Cooksditch House Care Ltd

# Cooksditch House Nursing & Residential Home

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

Cooksditch House Nursing & Residential Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service has 50 single rooms. It is registered to provide accommodation and personal care support for up to 55 people, if some people choose to share a room. At the time of the inspection there were 48 people living at the service: 31 people were accommodated in the nursing unit and 17 people receiving residential care. The service accommodated older people with a wide range of needs including chronic or long-term health needs, physical disability, mental health and dementia.

The inspection was unannounced and took place on 3 and 4 October 2018. This was the first inspection to the service since it registered with CQC on 25 October 2017. Prior to this, the service was owned and managed by a different provider.

The service was run by a registered manager and they were present on both days of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although systems to assess and monitor the quality of the service were being strengthened, they were not always effective in identifying and addressing shortfalls in service provision.

Safe systems were not in place for the management of medicines. Some people did not receive their medicines as prescribed.

There was not a systematic approach in place to determine the number of staff required to meet the needs of people. Staffing levels had been adjusted to meet the needs of people in the nursing unit. People in the residential unit told us that they had to wait a long time to receive staff support. The provider made some adjustments to staffing levels in the residential unit as a direct result of our inspection visit.

There was inconsistency in people's care and treatment records with regards to fluids, repositioning and personal care so it could not be assured that their needs were being met.

The activity coordinator was absent from the service and this had impacted on the opportunities available for people to take part in. The provider arranged for a member of the care staff team to work an additional three afternoons a week to provide activities as a direct result of our inspection visit. Links with the local community had been developed through open days and with a local school.

Staff understood how to support people to have a pain free and comfortable end of life, with people around who were important to them. However, not everyone who had life limiting conditions had been asked about their wishes at the end of their lives.

People and their relatives told us they felt safe and comfortable with the staff who supported them. Staff had received training in how to safeguard people and knew how to report and act on any concerns to help keep people safe. New staff were checked to make sure they were suitable to work with people.

Assessments of risks to people's safety and welfare had been carried out and action taken to minimise their occurrence. Health and safety checks were effective in ensuring that the environment was safe and that equipment was in good working order. Accidents and incidents were monitored and appropriate action taken in a timely manner to evidence that lessons had been learned.

People benefitted from a clean environment and staff knew what to do to minimise the spread of any infection.

People were supported to access health care services when needed. The provider worked in partnership with a range of healthcare professionals to ensure people received appropriate care and treatment. People had sufficient food and drink and were provided with choices and at mealtimes.

Staff received the training they needed to enable them to support people with a range of needs. Staff were suitably trained, received regular supervisions and felt well supported. The provider made sure the registered nurses had access to the training required to ensure their continuous professional development.

People were supported to have maximum choice and control of their lives in line with the principles of the Mental Capacity Act 2005. The provider had taken the necessary steps to ensure that people only received lawful care that was the least restrictive possible.

The provider had invested in the service for the benefit of people and staff. They had undertaken maintenance and repairs, installed new flooring and commenced a programme of redecoration. This had improved the standard of décor and people's satisfaction with the environment.

Staff were kind and caring and treated people with dignity and respect. Staff had developed positive relationships with people. Visitors such as family and friends were welcome at all times.

A new care planning system was being rolled out to help improve the consistency of guidance available to staff.

Consideration had been given to presenting information to people in a way that they could understand. This included the use of whiteboards to write messages for people who were hard of hearing.

The provider had a complaints procedure in place and people who used the service and their relative were aware of how to make a complaint.

Staff felt well supported by the management team. People and their relatives said the service was well run and the registered manager was approachable. Feedback from people and their relatives was regularly sought and acted on so that the service improved for their benefit.

The service worked in partnership with other organisations and sought their advice to improve outcomes for

people.

Further information is in the detailed findings below.

## 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 always safe.

Checks were in place to recruit suitable staff but they were not always available in sufficient numbers to meet people's needs.

People did not always receive their medicines as prescribed by their doctor.

Staff knew how to recognise any potential abuse and so help keep people safe.

