New Century Care (Ash) Limited

High View Oast Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection visit was carried out on 15 and 16 September 2015 and was unannounced. The previous inspection was carried out in February 2014, and there were no concerns.

High View Oast Nursing Home is a converted Oast house, which is registered for 33 nursing beds. The bedrooms are situated on both ground floor and first floor, and consist of a mixture of single and double rooms. There is a lift providing access between floors. The communal accommodation is situated on the ground floor and consists of two interlinking lounge areas, a dining room, a small quiet lounge, and a porch area. On the day of the inspection there were 29 people living at the service

Summary of findings

There was a registered manager in post who was not available at the time of the inspection. We were supported by the deputy 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 and associated Regulations about how the service is run.

People told us they felt safe living at the service. Staff had been trained in safeguarding adults, and understood how to keep people safe and were aware of the service's whistle-blowing policy. They were confident they could raise any concerns with the manager, or with outside agencies if required.

There were individual risk assessments for each person, which included the risk of falls, nutrition, the use of bed rails and the risk of developing pressure sores. Appropriate actions were identified and put in place to reduce the risks and moving and handling risk assessments were being reviewed to include further information. Nursing staff ensured that medicines were stored and administered to people safely.

Checks on the equipment and the environment were carried out and emergency plans were in place in the event of an emergency such as fire. People had a personal emergency evacuation plan (PEEP) which were not detailed enough to show how people should be supported with their mobility, to ensure that they could be safely evacuated from the service in the event of an emergency. Regular fire drills had not been carried out since December 2014. After the inspection the service notified us that a fire drill was carried out on 18 September 2015. There had been no analysis of the accidents/incidents since April 2015 to identify any patterns or trends to reduce the risk of re-occurrence.

People were being supported by sufficient staff who had the right skill mix, knowledge and experience to meet their needs. Recruitment procedures were in place to check that staff were of good character and suitable for their job roles. There was a training programme in place and further training had been arranged to address the shortfalls identified in the training matrix. Staff received additional training relevant to their job roles. New staff were given a detailed induction, and were supported through their probationary period.

Not all staff had received a yearly appraisal to discuss their training and development needs. The programme of staff supervision was not up to date; therefore staff were not regularly meeting with their line manager on an individual basis to discuss their role. Meetings were held with the nursing staff, care staff and catering staff to encourage staff to voice their opinions of the service and discuss any issues.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The registered manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Applications had been made to the DoLS department and authorisations had been processed so that people remained safe. When people were unable to make important decisions for themselves, relatives, doctors and other specialists were involved in the decision making process regarding their care and treatment and decisions were made in people's best interest.

People told us there was always choices on the menu and records showed that people were assessed to make sure they received a healthy diet to ensure their nutritional needs were met. People's physical and mental health was monitored and people were supported to see healthcare professionals and visit the hospital when required.

People and relatives told us the staff were kind and respected their privacy and dignity. Staff were familiar with people's likes and dislikes, and supported people with their daily routines.

People's care plans were personalised and contained clear information about people's care needs. Separate care plans were written for each aspect of care, and monthly reviews were carried out. Records about people's end of life care were not always completed and in some cases there was a lack of people's personal histories to ensure that staff would know what was important to them. People or relatives had signed the plans to confirm they had agreed with the care to be provided.

The service was in the process of developing the activities programme in line with individual's choices and preferences. Many people had high nursing needs and were confined to bed or preferred to stay in their own

Summary of findings

rooms. The activities co-ordinator held group activities as well as spending time with people individually in their rooms. Staff greeted people as they went about their duties and people were asked if they preferred to have their doors open to prevent feelings of social isolation.

The complaints procedure was on display to show people the process of how to complain and there was a suggestions box at the entrance to the service. People, their relatives and staff felt confident that if they did make a complaint they would be listened to and action would be taken.

People had opportunities to provide feedback about the service provided. Quality assurance surveys were sent out annually and the recent survey showed that people were satisfied with the service being provided. However, feedback had not been sought from a wide range of stakeholders such as staff, visiting professionals and professional bodies, to ensure continuous improvement of the service was based on everyone's views. Although resident meeting had been arranged, people had not attended although they did join in with other events such as coffee mornings.

There were systems in place to review the quality of all aspects of the service. The service had received a 'mock inspection' from a quality assurance provider and completing an ongoing action plan to address any identified shortfalls. Audits had been completed in medicine management, infection control, wound care and call bell monitoring. The evaluation forms had not always been completed to show what issues had been raised, what action had been taken, and if checks had been made to confirm the identified improvements had been made.

Staff said that the service was well led and they were supported well by the management team. They were clear about their roles and responsibilities and felt confident to approach senior staff if they needed advice or guidance. They told us told us they were listened to and their opinions were taken into consideration.

Records were stored safely and securely. Some records such as the evaluation on the audit process, life histories in care plans and end of life documentation were not always completed appropriately.

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?

