Abbey Ravenscroft Park Limited

Abbey Ravenscroft Park Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Abbey Ravenscroft Park Nursing Home is a 'care home'. The accommodation is purpose-adapted with passenger lift access to all three residential floors, each of which have separate adapted facilities. People in this care home receive accommodation along with nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service has a registered manager, which is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service is registered to provide accommodation for up to 67 people, although records informed us the maximum practical occupancy was 64. There were 52 people using the service at the start of this inspection. The service specialises in dementia care and is operated by a regional care provider.

This was an unannounced comprehensive inspection, to make sure the service was providing care that is safe, caring, effective, responsive to people's needs, and well-led.

At our last inspection of this service, in September 2017, we found two breaches of legal requirements. These were in respect of safe care and treatment, and safeguarding people using the service from abuse. The service was rated 'Requires Improvement.' The provider completed an action plan to show what they would do and by when to improve the rating of key questions of 'Is it Safe?' and 'Is it Well-Led?' to at least 'Good.'

At this inspection, we found the necessary improvements had been made. Systems, processes and practices were now safeguarding people from abuse. The service was also now ensuring people received medicines as prescribed. The service's overall rating from this current inspection has therefore improved to 'Good.' However, the rating for 'Is it Safe?' remains 'Requires Improvement.' This is because we identified some concerns about staff recruitment processes, maintaining sufficient staffing levels in practice, and upholding infection control standards. Whilst the provider sent us a comprehensive written response to address these matters shortly after our visits, we could not be assured that these matters would have been identified without our involvement. We have recommended the provider seek and implement best practice guidance on staff recruitment checks.

People using the service spoke positively about it, describing it as 'very nice' and 'excellent' for example. Everyone said they would recommend it to friends and family. People's relatives and representatives provided similarly positive feedback. There was particular praise about supporting people with health-related matters.

We found the whole service worked in co-operation with other organisations to deliver effective care and support. This helped ensure that people's health care needs were well attended to, for example, for skin integrity, swallowing concerns, and with helping people to reduce aggressive behaviours. People were supported to eat and drink enough and maintain a balanced diet.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. Staff were committed to people's care, and treated people with kindness, respect and compassion.

The service supported people to maintain relationships that mattered to them. People's visitors, relatives and representatives were welcomed into the service, and kept updated where appropriate.

People were supported to express their views and make decisions about their care and support. Their independence was promoted, and their privacy and dignity was respected including for end-of-life care.

People's needs were holistically assessed to help ensure the service could meet their specific needs. These were kept under review, to help ensure people received a responsive service.

The service provided a range of activities that aimed to reflect people's preferences.

Attention was paid to providing a safe service, both in terms of the premises and equipment, and in respect of people's individual abilities and needs. Accident and incidents were kept under review, to aim to minimise risks of reoccurrence.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. Systems at the service generally enabled sustainability and supported continuous learning and improvement.

The feedback of some staff indicated weaknesses in the service's working culture. The provider sent us an action plan shortly after our visits, that aimed to address this. Nonetheless, the provider, management team and staff upheld a clear vision and credible strategy to deliver the good quality care and support that people and their representatives told us of and which we found.

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. Whilst recruitment checks of prospective staff were routinely carried out, the process was not always sufficiently comprehensive and timely.

Although staffing rosters always scheduled enough staff to be working, cover was not always provided for unexpected absences.

The service had systems to protect people by the prevention and control of infection. However, there were minor concerns with upholding cleanliness standards in practice.

Systems, processes and practices safeguarded people from abuse.

The service assessed and managed risks to people, to balance their safety with their freedom.

The service ensured the proper and safe use of medicines, so that people received medicines as prescribed.

Systems were in place to ensure that ongoing learning occurred when things went wrong.

Is the service effective?

Good

The service was effective. People's needs were holistically assessed to help ensure the service could meet their specific needs.

The whole service worked in co-operation with other organisations to deliver effective care and support. This helped ensure that people's health care needs were well attended to.

The service supported people to eat and drink enough and maintain a balanced diet.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

The adaptation, design and decoration of premises generally

supported people's individual needs to be met.

The service worked in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. It ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed.

People were supported to express their views and make their own decisions about their care and support. Their independence was promoted.

The service ensured people's privacy and dignity was respected.

The service supported people to maintain relationships that mattered to them.

Is the service responsive?

Good

The service was responsive. It generally enabled people to receive personalised care that was responsive to their needs.

The service provided a range of activities that aimed to reflect people's interests.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well-led. The provider had a clear vision and credible strategy to deliver the good quality care and support that people and their representatives told us of and which we found.

Despite these good outcomes, the feedback of some staff indicated weaknesses in the service's working culture. The provider sent us an action plan shortly after our visits, that aimed to address this.

Systems at the service generally enabled sustainability and supported continuous learning and improvement.

