Colville Care Limited

Beggars Roost Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 and 23 August 2016 and was an unannounced inspection.

Beggars Roosts Nursing Home provides accommodation and nursing care for up to 28 older people. At the time of our visit, there were 27 people in residence. The home is set in a rural area and had a variety of communal areas and a well-tended garden.

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

Feedback regarding the service was mixed. Most people and relatives were extremely positive, but others raised concerns about a lack of flexibility. They told us that there was a set routine and staff appeared 'put out' if this needed to change. We found that people were not fully involved in planning their care and that there was limited information about people's life history and interests to promote personalised care.

People and relatives spoke highly of the nursing care at the service. Staff understood people's medical needs, monitored their health and took prompt action to address any concerns. Where appropriate, referrals were made to healthcare professionals, such as the GP or Speech and Language Therapist (SALT).

There were enough staff to meet people's needs. Although nursing and care staff were focused on delivering personal care, activity staff provided stimulation and social contact for people, including those cared for in their rooms. People told us that the staff were kind. One relative had written to the provider saying, 'We couldn't have chosen a more kind or caring group of people to look after him'.

Staff had received training and were supported by management through supervision and appraisal. People and relatives had confidence in the staff and their abilities.

People felt safe at the home. Risks to people's safety were assessed and reviewed. Staff understood local safeguarding procedures. They explained the action they would take if they were concerned that someone was at risk of abuse. People received their medicines safely.

People told us that staff treated them with respect. Staff understood how people's mental capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People enjoyed the food and were offered a choice of meals. The chef had involved people in planning the menu. People told us they enjoyed the home's peaceful setting and we observed people enjoying their meals in the garden.

There was a system in place to monitor the quality of the service and to make improvements. This had been effective in many areas but had not picked up that qualifications for some staff to train others were out of date.

People, their relatives and staff told us that they felt confident to raise issues or concerns with the registered manager. Where concerns had been identified, actions were recorded and addressed.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place to help protect people from harm.

There were enough staff to keep people safe.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

Is the service caring?

Requires Improvement

The service was generally caring.

However, some people did not always feel involved in planning their care. Care plans provided little information about the person, their background or interests.

Some people expressed concern, saying that there was little flexibility in the routine of the home.

People told us that staff were kind and had a good sense of

humour.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People's care was planned and monitored to promote good health.

Staff understood how to support people and responded quickly to any changes in their health.

People enjoyed a variety of activities.

People knew how to make a complaint if necessary and were confident any issue would be addressed.

Is the service well-led?

Good

The service was well-led.

People were encouraged to share their feedback with the service.

There was a system to monitor the quality of the service and to drive improvement.

People spoke positively about the registered manager and leadership of the home.

Beggars Roost 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 inspection took place on 18 and 23 August 2016 and was unannounced.

One inspector and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for older people.

Before the inspection, the provider completed 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. We also reviewed two previous inspection reports and notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

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. We looked at care records for six people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with 13 people using the service, four relatives, the deputy manager, one nurse, two team leaders, two care assistants, the activities coordinator, the chef, the administrator and the provider. We also met with a church minister and a hairdresser who were visiting the service and asked them

for their views. Following the inspection, we spoke with the registered manager by telephone. We contacted a commissioner of services and a paramedic practitioner to ask for their views and experiences. They consented to share their views in this report.

Beggars Roost Nursing Home was last inspected in February 2014 and there were no concerns.

Good

Is the service safe?

Our findings

People told us that they felt safe at the home. One person said, "It's got a very high standard, I get on well with staff". Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff told us that they felt able to approach the registered manager or nursing staff if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

Risks to people's safety had been assessed. There was guidance for staff on how to minimise risks to people's health, safety and welfare in areas such as mobility, falls, skin care and nutrition. We saw that people at risk of skin breakdown used pressure relieving equipment and that staff applied prescribed creams to help protect people's skin. Staff also carried out regular checks to spot any changes. People identified as at high risk of falling were supported by staff to use mobility aids. Those who were not able to call for assistance had sensor mats in place to alert staff when they got out of bed. This helped staff to go to the person and offer support so that their risk of falling was reduced.

Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury. For example, when one person was found with their legs through the bedrails, a pillow was used as protection until rail protectors were delivered. Another person who liked to mobilise independently but was a high risk of falling was encouraged by staff to use their call bell. They were also given a call pendant to wear around their neck so that if they did get into difficulty they would always be able to ring for assistance. When two people incurred minor injuries using a new bath hoist, staff were offered additional training in its use to ensure people's safety.

There were enough staff on duty to meet people's needs. A registered nurse was on duty at all times, supported by a team of care assistants. In addition, the home employed activity, domestic, maintenance and administration staff. The registered manager was a registered nurse. She was available during the week and could step in to provide support if additional cover was required. One person told us, "They come reasonably quickly if I push the buzzer". Staff were confident that they could meet people's needs safely, although care staff told us they had limited time to chat with people or engage with them on a social level. Social contact with people was primarily given by activity staff. The deputy manager told us, "The home runs quite smoothly". At the time of our inspection, most shifts were covered by regular staff. Where temporary staff were used, staff told us that these were regular agency staff. This helped to provide continuity of care to people.

Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. The registered manager maintained a record of each nurse's registration with their professional body to ensure that they were safe to practice. These measures helped to ensure that new staff were safe to work with

adults at risk.

People received their medicines safely. Medicines were administered by nurses who underwent competency checks on their theoretical knowledge and practice in administering medicines. Details were recorded how each person liked to receive their medicines. We observed a nurse administering medicines during the morning. On each occasion they took care to ensure the correct medicine was administered to the right person. People were supported to take their medicines and were offered pain relief. Nurses demonstrated a clear understanding of medicines administration.

Medication was stored in locked cabinets that were clean and well organised. The cabinet was attached to the wall by a chain or stored in a locked room. When in use, the trolley was locked when unattended. Medicines that were required to be stored between two and eight degrees Celsius were stored in a fridge and the temperature monitored daily. We found a small number of liquid medicines and creams that had not been dated on opening. By the second day of our inspection the registered nurse had removed these products and replaced them with new. The date of opening is important as a medicine can lose its effectiveness if stored for longer than recommended by the manufacturer.

Medication Administration Records (MAR) demonstrated that people had received their medicines as prescribed. Where medicines were prescribed on an 'as needed' basis, there was clear guidance to describe the dose and the expected effect. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. Topical creams were administered and recorded.

Good

Is the service effective?

Our findings

People had confidence in the staff who supported them. New staff attended a period of induction. This comprised an orientation to the home and shadowing of experienced staff. An induction checklist was in place to ensure that key areas had been discussed and understood by staff. This included safeguarding, fire procedures and waste disposal. There were also practical supervisions of staff competence in moving and handling and infection control to ensure that staff were able to deliver safe care to people. The registered manager had introduced the Care Certificate, which is a nationally recognised qualification for staff working in health and social care. At the time of our inspection four staff were working towards this qualification.

Refresher training was delivered annually by the registered manager and deputy, both registered nurses. Topics included safeguarding, fire safety, moving and handling, end of life care, health and safety, infection control, first aid, The Mental Capacity Act 2005 (MCA), nutrition and dementia care. The deputy manager told us that they used external resources such as videos and e-learning to support their training. Each year staff provided feedback on the training so that it could be adapted to better suit their needs. The home was also accredited under the 'Six Steps Programme' which aims to develop awareness and knowledge of end of life care. The accreditation is a quality mark which demonstrates that the home had successfully demonstrated good practice in end of life care.

Additional training opportunities were available to staff and forthcoming external courses were displayed on a noticeboard. We noted that nurses had attended training in syringe drivers and catheterisation and that a visiting trainer had delivered a session on Parkinson's disease. Staff were satisfied with the training they had received. Some staff said that they wished to follow more in-depth training about dementia care. The registered manager explained that staff were completing a new e-Learning course. She said, "We felt we needed to develop it and through supervision some staff had said they needed a bit more help".

Staff received regular supervision and appraisal. Supervision meetings gave staff an opportunity to discuss their achievements, training needs and any concerns. One care assistant told us, "The two new nurses are absolutely brilliant, they're so helpful". Staff performance was reviewed annually during an appraisal meeting. Staff who had been employed for more than a year had attended an appraisal meeting in 2016, the remainder were scheduled to take place in December.

