Stowlangtoft Healthcare LLP

Stowlangtoft Hall Nursing Home

Inspection report

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Date of inspection visit: 11 January 2016
Date of publication: 19/02/2016

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 the 11 January 2016 and was unannounced. The last inspection to this service was on the 22 September 2013 and we found the service to be meeting the standards required.

The home provided residential and nursing care to up to 47 older people. At the time of the inspection there were 34 people.

There was no registered manager at the service but there was an interim manager and the provider was working hard to appoint a full time manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

This was a well-managed service run in the interest of people using it. People felt safe and there were processes in place to help maintain people's safety such as robust recruitment processes and adequate training for staff so they had the skills to identify where someone might be at risk and what they should do about it.

Risk assessments were completed and showed the home were proactive in taking steps to reduce the likelihood of accidents/incidents or other factors which might result in avoidable harm.

Medication processes were mainly robust and medicines administered by staff who were adequately trained to do so.

The home had enough staff but at times people felt their care was compromised by having to wait particularly in the morning. Staff said there were enough staff other than if staff rang in sick as short notice. They said they were able to meet people's needs in a timely way.

Improvements were being made in the way staff were supported particularly through their induction/ probationary period. Staff received the necessary training to ensure they had the skills and competencies for their role.

Staff supported people lawfully and care was provided safely in accordance to people's wishes. Where a person lacked capacity staff knew to support the person in their best interest and do this collaboratively.

People's dietary needs were being met and improvements in the way food was presented and received were reported.

People had their health care needs met and staff were identifying changes in people's needs and reporting them accordingly.

Staff were kind and caring. They promoted people's independence and respected people's right to determine how they wished their care to be provided.

People were regularly consulted about their own care needs and asked for feedback about the service delivery. This enabled adjustments to be made so people got the service they wanted.

People's needs were recorded and information gathered was constantly reviewed and added to. This provided the basis for personalised care which met people's needs.

The home provided opportunities for people to have meaningful engagement, stay connected with their past and provide sufficient mental stimulation. Staff were sensitive to people's needs and gave opportunity for reflection, celebration and learning and retaining new skills in an imaginative way.

The home was led in a consultative way where the value and contribution of each staff member was recognised and contributed to the provision of a service that had all the hall marks of excellence.

The provider engaged positively with the inspection programme and showed a real passion and enthusiasm to be the best they could be and address anything brought to their attention and through their own auditing processes.

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 is safe.

Staff recruitment processes were robust.

Staffing levels were experienced differently with some people feeling there were not always enough staff at all times but the provider had a robust system to determine staffing levels.

Medication practices were good but some improvement around individual medication protocols was being put in place.

People were kept as safe as possible through a robust risk assessment framework where risks were identified and positively managed.

Good

Is the service effective?
The service was effective.

Staff had the necessary competencies and skills.

Staff were supported with their professional development. Improvements to staff induction processes were being implemented.

People were supported to eat and drink enough for their needs.

People were supported and involved in decision making processes.

People's health care needs were monitored and met in the home.

Good

Is the service caring?
The service was caring.

Staff supported people appropriately and a treated person with respect and dignity. People's independence was encouraged as often as possible.

Staff engaged with people, asking them to tell them how they wanted their care and support to be provided so care was centred around their wishes.

Good

Is the service responsive?
The service was responsive.

We saw many examples of how staff had incorporated activities around people's wishes and they provided opportunity for meaningful engagement.

The home engaged with the community in the interest of people using the service and to provide them with an enriched experience.

Care was provided round people's individual needs and staff were sensitive to people's background.

Good

Is the service well-led?
The service was managed in an open consultative way.

Good

Summary of findings

Quality assurance systems were used to determine where improvement was required.

People's needs and wishes were paramount and determined how the service was run.

Staff all had the necessary skills and worked together to enhance people's 'lived experience.'

Stowlangtoft Hall 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 the 11 January 2016 and was unannounced. At the time of our inspection the service was without a registered manager but there was an interim manager in day to day control.

Before the inspection we looked at information we already held about the service; including the previous inspection report and notifications which are important events affecting the service which the provider must notify us of.

The membership of the inspection team included four inspectors one of whom was on induction.