Risks to people's safety and welfare were managed to make sure they were protected from harm.

Suitable systems were in place for the control of infections.

### Is the service effective?

**Good**

The service was effective.

Staff received on-going training and support to enable them to carry out their roles.

People had access to healthcare services when needed and were supported to be able to eat and drink sufficient amounts to meet their needs.

Staff were knowledgeable about people's health needs, and contacted other health if they had concerns about people's health.

Staff knew how to follow the principles of the Mental Capacity Act (2005).

The provider had acted to improve the environment for the benefit of people.

### Is the service caring?

**Good**

The service was caring.

People were supported by kind and caring staff.

Staff protected people's privacy and dignity and encouraged them to retain their independence where possible.

Staff communicated with people in a way they could understand and took into consideration their choices and preferences.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

The range of activities available was limited due to the absence of the activity coordinator.

People were supported to have a pain free and comfortable death, but some people had not been consulted about their wishes at the end of their lives.

People's support plans were being developed so they consistently gave clear guidance to staff.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

The quality assurance system was not effective in identifying and rectifying shortfalls in service provision.

There was inconsistency in people's care and treatment records so it could not be assured their needs were always met.

People benefitted from a staff team who were well supported and clear about their roles and responsibilities.

People and their relatives were regularly asked for their views and they were acted on for their benefit.

# Cooksditch House Nursing & Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3 and 4 October 2018 and was unannounced. The inspection team consisted of two inspectors, a specialist nurse advisor and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for family members.

Prior to the inspection, we looked at previous inspection reports and notifications about important events that had taken place at the service. We also asked the provider to complete a Provider Information Return (PIR). 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.

During the inspection we joined some people for lunch and attended a daily meeting with the head of each department. We spoke with 15 people and 9 relatives to gain their views about the quality of care provided. We also obtained feedback from a specialist care home nurse, member of the district nurse team, consultant for older people and a dietician. The views from people, relatives and health care professionals is contained in detail in the main body of the report.

We spoke to the registered manager, provider, residential unit leader, two nurses, two senior care staff, one care staff, the administrator, two cooks, housekeeper and maintenance person. We also viewed several records including thirteen care plans; the management of medicines; the recruitment files of five staff recently employed at the service; staff training records; health and safety records; complaints and compliments; accidents and incidents and quality monitoring audits.

Requires Improvement

# Is the service safe?

## Our findings

People and their relatives all told us that they felt safe at the service. One person told us, "The warmth of the caring staff makes me feel safe and wanted". A relative said, "Staff treat mum well and she feels safe here". Although people felt safe, some people in the residential unit said that there were not always enough staff around meet their needs in a timely manner. Comments included, "It seems they are always short of staff"; "If you can walk to the toilet good for you, but someone like me has to wait for hours to be toileted"; "When I press my call bell they respond but not quick enough"; and "Staff come and help me if I need them".

The provider had obtained a specialist tool to assist them to assess the staffing levels required at the service. However, it was not in use at the time of the inspection. This tool uses people's dependency levels, such as what tasks they need staff to support them with throughout the day, to determine how many staff are needed throughout the day and night. The provider had ensured that there were sufficient staff to meet the needs of people in the nursing unit. People in the residential unit had access to a lounge in the main part of the building and to the conservatory, which was situated away from the unit. Some people in both seating areas required staff to assist them to move around the service. We observed that people in both areas had to wait longer than it was comfortable for them to, to be assisted by staff to the toilet. There were also long periods when no staff were present in either seating area as staff were attending to people who required the assistance of two staff to enable them to move around the service. The staff dependency tool that the provider planned to use to assess staffing levels, did include reference to the layout of the building.

On the second day of the inspection an extra staff member was deployed between 2 and 4pm in the residential unit, to increase staffing numbers to three care staff throughout the day. Staffing rotas evidence that this extra staffing had been arranged for the next few days and the provider confirmed that this would be a permanent arrangement. The provider only made changes to staffing levels in the residential unit as a direct result of our inspection visit.