Requires improvement

The service was not consistently safe.

Risks to people were assessed but there was not always clear guidance in the evacuation plans to make sure all staff knew how to support people with their mobility in case of an emergency. Staff were trained in fire evacuation and knew what to do in the event of a fire but a fire drill had not been held since December 2014.

Staff knew the signs of abuse and had received suitable training to ensure people were protected from harm.

There was sufficient staff on duty to make sure people received the care they needed. Recruitment procedures ensured new members of staff received appropriate checks before they started work.

People's medicines were managed safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

The programme of supervision, including clinical supervision for nursing staff, was not up to date to ensure that staff had the opportunity to discuss their role on an individual basis with their line manager.

There was a training programme in place and further training, such as mental capacity had been arranged to address the shortfalls identified by the deputy manager.

The management team and staff understood the requirements of the Mental Capacity Act 2005, and ensured that people who lacked mental capacity were appropriately supported if complex decisions were needed about their health and welfare.

Staff were knowledgeable about people's health needs and ensured these were met. A variety of food and drinks was provided to ensure people received a nutritious diet.

Is the service caring?

Good

The service was caring.

Staff understood and respected people's preferences and individual religious needs.

People and their relatives were able to discuss any concerns regarding their care and support. Staff knew people well and knew how they preferred to be supported. People and relatives said they were treated with dignity and respect.

Summary of findings

People's families and friends were able to visit at any time and were made welcome.

Is the service responsive?

Good

The service was responsive.

People and their relatives were involved with their care planning, and the care plans reflected people's individual needs. The plans were reviewed and regularly kept up to date to make sure people's changing needs were being met.

There were some group and individual activities and people who chose to remain in their rooms were included in individual activities to prevent them from feeling socially isolated.

People knew how to complain and there was a system in place to ensure any complaints were investigated and resolved.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

Accidents and incidents were recorded and action taken, however, they had not been summarised to look for patterns or trends to reduce the risk of reoccurrence since April 2015.

Records such as people's life histories, the signing of care plans, end of life documentation and audit evaluation forms had not been completed properly.

People had opportunities to provide feedback about the service they received; however staff and other relevant bodies had not been included.

Quality monitoring systems were in place and shortfalls in the service had been identified, and an action plan was in place to improve the service.

High View Oast 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 15 and 16 September 2015 and was unannounced. It was carried out by one inspector, a specialist adviser with a background in nursing care and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service, and the expert was experienced in older people's care.

A Provider Information Return (PIR) was unable to be submitted by the service prior to the inspection as the form had not been received by the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. A notification is information about important events which the provider is required to tell us about by law. We also looked at information received from social care professionals.

We looked around all areas of the service, and talked with seventeen people who lived at the service. Conversations took place with individual people in their own rooms. We observed the lunch time meals and observed how staff spoke and interacted with people.

We talked with ten relatives who were visiting people; seven care staff and the cook. We also spoke with the deputy manager of the service.

We contacted two health care professionals but feedback had not been received at the time of this report.

The previous inspection was carried out in February 2014. No concerns were identified at this inspection.

Requires improvement

Is the service safe?

Our findings

People felt safe living at the service. People said: "Yes, all safe". "I think I am safe. Everything seems to be okay". "I feel safe here". "I do feel safe, I suppose, it is all safe here". "I feel very safe here". "I've never worried here".

Relatives of the people living at the service said: "My relative feels safe here, and she is". "Yes my relative is safe". "My relative is certainly more safe here that they were at home". "My relative is totally safe". "My relative is as safe as they can be, but they said that they cannot watch him 24 hours a day".

Staff had received training in how to keep people safe. They were able to demonstrate their understanding of what abuse was and who to report issues to if they had concerns about people's safety. They were aware of the whistle blowing policy and spoke confidently about reporting any concerns they may have to their manager and other external agencies, such as the local authority safeguarding team. Staff were confident that any concerns raised to the managers would be acted upon to ensure that people were protected from harm.

Risks to people had been identified and assessed, and guidelines to reduce risks were available for staff. The nurse with the lead role in moving and handling was in the process of reviewing all of the moving and handling risk assessments, to include the use of individual slings and to add more detail to make sure people were being moved safely. The risk assessments were individualised, for example, one person who was visually impaired had bed rails to reduce the risk of falls and as they were unable to use the call bell the bedroom door was left open and staff were instructed to check on them regularly. This person also had to be repositioned and records showed that staff were doing this every two hours to reduce the risk of developing pressure sores.

Risk assessments around people's behaviour were also in place. One assessment stated that the person may 'lash' out if they were uncertain what was happening and the moving and handling assessment emphasised what action staff should take by explaining what was happening, and gaining the person consent before carrying out the manoeuvres, to ensure that the person remained safe.