During our inspection we spoke with one visitor, twelve people using the service, eleven staff, including three nurses, the deputy manager, the acting manager, the house keeper, the chef, activities coordinator and care staff. We also spoke with three of the provider/owners. We carried out a medication audit and observations of medicines and care practices. We looked at records in relation to staffing, care and the management of the business.

Good

Is the service safe?

Our findings

The provider had clear systems in place to recruit staff that helped keep people safe. Relevant checks were carried out before a new member of staff was employed including a Data Based Search (DBS) for criminal convictions, and two satisfactory references. Staff had to complete mandatory training before they were able to support people with moving and handling. Newly appointed staff had to complete a probationary period, which included regular supervision and observations of their care practice.

People we spoke with all told us that they felt safe in the home. One person told us, "I've always felt safe here." Another person said, "Yes I do feel safe in the home. Staff never try to restrict what I do."

Staff spoken with were aware of their responsibilities in terms of safeguarding people from harm. All knew about whistleblowing and reporting suspected abuse. All felt able to raise concerns and felt the management team were responsive. Staff felt able to raise concerns outside of the organisation if necessary.

The home had not had any recent safeguarding concerns raised against them but had raised a safeguard against another professional where they felt they had not upheld the persons rights and safety., This meant they understood the processes and were not afraid to challenge poor practice. One staff member told us they had raised concerns and this was addressed immediately by management.

People told us that they were happy with the way that staff managed their medicines. One person told us, "I get my tablets at regular times." Another person said, "I get my medicines when I need them. My pain is well controlled."

Nursing staff administered people's medication. They received medication training and an assessment of competence. The competency assessment was repeated annually. There were systems in place to audit controlled drugs on a daily basis. An audit of the management of medicines was carried out by one of the owners every month.

There were medication profiles for every person in the medicine administration records (MAR) folders. The profiles were very person centred and described how people liked to take their medicines and the support they needed to take them safely. The usefulness of the profiles could be improved if information on the common side effects of the medicines were added. One person was taking all their own medicines and a few people were using their inhaler when they needed to. Risk assessments were in place and people's ability to take responsibility for their own medicines safely had been assessed. One person wished to continue taking some over the counter supplements when they were admitted to the home. Staff had checked the safety of the supplements with their GP and administered them to the person with their other medication.

We observed part of a medicines round. Staff were only signing the MAR when they had administered and checked that the person had taken the medicines. Staff did not have protocols for administering medicines that were given when the person required them, rather than at set times, referred to as PRN. This increased the risk that the medicines would not be given in a consistent way by different staff. Staff were not giving evening medicines to people if they had already fallen asleep even when the medicines were not prescribed 'as required'. They said that they would discuss the timing of the medicines with people's GPs.

Qualified staff could administer PRN documenting on the medication charts why additional medication was needed. However, they did not record the effects of the medication in the space provided. This meant that staff did not assess how affective medication had been. Staff did not know what formal assessment they had available to measure pain. The Abbey pain scale, which is an instrument designed to assist in the assessment of pain in people who are unable to clearly articulate their needs, was found in a folder but not used in assessments of pain. Staff told us that they asked individuals to assess their pain on a scale of one to ten, with ten being the worse pain. This did not take into account a person's ability to communicate. This meant that they did not measure individual pain acuity and did not formally recognise patterns of pain-associated behaviour.

Staff locked medications safely in a locked trolley in a locked room. The home had a system in place for receiving and disposing medications safely with the pharmacy provider. This ensured that medications were kept in date and did not run out. Fridge and room temperatures were monitored every day and we saw these were completed.

Good

Is the service safe?

Bottled medications and creams were labelled with opened and dispose of dates in line with safe practice. The local GP carried out medication reviews for residents twice a year and if individual needs changed.

The provider had a safe system in place for managing controlled drugs. Night staff completed controlled drug audits and we saw evidence that staff were identifying errors and communicating these to colleagues. The manager undertook comprehensive investigations into medication errors and a monthly medication audit. Photographs of medication cards, witness statements, and statements by individuals who had made errors were taken to support investigations. Errors were considered a learning opportunity, and Individual's completed reflective accounts of why an error had occurred and how to minimise the risk of these happening in the future. Staff told us that they felt able to report any errors they made.