The provider had failed to ensure there was a systematic approach to the assessment and deployment of staff so that there were sufficient numbers available at all times. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People said they had confidence in the staff who supported them to take their medicines when they were needed. One person told us, "My medication is always on time. I have a book that I record all the medications I am given. I record the time it's given to me". However, people's medicines were not always managed safely.

The providers medicines audits had highlighted shortfalls in medicines administrations throughout the service. The medicines audit of the residential unit on 12 August 2018 found that there had been errors with ten people's medicines which had not been identified until the time of the audit. Some people had more medicines in stock than records showed and other people had less medicines in stock than records showed. This meant that some people may not been given their medicines when they had been prescribed by their doctor; and for other people, staff may not have signed the medicines administration sheet after they had

given people their medicine. A medicines audit in the nursing unit on 25 March 2018 identified the same issues. We found that these shortfalls in medicines management continued to persist.

On the nursing unit four people's medicines had been taken out of the medicines blister pack but nurses had not signed the medicines record to show that they had administered. In addition, nurses had signed that they had given one person a water pill and another person pain relief and a medicine that treats irregular heartbeat, but these medicines remained in the medicine blister packs. In the residential unit we found that for one person they should have had six pain relieving medicines available to them but had only four. This meant that staff may have given them more pain relief than they required. For another person they had fourteen medicine tablets for treating respiratory tract problems when records showed they should have seventeen. This meant that this person had not received three doses of this medicine as prescribed by their doctor. In addition, the room temperature of the medicines room on the top floor of the nursing unit had not been checked since 22 September and on the bottom floor of the nursing unit for the last three days. This meant it could not be assured that medicines were kept at the necessary temperature so that they were safe to use.

Medicines were administered by registered nurses and trained care staff. Medicines competency checks were carried out on new staff and existing staff's competency was assessed through a practical task, including direct observation. These assessments had been carried out for care staff, but the clinical lead had yet to undertake them for nursing staff.

The provider had failed to ensure safe systems were in place for the management of medicines. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines, including those which are at higher risk of misuse and therefore needs closer monitoring. were kept secured and safely. Medicine Administration Records contained a photograph of each person so that they could be easily identified. Information was available to staff administering medicines as to if a person had an allergy to any prescribed medicines. Protocols were in place for people who were prescribed their medicines to be given 'as required' (PRN) and these were understood by staff. Staff recorded when patches for pain relief were applied to people's skin and when they were rotated to ensure they were regularly moved to maintain people's skin.

Staff had received training in safeguarding and keeping people safe. They demonstrated that they knew how to follow the provider's safeguarding policy. Staff knew about different types of potential abuse and their responsibilities to report any concerns to help make sure people were kept safe from harm. Staff had access to the contact details of the local authority who are the lead agency in safeguarding investigations. Staff felt confident that the registered manager would act on any concerns but knew to contact the local authority or the Care Quality Commission ( CQC) if they did not do so. Staff also knew how to "blow the whistle" which is where staff are protected if they report the poor practice of another person employed at the service, if they do so in good faith.

Risks to people's safety had been assessed such as the risk of falling, developing pressure ulcers and receiving adequate nutrition. For people at risk of falling risk management plans included the type of equipment and amount of staff support they needed to be moved safely. People were using a range of moving and handling equipment on the days of the inspection. Nursing staff provided appropriate treatment for people with wounds and monitored their progression through observations and records, including photographs. There was some inconsistency in records relating to people at risk of developing pressure ulcers. One risk management plan did not contain guidance for staff on the equipment the needed and frequency they needed to be repositioned. However, nursing and care staff knew which people's skin

integrity was at risk and the action they needed to take to keep people's skin healthy.