The service worked in partnership with other agencies and involved stakeholders to support care provision and development.	

Abbey Ravenscroft Park 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.

This unannounced inspection took place on 6 and 17 July 2018. It was undertaken by two inspectors, a pharmacist inspector, a specialist professional advisor nurse and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law. We also contacted the local authority and various community healthcare professionals who have a role at the service, for their views on the service. We received four replies.

There were 52 people using the service at the start of our inspection visits. During the inspection we talked with 12 people living at the service and 11 of their relatives and representatives. We spoke with seven care staff, two health advisor staff, five nursing staff, a domestic staff member, a cook, an activities co-ordinator, the deputy manager, the registered manager, the regional quality care manager, and a company director.

During our visits, we looked at selected areas of the premises including several people's rooms, and we

observed the care and support people received in communal areas including at meals. Some people were unable to communicate with us, due to the complexity of their conditions. For this reason, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This helped us observe how staff interacted with some people and the support they received during one afternoon.

We looked at the care plans and records of 13 people using the service, the medicine administration records for 32 people, the personnel files of six staff, and some management records such as for health and safety, accidents and incidents, complaints, and staff rosters. The registered manager also sent on request some further specific information about the management of the service in-between and after our visits.

Requires Improvement

Is the service safe?

Our findings

People and their relatives and representatives told us the service was safe. People's comments included, "I am happy, the staff look after me", "They are careful with everybody" and "They keep an eye on you." Someone's representative told us, "She is very safe and well cared for." Another said that safety was "100%." A third added, "The staff are very vigilant and I have seen that not only with my mother but other service users."

At our last inspection, we found medicines were not always managed safely, and whilst there was a safeguarding procedure in place it was not always followed. This meant the provider was in breach of regulations 12 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found improvements had been made which addressed the breaches as medicines were now being safely and properly used, and safeguarding procedures were now being followed.

People told us of good medicines support, for example, "I get regular paracetamol for pain relief" and "I am not in pain because I can tell someone. They will give pain relief. They are very good." A representative said, "Medication is given in a timely manner."

There were appropriate arrangements in place for obtaining medicines. We saw that supplies were available to enable people to have their medicines when they needed them.

Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. They showed people were getting their medicines when they needed them. There were no gaps on the administration records, and any reasons for not giving people their medicines were recorded. Body maps were used to identify the location of any patches applied, and quantities of medicines given when required were clearly recorded. The use of emollients and barrier creams was recorded on individual cream charts.

Medicines were stored safely and securely. Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. The room temperature in clinical rooms was recorded daily and these records showed the temperature was in the correct range.

Controlled drugs were managed and recorded correctly. Those no longer required were either destroyed or returned to the supplying pharmacy.

The provider undertook weekly and monthly checks to ensure the administration of medicine was being recorded correctly. There was a running stock balance kept for all medicines and the samples we checked were correct. The management team told us these checks had helped to eradicate medicines errors.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under

specific circumstances, some when-required protocols (administration guidance to inform staff about when these medicines should and should not be given) were in place. However, for six people who were prescribed medicines for agitation, there were no protocols in place. This meant there was no information to enable staff to make decisions as to when to give these medicines, to ensure people were given them when they needed them and in way that was both safe and consistent. The management team supplied us with individual guidelines soon afterwards, to show that these had been developed and made available for staff guidance in respect of these people.

The service's systems, processes and practices safeguarded people from abuse. Safeguarding guidelines were displayed around the building, to help raise awareness. Staff in all roles knew what they needed to do to make sure people were safe from harm and potential abuse, such as reporting concerns to the registered manager or the local authority safeguarding team. One staff member told us, "If staff find something they will always report. Even a small bruise on a person." They all received regular safeguarding training, including during induction training, to ensure they had the skills and ability to recognise when people may be at risk of abuse.

The service kept oversight of any safeguarding allegations, to make sure care risks were minimised and learning implemented. Safeguarding records showed the management team knew how to raise alerts in respect of allegations both against the service and against other involved people or organisations.

The service routinely carried out recruitment checks of prospective staff such as by obtaining written references and checking identification and right to work in the UK. There were interview records to help consider whether the applicant held appropriate and safe values in respect to the job role. However, we found concerns relating to the checks of staff members' Disclosure and Barring Scheme (DBS) disclosures. These disclosures are checks of police records and a list of people legally recorded as unsafe to provide care to adults. Records showed that three of the six newer staff we checked began employment in 2018 before the service had seen an up-to-date DBS disclosure by which to check the person was safe to work in the care industry. Records of three staff indicated that references from previous care providers had not been acquired or reasonably sought before they began employment. However, records also showed most of the staff involved in these shortfalls has previously been employed at the care service and had returned to work after a period working elsewhere. The provider also sent us evidence shortly after our visits, to show they were taking actions to address any outstanding issues and improve on the robustness of future recruitment checks.