There were records to show that equipment and the premises received regular checks and servicing, such as checks of the hoists, boilers, electrical system, nurse call system and temperature of the water. The scales to support people to maintain their weight had been calibrated but the syringe drivers had not been done. We were told by the deputy manager that this would be arranged in the near future. The service had recently purchased a new syringe driver (a device to administer medicine for severe pain) but until all staff had been trained on this device, they were currently using two other drivers which had different settings. We discussed the risks that the wrong syringe might be used in error and the service immediately withdrew one syringe to ensure that people would remain safe and use the correct equipment in place.

Emergency plans were in place in the event of an emergency such as fire. People had individual personal emergency evacuation plan (PEEP) which were not detailed enough to show how people should be supported with their mobility to ensure that they could be safely evacuated from the service in the event of an emergency. Staff were able to demonstrate what action they would take if the fire alarm sounded as they had received fire evacuation training, but records showed that a fire drill had not been carried out in the service since December 2014.

There were major plans being implemented to completely refurbish the premises together with a maintenance programme to ensure the premises remained in good order. At the time of the inspection the maintenance team were improving the bathroom on the ground floor. There were several signs warning of this work and apologising for the disruption, and people had all been told of the details of what was happening. People said that any request to mend things were attended to promptly. They said: "The door was broken, but they sent a man to repair it". "You just ask if you need maintenance and the man comes in" A relative said, '"When the stop to keep the door open was loose, I mentioned it and the guy came the same day".

Staff demonstrated they understood the importance of reporting and recording accidents/incidents. The accidents and incidents were recorded and action taken to mitigate the risks. For example when a person had fallen and returned from hospital, the moving and handling and falls risk assessments had been updated, the falls prevention health care professionals had been contacted and the

Is the service safe?

person was also seen by a physiotherapist. Although all accidents/incidents had been recorded there had been no analysis of events since April 2015 to identify any patterns or trends to reduce the risk of re-occurrence.

People told us the premises was kept clean. They said: "It is nice and clean". "There are two nice cleaners here". "My family all say that there are no nasty smells here". Relatives told us: "It has always been clean; I've never had cause for concern". "It always smells nice and it is clean". "the toilets are always clean but I don't always think the visitor's toilet is checked enough". "The kitchen is clean, I have seen it". There were cleaning schedules in place to make sure the service was clean and tidy. Hand washing facilities and liquid soap and paper towels were available in all the rooms, clinical room and bathrooms. There were also hand gel dispensers. Staff were observed washing their hands in between care episodes and also when giving medicines, including eye drops. One person told us that staff always washed their hands, wear gloves and aprons before emptying their catheter bag, attending to their leg dressings and undertaking their care. There were no smells unpleasant odours. There were procures in place to reduce the risk of infectious diseases, such as barrier nursing and advising visitors of restrictions if required.

There had recently been an issue with regard to the access of the premises via the back door. The service had taken appropriate action to improve security, and the front and back door were being replaced with key pad locks to ensure people were able to access the service safely.

Some people and their relatives told us that at times they were some staff shortages. The deputy manager told us that they had recruited two new recruits, one for days and one night staff member. They had also recruited a registered nurse and all vacancies were now covered. At the time of the inspection the service there were two registered nurses on duty throughout the day, five care staff in the morning, four care staff in the afternoon, one registered nurse and three care staff during the night. Although there were sufficient staff on duty there was one member of staff completing their induction and they had been counted as a permanent staff member and not supernumerary. Staff felt that this was not good practice. The deputy manager told us that an additional registered nurse was on duty to support this person through their induction training and was also available to support staff if needed.

To determine staffing levels the service had introduced an assessment dependency tool which had been reviewed in July to make sure the staffing levels were in line with people's needs. Staff told us that cover was provided in times of sickness and annual leave and agency staff were provided. The staff rota showed that there were consistent numbers of staff available throughout the day and night to make sure people received the care and support that they needed. The deputy manager told us that agency staff cover would now be reduced as the service had recruited new staff. Staff told us that there was enough staff on duty but sometimes the system to agree to use agency staff was slow.

Staff recruitment procedures included the required checks, such as ensuring the applicant had provided a full employment history; proof of their identity; satisfactory written references; a Disclosure and Barring Service (DBS) criminal record check; and proof of qualifications obtained. Staff had job descriptions and contracts so they were aware of their role and responsibilities as well as their terms and conditions of work. Successful applicants were required to complete an induction programme and probationary period. Staff confirmed that the induction was thorough and they had completed training, through practical face to face training and on line training. Nurses were checked to make sure they were registered with the Nursing and Midwifery Council and a note of the expiry date of their individual number was kept to prompt the manager to check the their registration was kept in date. The service had recruited registered nurses and care staff to ensure they were fully staffed. At the time of the inspection one registered nurse and one member of care staff were on induction training.

People received their medicines when they needed them. People said: "They give me my tablets every morning, no problems with that, and I've no pain". A relative told us that their relative had allergies and the service were trailing different drugs to make sure they received the medicine that suited them best.