The provider carried out regular checks on the premises and equipment to ensure the service was safe for people and staff. This included the servicing of fire-fighting equipment, gas and electricity supply, air mattresses and moving and handling equipment. A maintenance person was employed to attend to repairs and make sure they were dealt with in a timely manner. Each person had a personal emergency evacuation plan which was kept in the fire folder in reception. These identified the individual support and/or equipment people needed to be evacuated in the event of a fire. Day and night staff had taken part in fire training and drills so that they knew what to do in the event of a fire. A health and safety meeting had taken place in September 2018 to discuss the safety of the environment any new risks and to make sure that appropriate action was being taken. For example, it had been identified that some plug sockets were being damaged by nursing beds and staff had been advised to move these beds away from the wall. Staff were also reminded of the importance of keeping fire escapes clear.

Staff made a record if an accident or incident occurred which included a description of what had occurred, any treatment given and who was informed such as the next of kin. The registered manager reviewed all significant events to see if there had been any common themes or patterns and that the appropriate action had been taken. Accidents and incidents were also discussed at health and safety meetings. There were systems and processes to make improvements when things had gone wrong. When people had fallen, an analysis was undertaken to identify if the person had fallen previously and when this had occurred a referral had been made to the falls clinic.

Appropriate checks were carried out to ensure that staff recruited to the service were suitable for their role. This included obtaining a person's work references, a full employment history, checks on nurses' registration and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People and their relatives were satisfied with the cleanliness of the service. Cleaning staff followed a schedule and worked hard to ensure the service was clean and free from unpleasant odours. A resident of the day scheme had been introduced and this included the designated person having their room deep cleaned. The housekeeping team consisted of domestic staff and laundry staff. There was a separate room for clean and dirty laundry and each person had their own labelled laundry basket. Systems were in place for dealing with soiled laundry and sluice rooms were available throughout the service. Infection control audits were carried out and staff had access to and used personal protect equipment such as disposable gloves and aprons to prevent any cross infection. All these actions helped to minimise the spread of any infection should it occur.

Good

# Is the service effective?

## Our findings

People and their relatives told us the staff team had the right skills and knowledge to support them. One person told us, "Staff are well trained, but they could always use some more". People said that staff arranged appointments with health care professionals such as their doctor when they were needed. One person told us, "Sometimes staff escort and support you when you are unwell and you have to go and see the doctor".

New staff undertook a structured induction and staff confirmed that it provided them with the skills and knowledge they required for their roles. A staff training matrix was used to identify when staff training needed to be refreshed so that staff's knowledge was kept up to date. Training for staff included essential areas such as health and safety, fire and moving and handling. Most topics were taught through e-learning with a check in place that staff knowledge met a specified requirement.

Two staff members were trainers in moving and handling and provided practical training in this area. Staff demonstrated they were skilled in moving and handling techniques when transferring and moving people. A staff competency framework had started to be rolled out which checked staff's skills in a wide range of areas including assisting people with personal care and food and nutrition, pressure care and catheter care. Specialist face to face training was also provided in palliative care. Nursing staff completed additional courses to make sure they continually validated their nursing qualification with the Nursing and Midwifery Council (NMC). The provider encouraged staff to complete a Diploma in health and social care level two or above. 72% of care staff had achieved this qualification which gives staff the ability and competence to carry out their job to the required standard.

An initial assessment was undertaken before people moved to the service to check the service could meet the person's care and support needs. Assessments included nationally recognised specialist tools with regards to identifying people at risk of pressure ulcers and malnutrition.

The provider made referrals and sought advice from other professionals, such as a person's GP, district nurse, speech and language therapist, diabetes nurse and dietician when required. Feedback from three out of four health care professionals was that this was done in a timely manner. A team made up of different health care professionals regularly visited the service and staff made sure that a record was made of any advice that was given in relation to each person. For people with diabetes staff liaised with the diabetic nurse and monitored the person's blood sugar at the required intervals to help maintain them at safe levels. When it had been identified that people had difficulties with their hearing an appointment had been made for them to have a hearing test. Staff knew how to follow the recommendations of the speech and language therapist to safely feed people who had a percutaneous endoscopic gastrostomy (PEG). PEG is a tube that feeds directly into a person's stomach. Clear instructions and a pictorial guide was available to staff together with information about how to safely manage the PEG.