Qualified staff had a good understanding of how to manage risks. We saw from people's care plans that there was a range of risk assessments related to individual needs, such as moving and handling and falls prevention.

We looked specifically at pressure care and saw this was well managed. People were weighed and had a full body check on admission. This would Identify any sores or issues around skin integrity. Equipment was supplied as required to prevent tissue damage. Skin assessments and risk assessments were updated monthly as well as daily visual checks and regular repositioning of people identified as being at risk. No one had pressure sores. One person who had them in the past told us they had been successfully healed, this was confirmed by their notes.

All carers were given a handbook when they started. This included a clear and helpful section about pressure sores what to look out for, prevention & treatment and included pictures of pressure ulcers of varying grades.

Staff told us that people who had falls and were at high risk of further falls had been referred to the falls prevention service for advice. People who had fractures following a fall were automatically referred to the falls prevention team by the hospital. Staff described the steps they took to reduce the risk of people having further falls. This included making sure that they had appropriate footwear and walking aids. Pressure mats were occasionally used to alert staff if people got out of bed or out of their chair. They were only used if people had poor balance so were at high risk of falls and sometimes forgot to call staff for assistance when they wanted to move.

We spoke with people about staffing. One person told us there were lots of new staff at the moment. They said, "You have to wait but I don't think it's long although, it seem like it at times." One person told us they did not think there were enough staff. When asked for more information they said mornings were busy and they had to wait. A third person also commented on staffing and felt the response to the call bell could be slow. There was no way to quantify this as the call bell response times were not recorded. Throughout our inspection call bells went off frequently but were always answered quickly.

Lunch was served efficiently although there were few staff in the dining room and they did not routinely sit with people which may have enhanced the dining room experience for some. At lunch time there were about half the people using the service in the main dining room. One person told us they did not come to the dining room for their meals because they felt embarrassed. This could result in people becoming socially isolated.We received a complaint from a relative who stated people could spend a long time in their room and were not being encouraged to socialise. This complaint related to care provided in Spring 2015. The provider has now put steps in place to address gaps in activities provision."

Another person told us, "I have to sit in a wheelchair with my feet dangling if I go downstairs for meals so I prefer to eat in my room." Because staff failed to fit foot plates to the wheelchair to aid comfort this person chose to isolate themselves. Also, not using foot plates is poor practice and could potentially put people at risk of injury.

Staff told us shifts were well organised. A shift planner was in place which stated which area staff were allocated to and included scheduled breaks so there was always adequate cover on the floor. The manager said they monitored staff sickness carefully and completed back to work interviews with staff. One staff told us, "When fully staffed, eight in mornings and five in afternoons, you can do everything without feeling under pressure." They said it was sometimes difficult to get cover for last-minute

Good

Is the service safe?

sickness absence. There were no bank staff that could be called in easily. They said they tended to get the same agency staff when needed and any concerns about agency staff were acted upon.

Staffing was adequate on the day of our inspection. The home had an interim manager in post covering two homes and there was an advert out for a new manager. They told us they were well supported by the owners who had a daily presence in the home and worked in a supportive way.

They reported some agency usage, particularly at night. To overcome this they now required their nurses to work a rotating shift both day and night which helped with continuity of care. Apart from the managers vacancy there were no other vacancies. Staffing was determined according to people's assessed needs.

Good

Is the service effective?

Our findings

One person told us, "Staff seem to know what they're doing." Another person said, "I feel the care staff are experienced and there's always a nurse in the home."

Staff had the skills and knowledge to provide appropriate care and support to people. The provider had recently introduced the care certificate as part of their induction programme for unqualified new starters. The care certificate, launched by Skills for Health in 2015, supports staff to achieve competence in 15 essential standards of care. The Department of Health recommends that providers implement the care certificate, but it is not a mandatory requirement. Staff's knowledge and skills were kept up to date. Staff received financial reward for undertaking further study and there was a high uptake of this. Recently many staff had been trained to use a defibrillator held at the home. Nurses had undertaken recent medication training and a refresher course on using a syringe driver.

We asked about staff about their training. They told us they have annual mandatory training. Including manual handling, safeguarding of vulnerable adults, Mental Capacity Act and Deprivation of Liberties and infection control. Other training opportunities were advertised to staff e.g. 'Dispelling the myths' course that consists of staff going to funeral directors for a talk about the procedure followed when someone has died. This included a visit to a crematorium and a green burials ground.