There were policies and procedures in place to make sure that people received their medicines safely and on time. On admission to the service the person was visited by their doctor for a medicine review. Medicines were clearly labelled with name, administration times and routes, dose, expiry date, batch numbers and any special requirements such as before or after meals. The records showed that

Requires improvement

Is the service safe?

medicines were administered as instructed by the person's doctor. Medicine Administration Records (MAR) charts and the controlled drugs register were clearly signed and dated, and reasons for non-administration recorded.

We observed nurses giving people their medicine safely and routinely offering people pain relief medicine. There were protocols in place for giving medicines as required ('PRN' medicines), which did not always give clear directions about what these medicines were for and when they could be given (for example, for pain relief). We noted four 'as and when medicines' needed to be administered but only two had direction and guidance for staff to follow. There was, therefore, a risk that new or agency nurse may not have the information and guidance to give this medicine safely.

Staff were observed asking people if they needed pain relief and people were receiving pain relief medicine safely. Staff were able to tell us how they made sure people who were non-verbal received the pain relief they needed. They told us they knew the people well and would look for facial grimaces and agitation. It is good practice for people to have a pain assessment in place with guidelines to show staff how their pain should be effectively managed.

It is, therefore, recommended that the service refer to the National Institute for Health and Care Excellence (NICE) (which provides national guidance and advice to improve health and social care) for pain management in palliative care and for people living with dementia. (NICE CG42 2006)

Medication was stored securely and when medicine was being administered the medicine trolley was not left unlocked or unattended. The clinical room temperature and also the medicine refrigerator temperature were checked and recorded daily to ensure medicines were stored at the correct temperatures. There were suitable procedures in place for destroying medicines which were no longer required, and records were correctly maintained.

Requires improvement

Is the service effective?

Our findings

People and their relatives were happy with the care and support they received. People told us that the service had carried out care assessments when they came to live at the service. People's relatives said: "We attended a meeting with the staff and social services about all of the care issues and these were all addressed. We were pleased that this meeting was arranged to keep us up to speed, they seem on top of things here".

People and relatives told us that the staff knew how to care for them well. New staff told us they had received a good induction when they started work at the service. The new Care Certificate had been introduced, which is the recommended training from the government for health and social care staff. Staff confirmed that they shadowed experienced members of staff to gain experience in the role they would be undertaking.

People told us that they felt the staff were well trained. They said: "There are always two staff when they hoist me, they explain well. They do know their jobs". "Most' of the staff know what they are doing".

Staff told us that they received regular training, including face to face training, long distance learning workbooks and on line training. They said that there was an ongoing training programme and some specialist training such as diabetes and dementia training had also been provided. One staff member told us that they were completing distance learning courses on dementia which had helped them understand the behaviour of some people and how to approach them for their consent to care. The training matrix showed that there were shortages in staff completing some basic training such as fire training, infection control training, health and safety training, safeguarding training, infection control, food safety, emergency first aid, and mental capacity training. The deputy manager had recognised these shortfalls and there was a training action plan in place with timescales for staff to complete the training by October 2015.

Nurses had received training such as venepuncture (taking blood samples) and the use of syringe drivers. Senior staff had accessed the six steps to success training, which aims to enhance end of life care and there were plans in place to cascade this training for all staff. This was delivered to senior staff to improve end of life care in care homes. Three registered nurses were also booked to attend a tissue viability study half day course.

The deputy manager had recognised that the staff supervision/appraisal programme was not up to date. New documentation had been given to the senior staff to improve the new supervision programme to ensure that all staff would have the opportunity to meet with their line manager on a one to one basis to discuss their role and responsibilities. Appraisals to discuss their personal development needs and any areas where they could benefit from further training were also programmed to take place. Staff meetings had been held to give them an opportunity to discuss the service. Staff told us that they had not received regular supervisor lately but told us they felt supported by the management team who were always available for advice and guidance. They told us that communication was good; including detailed handovers at each shift and senior staff listened and acted on their concerns. Staff said: "I did have supervision last year". "Any problems are sorted out quickly". "They listen to us and take action to resolve our issues". "I have had supervision in the past and we have discussed my training at an appraisal".

Some staff had received or were booked to complete on line training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Act protects people who lack mental capacity, and assesses their ability to make decisions or participate in decision-making. The service had applied to the local authority for deprivation of liberty safeguards to be assessed and obtained deprivation of liberty safeguards (DoLS) authorisations. Staff were aware that some decisions made on behalf of people who lacked capacity should only be made once a best interest meeting with relatives, health care professionals and advocates had been held. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

People and relatives were encouraged to be involved with the planning of their care. They told us they were asked for their consent about the tasks staff were about to undertake. Some people or their relative had signed

Is the service effective?

documents to confirm their consent to the taking of photographs and their consent to the care to be provided, however, other care plans had not been signed to show what involvement people had in their care plan.