People were complimentary about the quality and choice of meals provided. One person told us, "There is a menu you are assisted to choose from and there are alternatives choices a well". Another person said, "For

breakfast you can come down from 8am and get served. It's quite good". One person said that they did not like the way that the cook made the macaroni cheese as it was not made properly with a cheese sauce. However, when we asked both cooks how they made macaroni cheese, their described how they made a cheese sauce for the pasta and added grated cheese on the top. Care and catering staff were aware of people's individual dietary needs such as if people were diabetic, required their food pureed and of people's likes and dislikes.

Feedback from the community dietician was that the staff supported people appropriately with eating and drinking and that they no concerns about how people's nutrition was managed. One person had assessed as finding it difficult to swallow and had been referred to the speech and language therapist. The cooks had been informed that this person required a soft diet and a referral had been made to the dietician. Staff knew which people were at risk of poor nutrition and who was at risk of choking and needed close supervision at mealtimes to keep them safe. People were offered drinks throughout the day. At lunch time people were provided with the support they needed to eat their meals. People were weighed regularly and their weights monitored so that action could be taken if people gained or lost significant amounts that may affect their health.

Staff felt supported by their colleagues, senior staff and the management team. Staff received individual or group supervision. The registered manager had supervised all care and non-care to get to know the staff team when they first came to the service. Each head of department had attended supervision training and regularly supervised their respective team. Nursing staff took part in clinical supervision with included training and discussion in key topics such as pressure area care. A format for staff appraisals had been developed and the registered manager told us that these were being rolled out from November 2018. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

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. Staff understood the main principles of the MCA and how to put them into practice. People's capacity had been assessed and information about this was available in people's care records. For example, one person had capacity and it was recorded they could make all daily living decisions such as what they wanted to eat and drink, how they wanted to spend their time and what they wanted to wear. Another person had become more confused after returning from hospital. Staff were guided to support this person to make an informed choice, by explaining the potential outcome and any decisions they made. One person told us, "Staff always ask for your consent before giving you personal care, or cutting up your food into bits".

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 authorisation procedures for this in care homes are hospitals are called the Deprivation of Liberty Safeguards (DoLS). Applications had been made to the local authority for people who may be restricted in their freedom. The registered manager monitored DoLS authorisations and had a planner in place. This was so they knew when to resubmitted applications before they expired to ensure that they only restricted people's liberty when it had been assessed as lawful to do so.

The provider had acted to make improvements to the environment, which benefitted people and staff. Part of the roof in the residential unit had leaked which had resulted in water damage including a downstairs toilet. Staff told us that the roof had leaked on several occasions before the current provider took over

responsibility for the service. The current provider had ensured that works had been undertaken so that the roof would not leak again. One person told us, "The place looks a little shabby, but it feels homely". The service was not in a good state of decoration when the current provider took over responsibility for the service. A programme of redecoration was taking place at the time of the inspection. In the residential unit the downstairs lounge had been painted and decorators were painting the lounge. There were also plans in place to decorate the corridors and samples of paint were on the wall to help people decide about the colour. New flooring had also been laid where it had been identified that the carpet was worn and tired. Some people using the service were living with dementia. Signage had been purchased to put up when the redecoration was complete, to help people find their way around their home.

Good

# Is the service caring?

## Our findings

People and their relatives told us that staff were kind and caring. One person told us, "Staff are very caring. They try their very best". People said that staff took time to get to know them, including their likes and dislikes and that this was important to them. One person said, "Staff know my favourite clothes and when I like to wear them". Everyone said that staff treated them with dignity. A relative commented, "Mum is very happy here. She is well looked after and respected". Some people and their relatives described the welcoming and friendly atmosphere of the service. One such comment from a relative was, "We fell in love with the place as soon as we came in. The family can come anytime to visit dad and he is enjoyed it here". Comments from vising health care professionals were positive about the caring nature of the staff team. One professional described staff as, "Kind and caring" and another that the atmosphere at the service was "Lovely".