We recommend the provider seek training on safe and robust recruitment practices in the care industry, and review their policy on staff recruitment in light of this.

The service was not consistently ensuring sufficient numbers of suitable staff worked in practice to support people to stay safe and meet their needs. This was because cover was not always provided for unexpected absences, despite staffing rosters always scheduling enough staff to be working.

People generally had no concerns about there being staff available when needed, although one person told us, "Mealtimes are sometimes short staffed and you have to wait." Some people's representatives also wondered if there were enough staff working. Comments included, "They are a little bit understaffed" and "They need more staff." However, others made comments such as, "There are enough staff." Our observations during our visits indicated there were enough staff to meet people's needs in a timely manner. However, we also saw that some dependent people were not engaged with anything including through no staff interactions for periods of thirty minutes.

Amongst the eleven care and nursing staff we spoke with, nine told us of concerns with staffing levels. One staff member said, "There's shortage of staff at times. We are accepting too many patients on their end-of-life and many challenging residents who are on one-to-one that affects the ratio of residents to care staff." Another told us, "Sometimes we are short of staff and nothing is being done about it." They explained that staff then are "not able to find enough time to sit and chat with the residents." A third staff member explained that staff shortages were "having a negative effect on the staff who have to cope with high demanding residents." They also told us of there being "so much paperwork."

However, staff generally told us that care and safety was not compromised. As one staff member put it, staff "also display a good team-work despite of having shortage of staff at times." Another stated, "staff are devoted to give quality care."

We checked a recent two-week period of which staff were working, both the planned rosters and what occurred in practice. This showed three occasions when unplanned staff absence resulted in less staff than the minimum staffing levels that the registered manager told us, which was based on the collective dependency of people using the service. There were also two occasions of less domestic staff than planned for. This corroborated the feedback we received.

The provider sent us evidence shortly after our visits, to show they were taking robust actions to address these matters and minimise risks to people using the service. This included the use of agency staff where permanent employees could not cover minimum staffing levels in the event of unplanned staff absences.

The service generally protected people by the prevention and control of infection, but we identified minor consistency concerns in this area. People told us the service was kept clean. Comments included, "I like the rooms, they are very attractive and clean here" and "Relatively clean but not five- star; They do bathrooms and hallway every day." Some people's representatives praised the cleanliness of the service. One said, "There are no smells and it is not dirty." However, others told us the service could do slightly better. One representative said, "It is not 100% clean. Furniture needs a bit of a wipe." Another put matters in context: "The only thing that I could be critical of is the cleanliness but that is not the important thing when the care is so good."

During our visits, we came across no lingering odour, which indicated people received good continence support where needed. A domestic staff member told us carpet cleaning equipment was used where needed, and in two or three rooms daily on a rotational basis. We also saw people's rooms to be clean overall. Throughout the service there were hand-sanitising dispensers, all of which were useable throughout our visits.

Where people needed additional infection control precautions due to specific needs, we saw that procedures were put in place. Staff used protective equipment such as gloves and aprons where appropriate. They were aware of which bags to use for infection control. Sharps bins were also available and not full. The service attained a five-star rating, the highest possible, from the local food standards agency at their last check of September 2017. There were records of subsequent audits by the service, to ensure standards remained high.

However, we did identify aspects of the service that matched the inconsistent feedback. During our first visit, we noted people were not consistently offered the opportunity to clean their hands before meals. Some equipment in people's rooms such as a wheelchair and recliner chair had dried food stains on arm rests. At our second visit, we found food stains on the table cloths in two units after lunch was finished, and that dining chair legs in one unit had encrusted food stains.

The provider sent us an action plan shortly after our visits, to improve on the oversight of the service's minor cleanliness concerns.

There were systems in place to ensure designated staff at the service undertook safety checks regularly. These included bed-rails, hot water temperatures, window restrictors, and fire-release mechanisms on doors. Records showed this helped concerns to be identified and reported.

There were also professional inspection certificates in place where appropriate, for lifts and lifting equipment, the fire alarm and fire extinguishers, electrical devices, and the water systems in respect of Legionella risk. Where actions were required, these had been signed off as completed. There had been an overall health and safety audit by an independent body at the service earlier in the year. This identified good overall standards and a few matters for improvement. We saw evidence to indicate these had been acted on, for example, checks of individualised slings for hoisting people where needed.

The service assessed and managed risks to people to balance their safety with their freedom. There were a variety of individualised risk assessments in place in people's care files to recognise hazards to their welfare and help to keep them safe. These included assessments of skin integrity, choking, mouth care, falls, bed-rails and catheter use. Records showed risk assessments were regularly reviewed, often monthly. The assessments also encouraged people's independence where possible. Our discussions with staff showed they knew how to work with people to address these safety risks.