Lead roles for staff were not clearly established partly due to changes in the staff team, one staff member told us they would be taking a lead role in infection control, one staff was the medication champion and others areas had been identified where there would be a lead role such as dementia champions and dignity champions. Their role would be to support staff and promote good practice in these key areas.

Staff told us they felt well supported, although changes in management and currently having a manager oversee two services had impacted on the level of formal support staff received. Face to face supervisions had not been as regular, but going forward these were planned in for all staff. Annual appraisal dates were also in place. Clinical supervisions for the nurses were in place every two months and trained nurses were supported with their professional development and revalidation with the nursing and midwifery council to ensure they continued to be fit to practice.

People were supported to eat and drink enough for their needs. One person told us, "They ask you what you want off the menu." One person said, "The food is very good. There are choices but it's not quite like home cooking." Another person, who usually had their meals in their room, told us, "The food's quite good. The only thing I could complain about is that hot food should be hot and not lukewarm and lettuce should be crisp not floppy."

The catering staff showed a good understanding of people's dietary needs and had worked hard to accommodate people's individual dietary requirements. A lot of attention went into the choice and presentation of the food, particularly where people might have pureed food. The chef went into great details of how they tried to balance colours and tastes. One person we spoke with described the food as, "A piece of art."

The chef told us how they promoted people's weight by knowing people well and preparing food from fresh, fortifying it as required and making homemade milkshakes and smoothies to add calories. They told us they took round ice cream and fruit flavour jellies. We observed lunch and saw that people were offered appropriate choices of meals and their individual preferences were accommodated, nothing was too much trouble. For example people were enjoying glasses of wine if they chose and there was a range of soft drinks. Gravy was offered and not assumed people wanted it. One person asked for more vegetables and this was immediately accommodated. Staff told us they had raised this with the kitchen who made a note to ensure in future this person who was described as having a 'large appetite' would be offered a bigger portion. The ambience in the dining room was pleasant. With people socialising in small groups. However, the dining room was only about half full and staff, although kind, were busy and did not sit with people or encourage conversation. One person told us they were too embarrassed to eat in the main dining room and we asked the provider if they ever hosted smaller dining room experiences. They said there were other rooms which were available and could be used by families or to host smaller gatherings.

Good

Is the service effective?

Improvement was identified in the way people were offered a choice of food. We felt some people might benefit from either a pictorial menu or a visual choice of two plated alternatives. The provider said this would be done with the input from the chef and activities coordinator. They also suggested they might introduce placing serving bowls on the tables.

People's weights were monitored and the home had a designated nutritional champion who had an educational background in nutrition. At the time of our inspection there was no one specifically on food or fluid charts so it was difficult for us to assess if people always had enough to eat and drink for their needs. Daily records sometimes indicated where people might have missed a meal but information was not in sufficient detail for us to ascertain how much people were eating and drinking. We discussed how this information might be collated along with a weight tracker.

The provider has since devised a record of people's needs using a traffic light system, which indicates those at risk and where there is an emerging risk maybe as a result of an infection or sickness. People's needs were discussed daily and a nurse oversees people in their care and reports any changes. This document will help provide the information visually and the information links risk to actions taken to safeguard people from dehydration and, or malnutrition.

Qualified staff carried out formal risk assessments using nationally recognised tools including the Waterlow score for assessing the risk of developing pressure ulcers and the Malnutrition Universal Scoring Tool to assess risks associated with nutrition. However, two people had been identified has being high risk for malnutrition and interventions included to be weighed weekly. We found that weights had not been recorded for two months. We brought this to the attention of the deputy manager who explained that the provider had recently invested in a new computerised notes system. This had only been working for a few weeks, and information was still being transferred onto the new system. On checking the records, we noticed that for the two individuals in question, risk had reduced because they had gained weight.

People's health care needs were met. A person we spoke with told us, "I see the doctor when I need to." Staff told us that they had, "fantastic" support from the local three local GP surgeries during the day but that there could be problems getting out of hours support People had access to the dieticians and to the speech and language therapists if there was a problem with their weight or they had swallowing problems. People also had input from the local mental health team if there were concerns about their mental health. Staff also had access to clinical nurse specialists when specialist nursing advice was needed. People had regular chiropody and checks of their eye sight. Some people attended a local dentist others received dental care in the home. Staff had received training on how to support older people with dental hygiene.