The 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 to 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). At the time of our inspection, 16 applications had been made to deprive people of their liberty and one had been approved by the local authority.

We checked whether the service was working within the principles of the MCA. During our visit we observed that staff asked people's permission before delivering care and involved them in decisions on how and where they wished to spend their time. In a letter to a relative we read, 'We have gained (name of person's) permission to hold a care plan review'. This demonstrated that staff respected people's right to decide who was involved in discussing their care and support. We noted examples in the daily notes of where they had refused care or support. For example, one person had refused to have their bed rails up and another had refused a wash. These wishes had been respected. Where people had appointed representatives to act on their behalf, the home had a clear record of this, namely a copy of the authorisation for that person to make decisions on behalf of the person regarding their finances or health and welfare.

Staff understood the requirements MCA and put this into practice. One staff member said, "They have their own choices. Even if it isn't the wisest of choice, if they have capacity you have to respect their choices. If they don't have capacity then you have to involve others in a best interest decision". We noted examples of decisions that had been made in the best interest of people who lacked capacity to decide for themselves. For example, one person's family, staff at the home and the GP had made a decision to avoid future admissions to hospital. This was because treatment for the person was not likely to be effective and the transfer and change of environment would cause them distress. For another person, we read that they had been unable make a decision on which staff member they would like to act as their keyworker. Staff and the person's relative had made a decision based on who they felt had a good relationship with the person.

Information on assessing people's capacity and best interest decision making was displayed in the office. We noted that the records of some decisions did not demonstrate that staff had followed the principles of the Act. For example, the use of bed rails had been risk-assessed but there was no detail on how staff had evaluated the person's capacity to make this decision or on any less restrictive alternatives that had been considered. We noted, however, that the use of bed rails, which can be considered a restriction, formed part of the DoLS application for the person. The deputy manager confirmed that they would review their record keeping concerning consent and capacity to ensure that it consistently demonstrated how people's rights had been protected.

People enjoyed the food at the service. One person told us, "The questionnaire regarding food and the menu came round several weeks ago. I had great pleasure ticking the column that says 'Good'. I look forward to the meals. I definitely enjoy my meals". People were involved in planning the menu and had been asked for their suggestions of dishes to include. On a daily basis, staff asked people which option from the menu they would like, or if they preferred something different. These choices were given to the chef. The chef told us, "If I've got it they can have it". At lunchtime, the activity coordinator ate lunch with a group of people in the conservatory; others enjoyed their meals in the garden. Those who required support were assisted, mostly in their bedrooms. For others there were specific details, such as if they required adapted crockery or cutlery to enable them to eat independently.

The chef was aware of people's preferences and dietary needs. When a person moved to the home they were asked to complete a dietary preference sheet. This detailed the foods the person enjoyed, any special requirements such as for allergies, special diets or modified textures and the preferred portion size. The chef also shared specific details such as that one person always liked a piece of lemon with their jacket potato and prawns. Key details were displayed in the kitchen, including whether people were diabetic, drank soya milk or needed to avoid pips and skins due to diverticulitis, a condition affecting bowel function. A communication book was in place for nursing and care staff to share information with the kitchen staff. We saw that details of when people were losing weight were shared and a request made for fortified meals. Some people were offered milkshakes containing ice cream to boost their calorie intake. One person told us that they had seen a Speech and Language Therapist (SALT) due to concerns over their swallow. She told us

that she now had thickener in her drinks. She added, "If there is nothing suitable on the menu they will provide an alternative for me, accommodating my menu needs".

People were supported to drink enough to meet their needs. Drinks were available in the lounge area for people to help themselves. Jugs of squash or water were also available in people's rooms, along with a full glass readily to hand. Staff offered people a choice of drinks. When one person did not seem keen to have a cup of tea or coffee, the staff member offered to go and fetch a honey and lemon teabag from their room. In the daily notes staff recorded when people had drinks and noted any drinks that had been refused or left. This helped nursing staff to monitor people's fluid intake and ensure they were drinking enough.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. People were able to see their GP. In the daily notes for one person we read, 'I have requested (name of person's) own GP if possible'. We noted examples of referrals to the mental health team, to the falls prevention team and to the dietician. This helped to ensure that people received appropriate support. A paramedic practitioner told us, "The nursing staff are always 'on the ball' so to speak and quickly identify when they need to call the surgery for advice or a home visit".