The service followed appropriate moving and handling procedures to safely help people to move around. People received regular support to move and reposition. We saw staff safely supporting or hoisting people to transfer between seats. They communicated clearly with the person, and worked together to undertake the manoeuvre. Floor areas were generally uncluttered with space for manoeuvring chairs and hoists. Staff confirmed they were trained and updated annually on moving and handling procedures.

Behavioural risk assessments and monitoring charts were in place for people who had displayed behaviours that challenged the service. The assessments included details of how the person behaved, what made them agitated, possible injuries and how staff were to respond. This was reviewed monthly. Charts were comprehensively completed, in support of keeping the service's responses under review.

The service learned lessons and made improvements when things went wrong. This followed from the service's stated policy aim of reviewing accidents monthly for identification of trends. The service's accident records included newly-developed summaries of each accident, immediate and longer-term responses, and reviews of what had been learned. These showed appropriate responses to accidents and injuries, for example, calling 999 where needed, monitoring people with minor injuries in case of developing concerns, or ensuring sensor mats were in place for people who needed support but were unlikely to call for it. We saw mats to be in place in some people's rooms.

Specific accident and incident records included staff statements of what occurred, body maps where appropriate, checks that relevant people such as family members had been informed, and actions taken to prevent reoccurrence. We saw that an additional care plan was set up for one person after their return from hospital, to reflect their additional needs and minimise the risk of another accident. The management team told us that for another incident, the involved staff were interviewed, sent letters about expected standards, and provided with further supervision. Wider learning was also clarified at a subsequent clinical and staff meeting.

Good

Is the service effective?

Our findings

People spoke positively about the service. Comments included, "They are excellent. I couldn't wish for better", "We are well looked after" and "On the whole very nice here." Most people's representatives provided similar feedback. One said, "It is a top-class home. He gets looked after." Another told us that their family member "has gone from strength to strength" since moving into the service, adding that "the carers do a brilliant job" and "every bit of the service is fantastic." A third told us of their family member's health having improved since moving in, both physically and mentally. A fourth explained that knowing their family member was well looked-after "makes such a difference." A community professional told us of a calm atmosphere at the service and everyone appearing content.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. People and their representatives told us of staff being capable, for example, "They seem very well trained" and "I think the staff are 100% excellent; they on the ball, they know what they are doing." A community professional told us of well-trained staff throughout the service. Some staff members also praised the quality of staff working at the service. One said, "the main strengths are the nursing and care staff." Another said, "Staff look after residents properly."

Staff told us of receiving sufficient training for their care roles, much of which was classroom-based. Some praised the training and its impact on care provision, including, "Quality of care improved due to training provided and more team work." Nurses we spoke with showed good knowledge of their roles, for example, around supporting people with specialist nursing equipment. They confirmed their training was comprehensive and up-to-date.

The management team told us of the provider's designated trainer who ran sessions at the service monthly. Staff could also attend their sessions at one of the provider's other homes across London if needed. Records confirmed the sessions took place regularly. We therefore found that staff were up-to-date on necessary training topics such as fire safety, safeguarding people from abuse and moving and handling. There was also a comprehensive update on other relevant courses such as falls management and end-of-life care.

The management team told us of there being an embedded process for ensuring new staff completed a national training program on essential care standards, although it took a while to complete. We saw individual staff records in support of this. Oversight records showed care and nursing staff ordinarily received developmental supervision on a quarterly basis, and that there were annual appraisals, in addition to the training support provided.

The service assessed people's needs and preferences so that care and support was delivered to achieve effective outcomes. The service used a range of assessments to consider people's care and welfare needs. These included, for example, people's strengths, levels of independence, and health and quality of life matters. These processes all contributed to people's individualised care plans. We saw handover records by which outgoing staff communicated to incoming staff on how people had been and what current needs they had.

The whole service worked in co-operation with other organisations to deliver effective care and support. Some people told us this was the case. Comments included, "I had a painful gum. I had a dentist and he referred me to the hospital" and "They got a speech therapist in." A community professional told us of good collaborative working and systems at the service to provide 'excellent' care. Each person's care file had a record of all community professional visits and action taken as a result. This included visits from GPs, psychiatrists, chiropodists and opticians.

Staff involved health and social care agencies when needed, and responded to recommendations to meet people's best interests. For example, for one person assessed having difficulty swallowing food, the service had arranged for a GP to visit, and for the Speech and Language Therapy team to assess the person. We saw that their recommendations had been promptly applied, including kitchen staff being updated of the person's requirements for a soft diet and an urgent referral to a dietician.