Staff were acting in consultation with people to ensure their rights and needs were upheld. People told us that they were always offered choices. Staff received training in the Mental Capacity Act and in Deprivation of Liberty safeguards. People had mental capacity assessments that assessed different conditions that could impact on their mental capacity. It also identified the help they might need to increase their ability to make their own decisions.

People's records included details on any restriction and why it was in place. This included a discussion with the person and, or relatives. For example where bedrails were in place. In the care summary in people's care plans there were details of when and how decisions were made in the person's best interest and a rationale for this. It also included details if relatives had a lasting power of attorney for welfare and, or finance and whether it was active. The provider had identified one person whose liberty was restricted. They periodically wanted to leave and would not be safe to do so. The home had made an appropriately application to the Local Authority to deprive the person of their Liberty to ensure their rights were upheld. One person liked a very hot hot-water bottle. They had mental capacity and had signed a form accepting the risk. This shows that the service respects people's rights to make their own decisions, even those that seem unwise. There had been an annual review of the capacity assessment.

Good

Is the service caring?

Our findings

People were mostly complimentary about the staff describing them as, "very kind and helpful" and "particularly nice and very friendly". One person told us, "The home is very nice, the staff are wonderful. The care staff are extremely nice and caring." One person told us how they sometimes needed help with personal care and how they could get into a muddle. They said, "Staff might think me stupid, but they never say it, I feel like I am home and surrounded by family."

Another person told us, "Nothing is too much trouble for them." Another person said, "I get wonderful care but one or two staff can be over strict. I'm made to feel that I should make more effort. It's extremely easy for them to forget what I can't do when they are busy." One person told us, "Staff are nice but there are a few exceptions." They told us they would raise a concern where necessary. Another person said to us, "Not all staff are so patient." They told us staff were busy which they felt contributed to this

People told us that staff treated them respectfully and treated people's rooms as their private space. One person told us, "If I shut my door they respect my privacy." Another person said "They cannot do enough for you". They confirmed that staff treated them with dignity and respect, as illustrated to us by the deputy manager knocking on the person's door and asking whether they would be happy to talk with a CQC inspector.

Staff were able to give examples of times when they supported people's choices and independence even when this, at times, carried an element of risk to them. For example, one person wished to continue to eat as normally as possible as this improved their quality of life, even though they had swallowing problems.

We observed staff treating people with kindness and warmth and we observed positive relationships. Staff seemed to know people really well which helped them hold appropriate conversations. The house keeper told us how they had helped a person make a posy for their very ill spouse, who died soon after. The posy was the last thing the relative was able to give their spouse and this meant a lot to them.

People had detailed social history's that also recorded individual preferences, hobbies, likes and dislikes. One person was identified as enjoying painting. The care plan told staff of what to do when the person had run out of art supplies. Staff spoke of people in their care with warmth and compassion.

Care plans were person centred and detailed information that supported people to maintain their individuality. For example, one care plan identified how a person liked to have hair clips in her hair and another identified that a person preferred to be called by their title and surname. We observed staff addressing this person in this way respecting their wishes.

All care plans reviewed documented death and dying preferences had been considered. For example, access to the a named priest, identification of a funeral director and who should be informed in the event of death in the home, such as family and friends. People requiring end of life care were treated with dignity.

People told us they were consulted about the service they received and we saw people's preferences were recorded. There was engagement with people through one to one interactions but also through resident/relative meetings. However the manager said these were not well attended, but there were other means to engage with people. We were told about how the home tried to identify what people's experiences were where they might not be able to say. For example one person regularly ate in their room. A staff member carried out an audit identifying how quickly the person got their meal, the level of interaction from staff and if the person's dining experience could be enhanced in any way.

Good

Is the service responsive?