People told us that their health care needs were fully met. Their health was closely monitored by the registered nurses and when it was necessary, health care professionals were involved, to make sure people were supported to remain as healthy as possible. For example some people had been visited by the Parkinson's nurse specialist; people with complex needs had also been visited by the community psychiatric team and dieticians.

When people needed support to eat properly they were referred to dieticians and if people had swallowing difficulties they were seen by the speech and language therapists. Two people had a 'PEG' feed had regular visits from specialist nurses to monitor their food and fluid intake. (A 'PEG' is a Percutaneous endoscopic gastrostomy which is when a feeding tube is inserted directly into the person's stomach when they cannot maintain adequate nutrition with oral intake). Care plans had detailed guidance for the management of the PEG for example, daily inspection by the nurses and how to clean the area effectively to reduce the risk of infection. Outcomes of visits from health professionals were clearly recorded, and care plans showed that treatment was given according to their directions, such as adjusting the feeds to include more fibre.

Support was obtained from hospice nurses for giving end of life care. Doctors visited the service regularly to review people's medication or assess their medical needs and people were supported to attend medical appointments or hospital outpatient clinics. One person said: "I have seen a speech therapist and all of the staff are now aware of my problem. They know their job well and know how to make up my drinks". Another person said: "The doctors are in touch with the nurse here, as they come in every day" One person praised the service for the effective catheter care being provided, they said "My relative gets very good catheter care here, they attend to the issue daily to reduce the risk of infection which has resulted in no infections. Marvellous!"

People were supported to maintain a balanced diet. People had their nutrition needs assessed on admission and were weighed monthly or more often if there was a clinical need. Four of the residents were on thickened fluids and puréed diets. The meals were puréed in separate sections so as to be more appetising. Staff had completed a 'resident mealtime form' which gave information to staff on where the resident liked to eat, what position they liked to be in, for example, sitting up or in a more relaxed position, what spoons and/or knives and forks they preferred to use, what help they needed, whether to thicken drinks and the consistency. There was also information on things to look out for, such as choking or keeping food in their cheeks. These forms were useful when the resident was unable to communicate clearly.

Most people preferred to eat in their rooms, and some needed support to eat, while other preferred to eat alone. We observed people in their rooms coping quite well with their food, sitting in their armchairs, others were observed being assisted to eat. People had their drinks throughout the day and jugs of fluid were also available. People said: "There's tea or coffee of fruit juice, whatever you like". "They are always asking if we'd like more drinks". A relative said: "We all, the staff and I, make sure my relative drinks enough".

There were mixed views with regard to the food being provided. Two people said: "It has less quality than I was used to. They can be bland, there seems to be a lot of meat casseroles with vegetables and mashed potatoes and the salads are very plain". "The food has deteriorated a bit, I don't know why. It was rather good. Lately, it has all become slices of bread and sandwiches". All of the other comments about the food were positive: "The food is very good. I have funny food fads and they are nice boys in the kitchen. They say what kind of soup, they know I like carrots and they make extra marmite sandwiches for me". "The food is very good food here". "There is a very good cook and it is fresh food". "The food is fine, you can always have more". "A very good cook who comes in to take your order, good team work. It is fresh food and I've never been hungry here". "The staff are always willing to make me scrambled eggs or omelettes".

People's relatives were happy with the food. They said: "They serve my relative pureed food for me to feed her". "I give my relative dinner, they like egg on toast. "My relative lost weight in hospital, the home give them cream and cakes now and weigh him here". "My relative seems to

Requires improvement

Is the service effective?

enjoy the food". "The food is adequate and we add to it". A family described how hard the staff were trying, to get their relative to eat a little, and said: "My relative is now eating a little and we'll try her favourite foods".

Good

Is the service caring?

Our findings

People and relatives told us the staff were kind and caring. They said: "The staff nurse is wonderful". "I feel well cared for here". "The staff joke with me and do everything for about tuppence an hour. I was a health care professional and I feel very well cared for". "I've nothing to compare it with but the staff are good and helpful". "The service is excellent. When I want help, they are there". "The staff are lovely, they don't worry me but they do look after me". "The staff know me and treat me well". They know me after all these years. They are very good, super staff". "The staff take all the time to read my cards to me when they come, and put them up". "I never thought I would, but I like the male staff, but they are sometimes better. They are very kind to me". "I don't mind the male staff at all, I've got used to it. It's fine". "The staff work like 'billy-o' to make sure it all gets done".

People's relatives said: "I am happy with the care that I see and I come most days. "Basically the care is good" "We are very happy with the care". "On the whole, I am happy. They (the staff) are all kind." "the home seems to listen to me. They are very attentive to my relative and keep me informed". "The nurse really took time to get to know my relative and it has really worked".

Visitors said: "Yes, we are happy with it all". "I find the staff friendly and caring. There was one member of staff who was abrupt but they have changed them now".