The provider had received some compliments from relatives about the caring nature of the staff. One relative commented, "Thank you for the wonderful care and help you gave to our mum. It was lovely to see her in pleasant surroundings looking comfortable and happy. It was also peace of mind to see how well she was being cared for". Another relative wrote, "Thank you for all at Cooksditch for your care, consideration and love to (name of person being cared for)".

People and staff had developed positive relationships. Staff promoted a non-discriminatory atmosphere where people were valued. This resulted in people feeling comfortable and relaxed. People were supported by staff in a caring and thoughtful way. They adjusted themselves so they were at the same level and maintained eye contact when speaking with people. Staff took time to listen to people, answer their questions and take an interest in what they were saying. However, there were occasions when staff were busy and they were not able to spend as much time with people as both they and the person would have liked.

Care plans contained information about people's likes, dislikes and interests. They also contained information about people's personal histories such as their past employment and family back ground. Several people's family members and friends visited the service on the days of the inspection. The registered manager had prioritised getting to know visitors to the service as they understood how important these relationships were to people's well-being. One person told us, "My family comes and visit me any time they want.". Guidance was also available to staff about people's preferred method of communication. For example, one found it difficult to hear and staff were advised to stand in front of this person when speaking to them, to help them understand what is being said.

People were treated with dignity and their privacy was respected. Staff knocked and waited to be invited into people's rooms. Where people needed support with using a bathroom this was done discreetly. People were addressed respectfully by staff, using their preferred names. Attention was paid to people's appearance including their clothes and ensuring that people who liked to dress smartly were enabled to do so. The registered manager said it was their intention to introduce dignity champions, to put dignity at the centre of the service. A dignity champion challenges poor care practice, acts as a role model and educates

and informs staff working with them.

People had been supported to express their views and be actively involved in making decisions about their support as far as possible. Care plans included information and guidance for staff about how they could promote people's independence. Some people could change their stoma bag by themselves and other people to self-inject their medicine with minimal staff assistance. A stoma is an opening in a person's tummy which allows waste products to be collected outside their body in a bag. Staff demonstrated that they understood the importance of promoting people's independence. They said that they offered people specialist cutlery so that the person could eat by themselves and encouraged them to wash parts of their body when providing personal care. People had access to a physiotherapist for rehabilitation where appropriate and staff encouraged people to undertake exercise programmes that had been put in place.

Some people had family members to support them and other people required advocates to help them air their views. Information was available about lay and independent mental capacity advocates and their services had been accessed when they were needed. Advocates are independent of the service. They can support people to express their needs and wishes and weight up and take decisions about the options available for people.

Arrangements had been made to ensure that private information was kept confidential and secure. Care staff had been given training and guidance about how to manage information in the right way so that it was only disclosed to people when necessary. Written records that contained private information were stored securely when not in use. Computer records were password protected so that they could only be accessed by authorised members of staff.

Requires Improvement

# Is the service responsive?

## Our findings

People said they were consulted and involved in decisions about their care. People and their relative's views were mixed about whether the service was responsive to their needs and requests. One person told us, "I feel I have enough care". Another person told us, "They do listen to you. The other day the chef came around and asked what we would like on the menu. I suggested a nice homemade whole roast chicken and a couple of weeks later, it was on the menu". However, other people commented on the lack of staff at times when they needed them and that they were not able to follow their hobbies and interests.

Some people were content with how they could spend their time. Comments included, "I like to sit in the conservatory watching people go by"; "I enjoy reading books and knitting. There is a little library in the conservatory where I pick the books from"; and "I go out for tea with staff". However, other people felt that there could be improvements made to the range of activities that were available. Comments included, "I spend most of the day in my bedroom. I can't really hear the TV in the lounge, so I prefer being in here"; and "The only trouble is there is not a lot of activity or things to do. The manager sometime does the activity herself which I find interesting".