Our findings

We spoke with people about their care and people told us they had a choice in terms of their routines and care preferences. One person said, "Yes I can get up and go to bed when I want, the staff are nice." They said staff help them to go downstairs to join in with activities. They said that staff were responsive to their needs. One person said, "They provide my care how I like it." Another told us, "Staff treat me as an individual." People told us that they were consulted when their care plans were updated. One person told us, "They discussed and revised the documents about what sort of person I am and what I need." Care plans were very well personalised to the individual person's needs, preferences and abilities. They included discussions about advanced care planning so that staff could record the care that people wanted towards the end of their lives.

Qualified staff completed monthly reviews for everyone's' care needs. However, not all information was on the new computerised system. Staff told us that they were still getting used to the new system, but felt confident that they would, "Get the hang of it." We found that some risk assessments identified when a person was high risk, but did not detail in the space provided the intervention to manage the risk. However, these had been documented within the care plans comprehensively. This meant we had to search to find the information that was needed as it was not clearly documented. We also noted a couple of minor discrepancies such as (female resident noted as 'male') and wrong date of admission. Where data had been entered incorrectly this was fed back at the time. Record audits were in place so hopefully minor discrepancies could be addressed. In addition care plan audits included a new care plan checklist to ensure information was in place with 12 hours of admission. The manager spoke about a seven day record for people newly admitted to the home to establish more accurately their level of need. This was not in place for everyone only where risks had been identified prior to admission.

Risks to people were documented and we saw individual weight records. If a person was considered at risk of not eating or drinking enough for their needs, they would be weighed more frequently and a more detailed record kept of what they eat and drank. The provider said there are regular meetings with the nurses and members of the management team to discuss individuals, to highlight any concerns and to consider what actions were in place to address these. However, in the absence of a weight tracker over a six month period it was difficult to see how there was adequate management clinical oversight of weight loss over a period of time. Instead it was up to the skills of individual nurses to recognise, act and report on changes to people's weight over a period of time. They were supported by a staff member who came from a nutritional background.

Staff effectively looked after people with complex health needs who required additional physical monitoring. This included people who needed medicines to prevent blood clots, and manage diabetes. Risk assessments and care plan interventions clearly identified these peoples' needs. However, we case tracked one person who was regularly receiving additional medication for anxiety over a five-day period. Staff had not recorded this in the person's daily notes, and we could not see if treatment had been effective and whether the cause of anxiety had been monitored and reviewed.

Evaluating people's care depended on the quality of information and we found this could be improved. For example we saw very limited information about how people had been at night such as 'Appeared to sleep well.' Information about fluid intake was not always as robust as it could be. An example, entries encouraging staff to ensure people always had access to fluid, but not if they were always taking enough fluid. One entry (in their care notes?) told us the colour of a person's urine was normal and later the same day an entry read urine remains dark in colour. There was no further information about how this should be managed or reviewed.

Staff told us there was a handover of information following the end of each shift and at the beginning of a new one. There was also a written handover book so information about each person was known. Staff said there were not always kept up to speed about people's needs, particularly if they had been off for a while. This may have been because staff were not accessing the care plans which had the most up to date information. One page profiles were being introduced which would help staff unfamiliar with people see at a glance what their main needs were. The provider said this also helped staff to begin conversations and help the person have a great day. The provider told us they were doing this properly so it took time to implement. Life stories were being put together and staff were taking

Good

Is the service responsive?

time to talk to the person and their family to build up an accurate, representative picture of the person's life. Staff would still need to view the full care plan for more detailed information. There was also a one page medication profile for people which gave a good overview of the person's medication needs at a glance.

The homes Annual quality assurance survey April 2015- showed activities were an area which could be improved upon. The home had a full-time activities co-ordinator who worked alternate weekends as well as weekday. They took over full time as activities co-ordinator last October. Activities were not solely provided by the person organising them, there was usually a carer assigned to assist with afternoon activities and other staff participated in some, including dressing up as father Christmas and elves at Christmas. The provider encourages staff from other parts of the service to get involved in activities for example, the housekeeper ran a silver cleaning session. This enabled people to gain pleasure from care of treasured possessions. One person brought a silver necklace that contained a picture of their spouse and another person was able to polish up their war medals.

The gardener was creating a sensory garden and provided grow bags last year that people planted with strawberries and tomatoes which were then served up in peoples' meals.

Staff, including kitchen staff were encouraged to come and chat with people such as on their breaks.