All staff spoke respectfully and had a good knowledge about people living at the service, they knew their personal preferences and they offered choice. For example they asked people when they preferred to receive their personal care, where they wished to have their meals, and what if any assistance they needed. People said: "I like to get up at 6 o'clock and I'm usually the first one up. I have a shower sometimes. That's enough. They get me out of bed. I wash my face. They let me do those things". "They wash me and say what they are doing for me. I get up sometimes, but not very often". "I get up and go to bed absolutely anytime".

Staff told us that as they got to know the people and developed a caring relationship with them. Staff were able to spend time talking with the people offering them choices, identifying if they needed anything, if they were in pain or felt unwell. Staff said: "We work as a team here to make sure people are looked after properly, there is a pleasant atmosphere and we all get on like a family".

One person we visited in their room was unable to communicate but looked relaxed and comfortable. Staff told us that as this person spent most of their time in bed, they had changed rooms to be on the first floor to ensure they could enjoy the view across the countryside.

People were being supported with their religious beliefs. One person who practised their faith told us that a priest visited the service regularly. They said: "There is a gentleman who comes in to read our catechism and say prayers for us. He reads the Gospel".

Staff encouraged and supported people in a kind and sensitive way. For example staff were observed reassuring a person who was concerned about noise and they reminded a person that they wished to spend some time in the lounge. We also overheard one member of staff sensitively speaking with a person who had fallen asleep on a chair in the corridor, suggesting they may like to go to their room for a 'nap' and then they walked slowly with them to their bedroom.

People's independence was prompted. Care plans showed how they could be supported to bath or shower and what they could do for themselves, and when they needed staff to support.

Staff supported people to make decisions, such as what they wanted to eat or wear. We observed the chef talking with a person and offering them meal choices for teatime. The person told us that he was good and would prepare them a light meal 'to tempt their appetite'. Staff knew people well and we observed one member of staff giving a person a drink, they knew the person would request a straw and had one ready for them. Some people were being visited by an advocate to ensure they were supported to make the right decisions about their care.

People told us they were treated with privacy and dignity and staff always respected their wishes. They said and we observed that staff knocked on their bedroom doors before entering. People's rooms were personalised with their own belongings. A relative commented "The manager said that I can bring in whatever I like to make the room personal for my relative. Although my relative remains in bed, it is really their choice."

Good

Is the service caring?

People told us that they could see their visitors in private if they wished. All the visitors spoken with said they were able to visit at any time and all said that they felt welcome in the service. Several described the staff as 'friendly' and one noted, "I do feel welcome, and they offer me tea". One person said: "Sometimes, there are about eight of my family in here".

Some people had made advanced decisions, such as 'do not attempt to resuscitation' orders, to ensure their last wishes were recorded and end of life plans were in place. End of life care plans were not always completed to ensure that people's last wishes were fully recorded and would be carried out. One person receiving end of life care was deteriorating and was being seen regularly by their doctor. The relatives had been involved and were being updated on a regular basis. There had also been a care review with social services, the family, staff and an assessment from the mental health doctor had been completed to ensure that this person was receiving the care they needed. Advice had also been sought from the hospice to team to manage the pain effectively and the appropriate end of life medicine had been prescribed by the doctor. The doctor was still looking for treatable reasons for the deterioration of this person and contacted the service during the inspection with some detail regarding improved blood results. This shows the service was following best practice 'One change to get it right' (Leadership Alliance 5 priorities of care 2014), which is designed to support people in the last few hours of their life, and also the continual assessment being undertaken by the doctor which may reveal a treatable cause.

Good

Is the service responsive?

Our findings

People told us that they received the care they needed and the service always responded when they needed further medical attention. People said: "They get the doctor if you need him, they always do that. I see the nurse every day". "I can see a doctor, or I can always see a nurse when I need to".

People's relatives said: "They give my relative the same medication that he had at home with me. If he has a slight cold or cough, they get a doctor in". "They get a doctor, yes, and a very good nurse, too". "If I think my relative has a chest infection, I tell them. They get the nurse. They are wonderful to her."

One person had recently fallen and their relative told us that the service informed them straight away, they said: "The staff phoned me straight away and said that he had gone to hospital. They said I didn't need to go straight away if I'd rather not, but I wanted to of course as a member of staff was with him". Relatives told us that the service kept them informed of their relative's care, they said: "They phone if there is a problem and I see them when I come in". "They do keep in touch with my relative's next of kin". "The staff will come and talk to me about what has happened and keep me updated with my relative's care".

Call bells to summon staff were in easy reach of people using the service. There were mixed comments with regard to staff responding to the calls. Some people told us that the staff were responsive and usually came quickly when they called. They said: "The staff almost always come quickly". "They usually respond promptly". "It can take quite a long time, ten minutes can be quick. They haven't got enough people". "Sometimes they take a long time to come to me".

Relative comments: "The other week I did ask them for a new bell as my relative's had disappeared. I think they (the staff) come virtually straight away". "My relative worries about calling them, because she fells they are short staffed". "My relative wont ring the bell, but they do come in and check on her". "If I think my relative needs sorting out and moving, they come up really quickly." "Staff are always around, they turn my relative her every two hours and move them if I say they are uncomfortable, and they bring her pain relief".