A full-time activity coordinator was employed. One relative told us, "When we came around to have a look at the service, we saw how the staff were interacting with everyone and there were a range of activities taking place to keep people occupied". The activity coordinator was on a period of leave at the time of the inspection. To meet this shortfall, a decision had been made at the end of August 2018 for each team of staff to organise two days of activities a week. Some activities took place such as bingo and music and people could buy items from a shop which travelled around the service. This had progressed to a dedicated staff member undertaking activities three afternoons a week. However, there was not a comprehensive activity programme in place at the time of the inspection which met people' social needs and interests, as identified in their care plans. The provider immediately took action during the inspection to increase the role of the temporary activity coordinator to five days a week until the permanent activity coordinator's return.

Once a month people and their relatives were invited to an afternoon cream tea. There was a poster on display advertising the next event which would take place later in the week. The provider had developed links with a local school. Each week school children met a group of people in the conservatory and spent time talking to them about things that were important to them. One of these visits took place during the inspection and it was evident by people's facial expressions and conversations that they greatly benefitted from this interaction. Staff also arranged fetes and open days whereby people from the local community were invited to visit the service and take part in its organised events. This included BBQ's, clothes parties, a summer fete and pamper afternoons. At the open day in April 2018, people enjoyed interacting and cuddling a lamb and photographs about this were displayed.

Care staff understood the importance of promoting equality and diversity. This included arrangements that could be made if people wished to meet their spiritual needs by religious observance. People were supported to follow their faith and the service had developed a relationship with a local church. A church service was held each month. Special events such as Christmas and Easter were celebrated. At Christmas

local schools were invited to sing Christmas carols and the registered manager had started to make enquires to link with other organisations which would result in more frequent contact for people with young children. The registered manager recognised the importance of appropriately supporting people on an individual basis and with reference to their gender, ethnicity and sexuality.

Care plans covered all aspects of people's care and support needs. However, there was some inconsistency in the level of detail which was provided as guidance for staff. For example, there was clear guidance in place with reference what staff needed to do to minimise the risk of infection for people with a PEG. A diabetes care plan did not indicate what a person's normal glucose level should be although staff knew this information. The registered manager had identified that care planning could benefit from improvements and was introducing a new care planning system. This was being rolled out as part of the 'resident of the day' programme. Each day the person identified as 'resident of the day' had their whole care packaged reviewed in relation to their clinical, health, social and dietary needs. In addition, the person was offered one to one time with a staff member to have pamper session or undertake an activity of their choice such as a chat, game or walk.

People felt that they were listened to and they were confident to raise any concerns about the service they received if they needed to. One person said, "I've got no complaints. If I need anything they are there to help me". Another person told us, "I do not complain unless I need to. I think they would listen to me if I did complain". Information about how to make a complaint was displayed at the service. The complaints policy set out how a complaint would be investigated and the timescales for response. It also included the right for people to direct their concerns to the local government ombudsman if they were not satisfied with the way the service had handled their complaint. All complaints had been taken seriously, investigated and a record kept detailing all actions and progress of the complaint investigation.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The provider had looked at ways to make sure people had access to the information they needed in a way they could understand it, to comply with the Accessible Information Standard. One person had pictures of foods to help them understand what was available to eat on the menu. Whiteboards were also available for people who were hard of hearing. Staff could write a short message if people were finding it difficult to understand what staff were saying to them.

The provider understood the importance of consulting people and their family members about a person's end of life wishes. Advance care plans (ACP) set out people's future decisions and choices about where and how they would like to spend their time at the end of their lives. Where people had an ACP in place and were nearing the end of their lives, these plans were being followed in accordance with people's wishes. People's care plans were reviewed frequently, to reflect their changing needs. Professional advice and support had been sought and nurses took an active role in making sure people received a pain free and comfortable death. Family members were welcome to visit and sit with people at any time, including overnight stays. End of life boxes has been implemented containing personal items for the person and their family member to enhance time spent with loved ones towards the end of their life. However, a health care professional told us that not everyone with a life limiting condition had an advance care plan.

Requires Improvement

# Is the service well-led?

## Our findings

People and their relatives said that they knew the registered manager who was a visible presence at the service. One person told us, "Oh yes, I know the manager very well: She's always around. A relative said about the registered manager, "She is friendly, approachable and a good listener". Everyone responded that overall the service was well managed. Comments from people included, "I will absolutely recommend this place to anyone"; and "It feels like home". A health care professional told us, "It is a lovely care home to work in".