The home did all they could to keep people engaged and reconnected with their pasts. An example given to us was that people were asked last valentine's day to write what love meant to them and people's very personal experiences that they had chosen to share was displayed as a visual reminder of the importance of love.

One person said they did not feel there were always enough activities but did join in what was available. One person told us that they had a sensory impairment and found it difficult to join in things. They said they did enjoy the companionship of staff, but they did not always have much time to spend with them. Fortunately they told us they had family locally so were well supported. They said, "Yes I do get bored." Staff told us there were more activities now and people really enjoyed them. People were aware of the range of activities in the home and told us that staff encouraged them to join in when they wanted to. One person told us, "There's always plenty to do in the home. I get a sheet telling me what's on every week." People chose whether they wanted to join in the activities. One person told us that they found joining the activities, "A bit of a struggle." but did say, "I went out to the seaside and it was a great experience. I loved getting out in the fresh air." Two hairdressers visited the home. A beautician provided manicures, hand massages and facials and one person received reflexology.

The home had support from the local community, volunteers and the cadets. A dozen or so people using the service went into a local school and had Information technology lessons learning how to surf the net. This intergenerational experience was said to be of huge benefit to all those who participated. The provider told us iPads were available for people to use and commented on a person who played international bridge this way.

Quarterly Residents' meetings enabled people to give their views and feedback. In the last meeting more outside entertainment, especially speakers, was requested. The activities co-ordinator had accordingly arranged outside speakers and musical entertainers on a monthly basis. People could pick which topic they would like to hear about. Nutrition and hydration week was last March and a local bee-keeper brought in some honey and gave a talk about bee-keeping. They have also had guest speakers to talk about the history of the service and life as an evacuee.

People were given a choice of whether or not to celebrate their birthdays; Jehovah's Witnesses do not celebrate such events. If they wanted to, people received a card from the staff and can choose what sort of birthday cake they would like, which included a diabetic option. Night staff decorated the person's bedroom during the night with birthday banners for them to wake up to. The person's selected cake was brought on the afternoon tea trolley and staff gathered around to sing 'happy birthday'. The service also supported family celebrations, for example a family birthday party was held in the Orangery last summer.

The life histories for people were one way that staff could help people stay reconnected to their past. One person was a model railway enthusiast and was supported by volunteers to engage their passion. The home has on loan a 1950's Hornby 00 gauges.

Good

Is the service responsive?

One person's cat was brought in for visits. The home accommodated gender specific activities such as a games evening, trips to the pub and knitting sessions.

The home had an activity programme and copies were in people's rooms. The home also produced a quarterly newsletter to keep people and their families in touch with what was going on. There were trips out including a trip to Felixstowe and Bury St Edmunds. Volunteers included visits from local school children. The home held an annual cricket match involving the wider community; it was held in the grounds of the home, within sight of the dining room and some of the bedrooms. The cricket pitch was close enough for people to sit outside and enjoy the match if they wanted to. It is also local community event

People felt listened to. One person told us, they did have some concerns, although would not tell us what. They said they had been advised to raise them with the manager which they said they did. They said the manager had listened and took appropriate actions immediately to address their concerns so said they were satisfied. They told us they could raise concerns privately or at the residents meetings but said these were held infrequently.

The complaints procedure was on display in the home. There was a record of complaints and the actions taken to address them. One of the nurses said that they tried to address any small concerns before they became more serious complaints. However, staff did not document concerns. This meant that a person might have the same concern addressed repeatedly by a number of different staff and, if this was not documented and communicated to all staff it would be a continuing annoyance to the person who raised the concern. This would also mean that the management team would not be able to use the concerns as part of their quality assurance systems in order to improve quality of services and care. Although people told us that they did not have any complaints, one of them told us that sometimes the bathrooms could be, "rather cold." Staff told us that they would be happy to raise any concerns with the management team and know that they would be addressed.

Good

Is the service well-led?

Our findings

One member of staff who had worked in the home a number of years considered that standards had improved in recent years. They said that the décor of the home had improved and people now all had adjustable profiling beds. This made it easier for staff to provide care and support to people in bed and to adjust the beds in line with their needs and medical condition.