The deputy manager told us that there had been no concerns raised about staff not responding to calls and call bells were the subject of a monitoring audit to ensure that staff responded promptly and there had been no recent staff shortages. The last audit was carried out on 09/04/2015 and the outcome showed that all calls had been answered within three minutes. The deputy manager told us that a further audit would take place in the near future to make sure people were responded to promptly.

Before a person moved into the service a care needs pre-assessment was completed. These included all aspects of their care, and formed the basis for care planning. Care plans included people's personal hygiene routines, mobility, nutritional needs, continence, sleeping, skin care, breathing and pain management. They contained details such as what food people liked and disliked and how people wanted to remain independent with specific tasks and the areas where they needed support. People and relatives told us that the care plans had been discussed with them but records were not always fully completed with such detail as people's life histories, end of life wishes, and signatures to confirm people had agreed with their care. One person told us how they had been involved in their care planning and setting goals but they said they had not been asked to sign their plan.

The nurses and staff on duty during the inspection had a clear and sound understanding of people's care needs. They were able to explain in detail what clinical interventions and support people needed to keep them as healthy as possible. When any concerns were identified, the service had responded by seeking specialist advice. For example: The deputy manager had contacted health care professionals to discuss one person's complex care needs with regard to their leg ulcers. Advice had been given and a new plan of care had been updated to reflect the changes in their care. Another person had been referred to the dentist when they were having difficulty eating. They said: "'I can't eat much because of my teeth so the service are in the process of getting the dentist to call".

Each person had a care plan in place. The registered nurses were responsible for making sure people's care plans were accurate, reviewed and kept up to date. The care plans were personalised and contained information such as, people's personal care routines and their likes and dislikes. There was information in the plans of what people could do for themselves or when they needed support. Detailed

Good

Is the service responsive?

information was available for people who were visually impaired and guidance for staff explaining the nature of the disability and details if they may suffer hallucinations. There was also detailed information about when a person preferred to wear their hearing aids. People told us that staff chatted to them about their interests and personal life and staff demonstrated they knew people well, there was a lack of detail recorded in care plans with regard to people's background and life events.

People's skin was assessed on admission and reviewed on a regular basis. The service was following good practice guidelines such as (SSKIN care bundle, NHS Midlands and East 2012 "Stop the pressure pathway") to ensure that people's skin was as healthy as possible. Each person also had a continence assessment and were weighed monthly to ensure they were receiving a healthy diet to promote healing. People at high risk were nursed in profiling beds on alternating pressure mattresses, and position charts were being used to make sure they were being moved regularly. The lead nurse for moving and handling showed us new slide sheets to help reduce the friction when moving people to prevent further trauma on people's skin and special sheets to be left under people if they were receiving end of life care. Staff knew what signs to look for when people's skin showed signs of pressure areas and nurses responded quickly if any concerns were identified, and made sure people received the intervention and care they needed to keep their skin as healthy as possible.

Where people needed wound care, wound assessments and dressing changes were thoroughly recorded. Records included the size and appearance of the wound, condition of surrounding skin and signs of infection. Photographs were taken with the person's permission, and such records demonstrated wound healing. Each wound was photographed every two weeks and documented separately so as to provide clear records.

There were mixed views with regard to the activities provided at the service. Some people did engage in activities whilst others choose not to do so. There were two activity members of staff who provided group and one to one activities. The activities co-coordinator spoke about improving the activities and told us how they visited people in their rooms to prevent them from being socially isolated. One person told us that the staff read to them whilst another said they played cards.

One person showed us their 'masterpieces' they created every day with his crayons and pencils". Another person showed us their knitting and the activities' co-ordiantor was trying to encourage people to join a knitting club. People told us that they sometimes went downstairs if there was some entertainment, and a coffee morning had been arranged. Some people choose to stay in their rooms due to their nursing care needs or preferences to watch their own television or listen to the radio.

Relatives said: "There's nothing to do, but my relative doesn't want to do anything". "There is an activities lady and she visits my relative in their room for half an hour once or twice a week. It's not enough".

There was a 'craft corner' in the corridor where people's paintings and craft was on display. There was also greetings cards for sale, made by one of the people living in the service. There was no evidence to show that there were systems in place to make sure people were involved in the activities provided or had been spoken with to discuss what activities they may wish to participate in. Residents meetings had not been successful to encourage people to be involved in the day to day running of the service.

People we spoke with said that they did not have any concerns or complaints but would speak to staff if they had any problems. People said: "I would speak to a carer or my family if I had any concerns". A relative said that if there was a problem, she would go to 'the nurse, or the Care Quality Commission". They felt their issues would be responded to and resolved if they raised any concerns.