Another person's file showed good liaison with a hospital team in respect of specific foot care needs. This helped the person with management of pain. A third person's psychiatrist reports indicated the service had worked to reduce the person's aggressive behaviours, to the extent that this aspect of their care had now been discharged to the GP. Accident records showed staff attended hospitals with people using the service where needed, which helped ensure people's needs and preferences were communicated to other professionals.

The service supported people to live healthier lives, have access to healthcare services and receive ongoing healthcare support. People provided some positive feedback in this respect. One person said, "They are good if you are not feeling well. They pop in." Another told us, "There are two doctors, they are very good." The management team told us of weekly doctor rounds in addition to accessing GPs as needed. People's representatives also praised how the service attended to health needs. One said, "Health conditions are picked up." Another told us, "If my mother was unwell they would notice." They added that the GP would be called if needed and they would be informed. A third felt that the staff were alert to people's health needs as they had picked up on their family member having a urine infection.

Records and staff feedback indicated no-one had developed pressure ulcers or wounds as a result of using the service. A staff member said, "We take pressure sores seriously. Sometimes they come with them from hospital, but we work hard to heal them or stop them getting worse." Another told us, "We frequently observe skin during personal hygiene time, and we look for any problems." One person's files showed assessment of risk in relation to identified skin concerns on their feet. Their care plan guided them to be supported to wear heel protectors to relieve pressure, and to be supported to reposition every few hours. We saw this occurred. A referral for the input of a community tissue viability nurse had also been made. Another person's plan guided staff on how to apply specific creams and what to monitor their skin for. Where used, we found that pressure mattresses on people's beds were correctly set according to their weight.

There were specific care plans in place for most people's physical health conditions such as diabetes and skin care. Where people had a catheter in situ, a detailed care plan was in place with details of how and when the catheter needed to be changed and the signs to look for in terms of infection and blockage. Where required, people's blood pressure and sugar levels were monitored. A few staff spoke of recent training on a monitoring tool that helped to "recognise early symptoms of illness to prevent further deterioration or hospitalisation."

The service supported people to eat and drink enough and maintain a balanced diet. People praised the meals provided. One person said, "The best thing here is the dinners." Other comments included, "The food is good" and "Lovely food, tasty, good choice every day, love it!" People's representatives provided similar

feedback. One told us the food is "really good; people eat well." Another spoke of their family member receiving a balanced diet with fruit and vegetables every day. A third told us staff paid attention to their family member's diet and weight.

Records showed people's weight and malnutrition risk was kept under review each month, and more frequently if assessed as necessary. One representative told us their family member's "weight had gone down a bit and they were quick to make sure that she got the additional nutrients from Ensure." There was individualised guidance within people's care plans about the support to provide at meal times, along with any associated malnutrition or dehydration risks. People were offered a variety of diets for their specific needs, for example, chopped, pureed, diabetic, low fat, and low salt.

Meals and drinks were served to people, to manage independently or on a one-to-one basis as required, throughout the day. For example, a staff member gently supported one person who could not raise their head. There was particular attention to supporting people to drink, as it was a warm period. Drinks were available for everyone in front of them within easy reach. Jugs of water with cups were available in each person's room. Fans were also available due to the hot weather. Some staff told us of improvements to ensure people drank enough. One said, "A strength is that the residents who are not taking enough fluids are recorded so they are continuously kept hydrated."

Food and fluid charts were kept in support of helping to ensure people's nutrition and hydration needs were met. We found charts were completed each day, but our checks across both days of visiting found they were not always filled in instantaneously. This meant staff were sometimes relying on memory to document what and how much was eaten or drank and when. This had potential for inaccurate records to be made. However, whilst the management team made plans to address this as a result of our feedback, they also told us of twice-daily checks of food and fluid charts across the service, to make sure the charts were being used effectively in support of people's specific needs. We also recognised there had been much scrutiny of this aspect of the service, and that gradual improvements were being made in support of more effective care of people.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found the service was working within the principles of the MCA. Each person's care plan had a capacity assessment in place for decisions related to daily living. There was a summary of best interest decisions that had been made. For example, when medicines were administered covertly to people we saw that this had been agreed appropriately and a best interest assessment had been completed. Where people's representatives held legal status such as Power of Attorney, this had been clearly documented in the care plan.

Where people had a DoLS authorisation in place there were details of the authorisation and any conditions that had been placed. Where DoLS were due to expire there was evidence of the submission of a re-authorisation request. The management team used a tracking document to oversee this for everyone in the

service, to help ensure DoLS authorisations were up-to-date. We saw evidence of the service checking with the local authority on progress with applications.

We found one person who had conditions on the DoLS where we did not see any written evidence of the service working towards implementing one of the conditions around taking the person out from time to time when weather was nice and providing a stimulating environment. Staff told us they did try to take the person out but the person would insist on coming back into the home; however, this had not been recorded. The registered manager agreed to adapt the tracking document, to help audit that where DoLS had any conditions of agreement, records were made of taken in response.