One person we spoke with told us, "I'm full of praise for the home. I can't fault it." Another person said, "Staff get on well together, which is good. The management is pretty good and the owners are helpful and kind." A third person told us, "This is a better home than the last one I was in." A member of staff described the home as, "A friendly, happy home with a warm atmosphere." Staff told us that they felt well supported by the management team and the owners. One member of staff said, "We have a brilliant team. Communication is very good."

The management team used different methods to ensure that staff received up to date information. This included emails, memos on notice boards and reminders in with their timesheets. Staff described the management team as "very approachable". One of the nurses told us, "We can call the owners 24/7. They are in the home most weekdays and come in occasionally at weekends." One of the staff said, "We get of lot of new residents from recommendations. If you have happy staff you have happy residents. I look forward to coming to work. I would recommend the home to my own relatives."

Staff felt able raise concerns. They were aware of the whistleblowing procedures and how they would implement this. The providers, which were a family based team, was able to demonstrate that they had used the disciplinary policy when appropriate to ensure the safety of people. Staff and people knew the owners and said there was a real family ethos and each family member/owner were very hands on and proactive.

The provider had robust quality assurance systems in place which they used to drive continuous improvement. For example, they had recently implemented a new supervision system as they had found that they had been unable to meet their target of supervising staff every 4-6 weeks. The new system had identified clear lines of supervision and this had begun to work well. We saw that long standing staff had received yearly appraisals.

Annual surveys were circulated to people using the service and their families and action plans showed how the management team were addressing concerns if raised. We suggested, in the absence of night time care audits, that it might be beneficial to specifically ask people if their needs were met at night as currently there were no questions around this. We also suggested that an audit be developed for people who are only at the home a short time for a period of respite care. This has since been implemented.

The manager told us how they spent their time currently between two care services but how there was always a management presence in this home and regular daily communication. The deputy manager was well qualified and had enhanced care and management qualifications. The manager completed a weekly management report which would highlight anything affecting their ability to run an effective service such as a reduction in staff due to vacancies or sickness. Provider/managers audits were transparent enabling us to see how concerns were being addressed.

Improvements were being made in relation to people's records including the introduction of a one page profile. Life history and tools specifically in place to identify risks to people using the service in terms of their personal care needs and safety.

The provider had embraced the care certificate programme launched by skills for health as part of the providers induction programme for staff without qualifications in care. They provided staff with an incentive to complete the written work in their own time with an additional payment. The provider supported staff to undertake additional training such as NVQ in care. In seven staff training files we saw evidence that staff had received additional training such as blood takers courses. The management team expressed their commitment to staff training stating that they had seen the value of this in the care that was provided to people.

The provider had invested a lot of money in installing an electronic records system and was still to train the care staff in its use. This was being done in stages to minimise any

Good

Is the service well-led?

disruption and to ensure staff received adequate training. The home were still maintaining a paper record until such a time that everyone could successfully use the system. It was too early to judge the effectiveness of the system.

The provider told us how they continuously tried to improve their service and to take on feedback. We asked for an example and they told us handrails had been installed in one area of the home and new signage had been introduced to help people familiarise themselves with certain areas of the home. They attributed part of their success to working as a team. This family run business had all members of the family making a contribution. The families own grandmother was a resident at the home and the mother supported her children in the running of the business. The mother was particularly knowledgeable about the history of the home and the local area and had given talks to people using the service. They told us they spent time with people learning about their life history. They said this could take hours, but gained peoples trust.

Staff had been nominated for the Great British Care Awards and said two of their staff won awards at Regional level, both the housekeeper and a new carer will now be entered for the National Awards. In addition : One carer had reached the last five of the UK's National Care Awards Carer of the Year in 2015. Staff were encouraged to act in an inclusive way and across different roles to ensure people's needs were met in the fullest way possible. A suggestion box was another way the provider encouraged feedback to enable them to take actions to improve the service. We found the provider extremely responsive acting immediately on any suggestions made.

The providers engaged well with the local community and supporters of the home. One recent example was a quiz night held on behalf of raising funds for a local hospice. They raised over £700.00. This was well supported by people using the service, their family, staff and members of the local community.

The acting manager told us how they worked closely with other providers to improve the quality of the care they were providing. For example with the local hospice. The local hospice ran a 'pain management' conference hosted by the home and was open to all staff.