The service had a complaints procedure on display in the entrance hall and a suggestion box was available should people wish to remain anonymous and use this facility. There had only been one complaint about the service, which had been investigated and resolved. The deputy manager told us that people and staff were being encouraged to report all concerns, no matter how minor, so that a full and complete record of issues would be in place and any concerns raised could be dealt with promptly.

One relative told us that when they raised concerns with the manger she acted on what they said. They said: "I requested to the manager to remind staff that my relative had sight problems which resulted in him shouting, she was very good, she spoke with staff and also reviewed his medicine".

Requires improvement

Is the service well-led?

Our findings

People and relatives were satisfied with the service. They told us that there was always a member of the management team or senior staff available when they needed them. People knew that the registered manager was not available and were aware the deputy was in charge of the service and office staff were 'right on the ball'.

One relative told us that they had looked at about eight other homes, and preferred this one because the staff were so friendly and welcoming here, right from the start". One person said "My relatives say that this is the best home that they visited". A visitor commented: "This is my friend's third home and by far the best". "We think of this as her home now", if we go out she always says "It will be nice to get back home".

The service had a registered manager who was not available at the time of the inspection. The deputy manager was covering the management duties in the absence of the registered manager. People, their relatives and staff said that the manager was approachable and supportive. They said the service was well led. Throughout the inspection, relatives, staff and visitors came into the office to speak with the management team and despite the constant demands the deputy manager remained calm and carried out her duties in a professional manner.

Staff told us that the management team were always available to give practical support and assistance. Staff said they were able to raise concerns and that the deputy manager was approachable and knowledgeable. There was an open and positive culture in the home and staff morale was good. Staff were very positive and went about their duties in a cheerful manner. Staff understood the visions and values of the service to ensure people received the care they needed, for example they told us that they treat people how they would like to be treated themselves, with dignity, respect and privacy. Staff said they felt valued, part of a team and were clear about their roles and responsibilities. They were able to describe these well and were clear about reporting any concerns or issues to the nurse or management team.

The deputy manager and a registered nurse had undertaken a mentorship course for supporting staff to fulfil their role effectively. The supervision and appraisal system, including clinical supervision for nursing staff, was not up to date therefore staff had not received one to one meetings with their line manager. The deputy manager had recognised this shortfall and was in the process of implementing new documentation to address these issues. A supervision plan was in place to ensure all staff received a one to one meeting with their line manager by the end of September 2015.

Records were not always accurate and completed properly. Care plans were not always signed to confirm people had agreed with their care, there was a lack of life histories for each person, end of life documentation had not always been completed and there was little evidence to show how people had been involved in their care. Each time an audit was carried out staff had to complete an evaluation form but there was no form completed when the accident prevention audit was completed on 26/04/2015 to show what issues had been found and what, if any, actions needed to be taken. Accidents and incidents had been recorded but there were no records in place to show that these had been analysed by the manager since April 2015. Records were secure, stored appropriately and all records requested at the time of the inspection were available.

The area manager visited the service on a monthly basis to assess the quality of care being provided. The last visit by the area manager was 19 August 2015, and this detailed what action the service needed to take to improve the service. The service routinely completed monthly audits for pressure, wound care, and medication. There was also a three monthly health and safety audit. There were plans in place to completely refurbish the service and a maintenance report was completed weekly to assess the progress. The service had also completed a 'mock inspection' to identify areas where improvements were required to comply with the regulations. There was an ongoing action plan in place which had been updated on a regular basis to show what had been achieved. For example the action plan stated each person needed an individual sling for their moving and handling and this had been completed and gaps in the training were being addressed. Staffing levels were being monitored by the organisation as a weekly report was completed and sent to head office.

The service had sent a quality survey to people in August 2015. The results of the survey were in a folder on display in the entrance to the service. There was no evidence to show how people using the service had been made aware of the

Requires improvement

Is the service well-led?

outcomes of the survey or what if anything needed to be improved in the service. Although feedback had been received from people, the provider had not actively encouraged feedback about the quality of care from a wide range of stakeholders, such as staff, visiting professionals and professional bodies to ensure continuous improvement of the service.

The most recent Care Quality Commission (CQC) report was available in a folder near the entrance to the service and there was also other information such as the CQC booklet entitled 'what standards you have a right to expect from the regulation of your care home' was also available. This gave people the opportunity to assess the quality of care being provided in the service.

Quarterly meeting dates for 'residents, relatives and friends' were on display on a notice board, but no times were given. The next meeting was due on 28 October 2015. People and relatives did not seem aware of this meeting; one person said "I don't know anything about meetings". There had been a residents meeting arranged for 29 July 2015, but this had not been attended by anyone. The deputy manager told us that they would encourage people to attend by making sure they were informed of the meeting and what was to be discussed.

The management team worked proactively alongside organisations that promoted best practice and guidance. They kept themselves up to date with new research, guidance and developments, making improvements as a result. Staff regularly liaised with the local hospice to share ideas and best practice with their colleagues to widen their knowledge of end of life care.