs and a section for the chef to make comments. Actions that had been identified were addressed. There was advice on simple steps that could be taken to encourage a person to eat more. This ensured that there was a separate comprehensive plan for people at risk of malnutrition or dehydration and that information recorded was done in a consistent way.

The service had robust quality assurance and governance systems in place to drive continuous improvement. The regional manager undertook quality assurance audits on a monthly basis. Areas such as wound treatment, staffing levels, medicines, staff training, housekeeping and laundry were all monitored. The audits identified where the service was compliant with the provider's company standards. For example scores were colour coded for green – with a high level of compliance, orange which identified moderate concerns and red where major concerns were identified and urgent action needed to be taken. The audits showed that the service had overall performed well and no major concerns were evident. Where action needed to be taken, for example, that staff training was up-to-date, the registered manager had arranged for training to be delivered.

People were involved in developing the service, for example, people could, if they wished, be involved in the interviewing process for new staff and could ask their own questions. Residents' meetings were held and relatives were also invited to attend these. The chef said that people often "popped to the kitchen door" if they wanted to talk about food choices or had any concerns. Meetings covered a range of areas for discussion such as staffing and menu planning. People said they thought the service was well led. One person told us, "It's very good, very friendly, smiling, staff work well together". Another said, "For me it's okay. I'm satisfied. They take me anywhere I want to go". A relative told us, "I wouldn't change anything, he's very well looked after. It's brilliant. We saw five or six homes before we saw this one, which was the best. As soon as you walked in, you knew".

A questionnaire had been sent out to relatives in August 2014 and eight had been completed and returned. The questionnaire addressed areas such as 'appearance, welcome and friendliness of home, cleanliness, odours, décor and furnishings'. Whilst the overall analysis had yet to be completed, since the registered manager was awaiting more completed questionnaires, the overall results were positive. One relative had written, 'I found the home warm and clean with a lovely smell of lunch cooking. It was obvious from the decorations that the festive season was here and the staff were warm, friendly and welcoming'.

The service promoted a positive culture that was personalised to meet people's needs. The registered manager said that behaviours of staff were ingrained

Good

Is the service well-led?

during the induction process. Staff were questioned on how they communicated with people based on their individual needs. For example, a person experiencing dementia might find it less confusing to make a choice between a red jumper and a blue jumper, rather than being asked what they wanted to wear. One person told us, "Here you can do what you want to do, they never force you. You can please yourself".

The service demonstrated good management and leadership. Staff knew and understood what was expected of them. In addition to the handover meetings held throughout the day, staff had attended team meetings or had group supervision meetings. These were held on a quarterly basis. Topics such as training, infection control, discussion and reflection on accidents and incidents had been shared with staff and recorded. There were separate team meetings for night staff, nurses and kitchen staff. Questionnaires had been sent to staff to ask for their views on the service. Eleven completed questionnaires had been received. A strength of the service was described as 'teamwork' and a weakness had been identified as 'lack of communication'. The registered manager had addressed this by ensuring that staff attended handover meetings at the end of their shift. The registered manager and senior staff attended these meetings and could then update and meet face to face with staff to listen and discuss any issues they might have and update them on developments. A registered nurse thought that there was better communication now. Staff knew how to raise any concerns and were aware of the whistleblowing policy.

The registered manager was engaged at all levels of the service. On the second day of our inspection she was supporting and encouraging people at the Christmas party. When we asked her what she thought was 'good' about the service, she told us, "I just think it's a lovely atmosphere – good food and good choice." She felt that she had been key to implementing many changes at the service since she became registered manager and had seen the improvements that had resulted. The registered manager felt supported in her role by the senior management team and said, "Definitely, things have changed for the better" and felt that her suggestions were listened to and acted upon.