The provider was developing and strengthening the programme of audits and checks in place to monitor the quality of service delivery. However, these checks were not always effective as they had not identified shortfalls in staffing levels in the residential unit. When the provider had identified shortfalls in the management of medicines, sufficient action had not been taken to address them. In addition, there were inconsistencies in records about people's care and treatment. People who had been assessed as needing to be repositioned on a regular basis had a chart in place for staff to record when they had been moved. However, two people's charts were blank so it could not be assured that staff were doing all that they could to minimise the risk of pressure ulcers developing. Daily records also varied in the amount of detail that they contained. For example, some entries stated that "Personal care" had been given, but did not state whether this was a wash, shower, bath or bed bath.

The provider had failed to establish and operate effective systems to assess, monitor and improve the quality of the service. People's care records were not always accurate. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager understood their roles and responsibilities and when to notify the Care Quality Commission of important events that took place in the service. The registered manager led by example, treated people and their relatives with respect and spent time developing positive relationships with them. The registered manager and the provider were clear about the aims and values of the service and how to put these into practice. This resulted in a staff team that was motivated, felt listened to and had confidence in the way the service was managed. One staff member staff said, "I think the manager is a very good leader". Another staff member commented, "The manager is very approachable, understanding and extremely supportive. I have no problem speaking to her".

A range of meetings were held to aid communication in the service and ensure people's needs were being met. These included short daily meetings with nursing, care, housekeeping, catering and maintenance staff to discuss any issues. This gave the registered manager an overview of the service and enabled them to monitor the progress of any actions taken. Clinical meetings were also held with the clinical lead and nursing staff to share best practice and develop learning. The registered manager recognised the importance of ensuring that people received 'joined-up' care. Regular multidisciplinary team meetings were held with an older person's consultant and GP. A health care professional told us that at these meetings the clinical lead demonstrated that they were very well organised and that this was a good example of positive

collaborative working.

Staff told us there was an explicit 'zero-tolerance approach' to any member of staff who did not treat people in the right way. They were confident that they could speak to the registered manager if they had any concerns about people not receiving safe care. Staff told us they were confident that any concerns they raised would be taken seriously so that action could quickly be taken to keep people safe.

People and their relatives said that their views were sought and acted on. Relatives said that meetings were held every three months and that they felt confident to raise anything that they were not happy about. Relatives said they had raised concerns about the quality of the food and the poor state of the environment. As a result, changes had been made to the menu and renovations and redecoration had taken place in the dining room and the lounge was now being repainted. At the meeting in January 2018 some relatives said that they had missed events that had taken place at the service as they were not aware of them. It was agreed that relatives would be e-mailed about such events and this was occurring.

A satisfaction survey questionnaire had been sent to people and their relatives in January 2018. Everyone was satisfied with the overall level of care although some areas such as the environment and communication were highlighted as areas where improvements could be made. The provider had commenced a refurbishment and decoration programme to address shortfalls in the environment. The registered manager had taken action to address shortfalls in communication and introduced a separate communication book in the nursing and residential units. Comments included, "Generally good and improving"; "Excellent. I am very satisfied and do not think my relative would be anywhere better, given her needs"; and "Staff are always approachable and friendly". Some people also commented that they felt the management team were approachable, by comparison to the management team operated by the previous provider.

The provider understood their responsibility in displaying their CQC inspection report rating at the service when a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgements.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The provider had failed to ensure safe systems were in place for the management of medicines.<br><br>Regulation 12 (2) (g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider had failed to establish and operate effective systems to assess, monitor and improve the quality of the service. People's care records were not always accurate.<br><br>Regulation 17 (1) (2) (a) (b) (c) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider had failed to ensure there was a systematic approach to the assessment and deployment of staff so that there were sufficient numbers available at all times.<br><br>Regulation 18 (1) |