Nursing staff were aware who was to be resuscitated in a medical emergency and who was not. These details were clear in people's files on "Do Not Attempt Resuscitation" forms which had been signed by their GP and showed appropriate involvement of the views of the person or their representative. Staff described what training they had and said they were prepared to respond to emergencies.

The adaptation, design and decoration of premises generally supported people's individual needs to be met. Some corridors around the building were dementia-friendly with reminiscence pictures of famous people and locations. However, others were quite plain. Some people told us they liked the large garden, which we saw had a seated patio to one side and was used by some people with support from staff or visitors when needed. One person told us, "I like walking. The support is very good like that."

Rooms were reasonably decorated. Many people's rooms had items of their personal furniture, cherished ornaments and personal photographs. However, some rooms required attention where, for example, curtains were not hooked properly, pillows were bumpy, or walls required painting due to chipped or flaked paintwork. This matched a few comments we received from people's representatives. One said, "The home could do with a 'spruce-up'. However, the grounds are immaculate."

The director told us of plans to redecorate all areas of the service after some building extension work. This would include consideration of how to make the environment more dementia-friendly through consultation with a specialist.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion, and given emotional support when needed. People spoke positively about the care. Comments included, "They take care of residents and do everything they should do", "There are nice people to attend you", "I have a bed bath every day; I am kept very clean" and "Staff listen to patients who need a lot of time." People's representatives also praised the care provided. They told us, "Staff are nice", "The care is excellent", "Staff seem to be genuinely caring and friendly" and "even though my mother doesn't talk a lot the staff really do their best to engage her in conversation." A community professional also praised the caring nature of staff.

We saw that communication with people from both care staff and staff in other roles was warm and friendly. People responded positively. Staff also provided reassuring physical contact to some people from time to time.

A key-worker system was in place at the service. This enabled a personal relationship to be formed with each person that allowed greater thought and oversight of their needs and what was significant to them. Feedback and photos showed that people's birthdays were celebrated.

The service ensured people's privacy and dignity was respected and promoted. People using the service told us this was the case. Their comments included, "They treat me with dignity" and "On the whole they are very gentle." People's representatives spoke similarly. One said, "100% they respect his privacy and dignity." Another told us, "The staff are really respectful of my husband when they deal with his personal care." A third said their family member's laundry was done well and items of clothing did not go missing. There was positive overall feedback about laundry and clothing.

We saw that when staff interacted, they had considerate attitudes and addressed people appropriately. For example, staff knocked and waited before entering rooms. They spoke with people at eye-level wherever possible. Staff spoke in a caring and reassuring manner when helping people to move. We saw privacy screens being used when some people were provided with hoisting support to move between seats. People who had difficulty with coordination were supported and encouraged to be independent if they could.

Where needed, people had been supported to be appropriately dressed. A community professional also told us of this. For meals, staff offered some people clothing protectors to prevent risk of food or drink stains. Staff also encouraged people at lunch.

People on bedrest were observed to be mostly comfortable, warm, clean and tidy. Records showed they received regular attention. People received support to maintain tidy rooms where needed.

The service supported people to maintain relationships that mattered to them. People's care files included information on the relationships that were important to them. People told us the service enabled them to maintain contact with friends and family, and of straightforward visiting arrangements. Comments included, "Visitors can come at any time" and "Even in evening time visitors are always welcomed."

People's representatives told us of no restrictions on visiting times. One said, "When I leave my mother always likes to wave to me from the window and there is never a problem arranging for staff to oversee this." We saw many visitors coming and going throughout our visits, including relatives with young children and pets. The service made them welcome, which visitors also told us. Some people and their visitors used the garden.

The service liaised appropriately with people's representatives, who told us of being kept informed on their loved one if, for example, they were unwell or injured. One person's representative said, "The service communicates effectively." Another told us, "Communication between staff and relatives is exceptional. If there is anything, they phone me." The management team told us of improved communication with people's representatives, for example, through a communication pad left in people's rooms and ensuring people had designated key-workers to help liaise with representatives. We saw these in use.

People and their representatives were observed to be involved in decisions about their care or the care of their family member where possible. One staff member said, "Even if people don't have capacity, there are days where they can answer and tell you what they want." Records showed people and those close to them were encouraged to contribute to the assessment and planning of their care.

The service also sought people's views through meetings. A few people's representatives told us of being asked for feedback on the service's quality. We were provided with minutes of the last two meetings for people using the service and their representatives. These showed a three-monthly frequency. The meetings included updates from the service and on applicable legislation, activity discussions, and suggestions from attendees. However, the meetings did not conclude with action points, which we recommended to the registered manager, to help demonstrate ongoing improvements.

Good

Is the service responsive?