Requires Improvement

Is the service caring?

Our findings

People did not always feel involved in planning their care and some did not feel in control. One person told us, "If I ask a question, they do not take any notice of me and carry on doing what they are doing". Three people told us that they felt rushed by staff, especially in the mornings. One person who had moved to the home just over a week earlier did not have a care plan in place. This person and their family had provided detailed information about the person's life history, interests and background but there was little evidence this detail had been shared with staff or used in determining how support was given. The care plan for this person was in the early stages of development. The deputy manager told us, "When I've done (name of person's) care plans I will sit down with (name) and discuss it". This person told us that they wished to improve their mobility and had brought with them a list of suggested exercises from the physio. The copy of these exercises was held in the office and the mobility care plan which had been completed did not make reference to them. We also found that the chef did not have a completed dietary preference sheet for this person, despite the fact that the person had stated a particular preference regarding the bread they ate in their pre-admission information.

Systems to ensure that people were given information and involved in planning their care had not been completed. We noted that an admission checklist intended for keyworkers had not been completed for two people who had recently moved to the home. The checklist included tasks to be completed on admission, within 24 hours and within a week. For example, checking how the person would like to be addressed, sharing a copy of the service-user guide and assisting the person to understand it and liaising with the activity coordinator.

The care plans provided practical information on how staff were to support people and meet their physical needs. We found, however, that there was very little information to describe what was important to the person or to reflect their preferences. Having spoken with people, we sampled their care plans to see if they reflected the varied interests and experiences people had shared with us. They did not. This meant that new staff would have little detail through which to learn about the person or ideas on which topics of conversation might interest them. Information regarding activities was derived from an assessment tool which listed activities that might be suitable for the person. This list was included in the care records but had not been personalised or supplemented with any known interests the person enjoyed. Information about people's lives and interests was not available in the care plans or on the electronic records system. A commissioner told us, 'The only observation is that the care plans appear to cover all eventualities re. care but are not as individualised as I would like'.

Some people did not feel that their preferences were always accommodated. They referred to the 'rules' and 'routine' of the home. Of the 13 people we spoke with, seven made reference to how staff did not like it if the routine was disturbed. One person told us, "There is a lack of flexibility and they (staff) do not like their routine disturbed. It does not take much to do or say something before they get upset. They work so hard, so you have to be careful not to speak too long". Another told us, "The staff are just doing as they are told, rules are rules". When we discussed this with staff, one care assistant told us, "It's very much in a routine. It's routine straight down the line. Care staff don't really have time, we're just so busy". Another said, "I feel a lot

of pressure to get the job done or it won't fit in with the scheme of work'. While most relatives spoke highly of the home one told us, "The home runs a crisp and efficient regime. There is little empathy. Anything that interrupts the shifts of pad changes, tea and meals is seen as extra and onerous".

The service had not promoted people's involvement in planning their care to ensure that it was appropriate, met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider, registered manager and deputy manager were visibly saddened by this feedback. The registered manager said, "The plan comes about by what their (the residents') wishes are. That's a fail on our part if that's how they feel. If we'd had that feedback we could have addressed it". She added, "That isn't our ethos, it isn't what we strive to do. We all feel very sad about it". The provider told us that the vision was, "To modernise. To become more person-centred and less task-based".

Most people felt that staff encouraged them to be as independent as they were able. People's care plans included details on where they were able to manage and where they required assistance from staff. For example we read, 'Encourage (name of person) to participate as much as possible by providing a flannel to wash her own face and chest as able'. For another person who had weakness on one side following a stroke we read, 'Promote use of affected side by approaching from affected side'. Staff told us that they encouraged some people to walk and followed behind with a wheelchair for reassurance. They told us that another person might take five minutes to wash their face but were able to do this with time and reassurance. In a survey conducted by the provider one person commented, 'Staff are very helpful and very kind and have helped my confidence to grow'.