Our findings

The service provided personalised care that was responsive to people's needs. People told us this was the case. One person said, "I'm looked after well." Another told us their faith was important to them, which was supported by weekly visits from a religious leader. A representative said, "They know if he is in pain as he won't tell." Another told us, "If there is point I need to put across staff will do it." A third explained staff had worked hard to organise a minister of their family member's faith to visit. We saw staff support some people to have items with them that provided reassurance.

People told us staff responded to their requests. One person said, "They bring you a cup of tea if you want." People said call-bells were made available to them in their rooms and that staff attended when called. One person told us, "The bell is good if you are not feeling well." Another said, "They come quickly. They try their best." We saw staff quickly attending when call-bells and sensor mats were activated. We also saw someone saying they felt hot, so care staff set up additional fans for them.

Staff told us of responding to people's individual support needs and preferences. For example, one person tended to start shouting mid-afternoon. But this would stop if they could be engaged with sport on TV at that time. One person liked things associated with a particular foreign city. Staff spoke with them about this and tried to use that city's language. There were signs pointing to one person's room. Staff told us this helped them find their way.

The service supported the communication needs of people with a disability, sensory impairment, or whose first language was not English. One person had communication difficulties due to their complex health needs. We saw communication from staff to be caring and personalised. The person's body-language showed this made a difference to them. Another person's communication care plan was set up to help minimise the risk of aggressive behaviours. We heard staff attempting words and phrases in the first language of a few people. We saw someone say they could not hear during a bingo session, so the activity leader stood next to them to announce the numbers so they could hear better.

The service provided a range of activities that aimed to reflect people's preferences. There was an activities programme six days a week. People's comments on the activities included, "There is a volunteer who plays scrabble. There is entertainment, a poetry group and bingo" and "We go to the pub. The carers take me. There is bingo, scrabble and cards." Someone's representative told us, "The boys from the school come in and play games." Another said, "We see them batting the balloons around, and getting nails done." A third added, "The BBQ is next week. They keep them entertained. There is always something going on."

An activities coordinator told us of checking with new people and their representatives on the person's interests, to incorporate that into the activities programme where possible or find other ways to engage them. However, they also presented people with new opportunities, as they found that some people liked to try new things. They also told us of checking what music people liked and providing an ongoing variety of songs that tried to engage everyone.

We saw ball-throwing, bingo, music and reading sessions during our visits. There were many photos on display of activities that had taken place, such as visits to a local pub and the summer barbeque that occurred in-between our visits, including the use of an old-style ice-cream cart that may have reflected some people's younger years. Records and staff feedback informed us of poetry sessions being popular for some people, of clothes shows, flower arranging and quizzes, and of trips to a garden centre and an RAF museum.

There were individualised care plans in place that included information on people's physical and welfare support needs and preferences. This included, for example, mobility, personal care, management of health conditions, night care, eating and drinking, and mental wellbeing. The plans guided staff on how to provide personalised support to people that met their needs. Plans were kept under review, and updated when needed. The management team acknowledged there had been joint working with some community professionals to raise care planning standards.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death. People's end-of-life care wishes had been recorded, where provided, on an end-of-life care plan with preferred priorities of care. For example, one person's plan gave directions of what to do should the person be unable to drink and when to refer to the community palliative care teams. Another person's clarified what sort of funeral arrangements were to be provided.

Nursing staff told us that when people were at the end stages of their life, procedures were in place to ensure they were cared for in a culturally sensitive and dignified way as recorded in their care plan. They were supported by palliative care specialists such as hospice and Macmillan nurses and the GP surgery, and specialist equipment was acquired where needed. The management team told us of some staff completing extensive training on end-of-life care in 2016. Records showed most care staff had completed a standard end-of-life training course.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. People told us they could raise anything they were unhappy with and it would be responded to. Comments included, "I would complain to the manager but never needed it", "I would get the right person and they would sort it out" and "I would tell the nurses about any complaint." Some people clarified that they had never needed to raise concerns. People's representatives provided similar feedback. One said, "I can speak to anyone." Another told us, "I know the manager well and would not have any problem in approaching her if I had a complaint."

The service kept an oversight summary of complaints and actions taken to resolve matters. This helped to analyse for trends and look to make improvements to care quality. The management team told us of investigating complaints openly, through independent managers in the organisation if needed. Apologies were provided where standards had not been met. They confirmed no-one had been served notice to leave the service because of making a complaint.

Good

Is the service well-led?

Our findings

The service's registered manager had many years' experience in that role. They retained a long-established nursing registration. There was praise for the management of the service. A representative told us, "I know the manager, she is really good, I can talk to her when I want." Another said, "We see her quite often around." A third told us, "The manager is first class. I can honestly not praise this place enough." Some community professionals also fed-back positively on the service's management. One said the registered manager was very visible around the service. Another spoke of the registered manager having systems in place for upholding good care standards.

The service aimed to promote a positive and inclusive culture that achieved good outcomes for people. We found that good outcomes were achieved for people, as particularly reported under the question 'Is It Effective?' Some staff were positive about the registered manager's style and said she was "approachable." Another staff member told us of "better support." They reported they would feel able to raise any concerns or make suggestions if necessary. Staff also told us of senior managers' presence in the service from time to time. One told us the director "is always asking us about ideas."

However, six of the eleven care and nursing staff we spoke with had concerns about the management of the service. Staff told us of good training but few mentioned any other form of support when asked, such as staff meetings or developmental supervision. Three staff told us of poor communication from the management team. One explained, "It's mostly verbal communication and it doesn't help for someone who has been out on leave or off duty." This feedback indicated weaknesses in the service's working culture.

We checked on the management team's communication processes. In one unit we found the staff memo file to mainly contain information dating from 2017. A staff communication book in another unit had been purposefully used at the start of the year, for example, to provide updates amongst staff on care practices and to record an impromptu meeting led by the registered manager. However, it had no entries for over two months. This somewhat corroborated the feedback we received from some staff. In contrast, there were strong oversight records of people's clinical needs on each unit, which emphasised the commitment to achieving good outcomes for people using the service.

The provider sent us an action plan shortly after our visits, that aimed to improve the working culture of the service. This included senior management attendance at longer staff meetings, and reiterating and enhancing systems by which staff could raise concerns and make suggestions for improvements.

We found systems at the service generally enabled sustainability and supported continuous learning and improvement. The management team told us of reviewing the service in light of the last inspection and identifying that additional management support would be beneficial. The registered manager also reflected that she had more of a presence in the units, talking to whoever was present and observing care standards. She had tried recording observations of direct care, but based on feedback from staff that this eroded trust, had switched to more informal monitoring.

The management team made improvements to the service based on our feedback from the first day of visiting. This included installing portable air conditioning units on the first and second floor lounges to help bring down room temperatures, purchasing pillows to replace those that were lumpy, and updating specific medicines guidance for some people that we found was missing. Following our feedback at the end of the inspection visits, the provider sent us action plans to help address any minor shortfalls we communicated, such as with care-planning matters identified on a few of the care plans we checked. This all helped to demonstrate the responsiveness of the management of the service at reflecting on professional feedback and working to implement continuous improvements.

The management team told us of monthly manager meetings across the provider's services, by which learning, new legislation and good practice was shared. The director showed us a company structure that demonstrated the involvement of many specialists who helped guide and support the business. These included a development manager, and GPs for specific medical advice or hospital liaison. They also told us of imminent plans to refurbish and expand parts of the building, and of technological developments the company was working on that could help monitor people's safety and enable their independence.

The provider's governance framework aimed to ensure that responsibilities were clear and that quality performance, risks and regulatory requirements were understood and managed. The service was continuing to record regular audits of its safety and effectiveness across several areas. These included for infection control, food safety, medicines, health and safety, clinical matters and care plans. A professional health and safety audit was also undertaken, from which we saw actions had been addressed.

The qualities manager undertook monthly monitoring visits to oversee standards at the service. Records of recent visits included focus on staff training and staffing levels, in-service audits, the environment, the views of people in the service, and the needs of specific people using the service. The management team compiled monthly quality assurance data reports to help keep the provider informed of matters at the service such as complaints, accidents and safeguarding matters. The reports also stated the last date of various audits, to help ensure they were up-to-date.

The provider engaged with and involved stakeholders in the development of the service. 19 people's representatives responded to a quality survey in March 2018. Detailed analysis of the results was available. This showed a clear strength of the service as the friendliness of staff amongst a lot of positive feedback. An action plan had been drawn up to improve on the seven weakest areas. The plan had been updated to show what progress had been made. A similar survey of staff took place earlier in the year, from which an action plan had been set up to address key concerns.

The service worked in partnership with other agencies to support care provision and development. The registered manager told us of being involved in the continence pathway programme project that was being organised at certain care homes in the local area. The service was also involved in the new nursing pathways project and capital nurse programme, which would involve supporting the development of student nurses.

The local authority's 'quality in care homes' team had been working with the service for a while in support of helping to improve care standards. The registered manager told us of ongoing weekly visits from that team, which had now developed into specific projects such as the Significant 7 NHS England project. The registered manager explained that it helped care staff identify if people were starting to experience greater needs such as symptoms of a urinary tract infection, dehydration, or skin care concerns. This was then brought to the attention of nursing staff, who could make decisions on what additional treatment the person may need. We saw up-to-date records for people in relation to this work. A staff member told us, "The new training called the Significant 7 has really helped staff." A community professional provided us

with positive feedback on how staff and management at the service were positively engaging with the project.