People told us that staff treated them with respect and were mindful of their privacy. One person had been given a call pendant to wear around their neck so that they could ring when they had finished on the toilet, rather than staff checking on them. We observed that staff knocked on people's doors and checked with them before providing support. A commissioner told us, 'The care workers when observed always talk to residents with respect and with banter and appear to genuinely ask about what they would like to do or where they would like to go'. Staff received training on upholding people's dignity and the deputy manager had recently been appointed as a dignity champion. He told us that this meant he observed staff as they worked with people and made suggestions on how they could improve their approach.

People told us that they got on well with the staff who supported them. One said, "They're generally pleasant. You can have a natter with the staff". Another told us, "Normally staff make the effort, staff try to make conversation. They have a good sense of humour". Some people were more enthusiastic. One said, "They're marvellous, I cannot fault it, the staff are kind". Each person had a keyworker who took the lead in coordinating their care. All those who were able to had been able to choose which staff member they wished to work with them.

People appeared relaxed in the company of staff. During the afternoon the weekly quiz between residents and staff took place. There was gentle teasing between staff and residents that created a relaxed atmosphere. Even though there was a fun rivalry between the two teams, staff assisted the other team with some clues to the quiz. Some people who were unable to get out of bed were in their rooms but staff had positioned their beds so that they could enjoy the garden, or view birds coming to the feeders outside the window

Good

Is the service responsive?

Our findings

People had confidence in the care they were receiving. One person said, "If you can't live in your own home this is a very good substitute". A relative told us, "I think it's good and they're well looked after. It's such a peaceful atmosphere; I can see her looking better already".

When a person moved to the home, nursing staff completed an admission checklist. This detailed the person's medical history, key details regarding their care and specific details such as weight and height on arrival. Nursing staff used this, along with their pre-admission assessment and other information, such as a discharge summary if the person was coming from hospital, to plan the person's care and support. The registered manager was part of a focus group with the local hospital looking at discharge information and improving communication between hospitals and care homes.

Each person had a care plan describing how staff should meet their needs in areas such as communication, mobility, nutrition, sleeping and medication usage. Each area was presented in the format of 'needs', 'goals' and 'actions'. For example we read that one person needed a frame to mobilise. The goal was that staff promoted access within the home and for the person to mobilise safely. Action required by staff was to ensure the frame was accessible and for one staff member to support the person when transferring. For another person who had limited verbal communication, staff were directed to encourage communication by providing a writing pad and pens or using visual aids.

Staff had a good understanding of how to support people with their physical and medical needs. Monitoring was in place to ensure that any changes were quickly addressed. One relative told us, "They've definitely got their eyes open". Another had written in feedback to the provider, 'Staff are very caring and observant if a client is under the weather'. Staff were encouraged to highlight any changes in people's health or mood. A care assistant told us, "If I draw attention to something such as redness they (the nurses) are straight there". In the minutes of a meeting with activity staff we read, 'Matron (registered manager) reiterated about communicating to the nursing staff if they see any changes in the level of response, concentration or enjoyment as this may indicate a change in health'. A paramedic practitioner told us, "The staff are well led by (registered manager) and the nursing team are of a high standard in my opinion. This is evident in that their service demands on us at the surgery and through emergency call outs is not excessive but appropriate. This is testament to the quality of nursing care they provide which is pre-emptive rather than reactive".

Staff responded to changes in people's health and anticipated changes in their needs. In the mobility care plan for one person we read that they may need to use a stand-aid to transfer if they were tired. This had not yet been needed but since the person's mobility was declining, staff had assessed the person using the stand-aid so that it was available if needed. A second person had requested to change the time that a medication was given as it was making them drowsy. This was arranged by staff in consultation with the GP. In the daily notes of a third person we read that they had been distressed and frightened by the noise of maintenance work taking place outside their room. We read, 'She couldn't eat her lunch as a result of this. I spoke to the maintenance man, and asked him to stop for a while. Reassurance given to (name of person)'.

People were able to enjoy a range of activities. Those who were unable to participate in group activities were visited daily by activity staff in their rooms. The home employed two activity staff and had a variety of visiting entertainers. There was also a weekly Communion service which was taking place on the day we visited. People told us that they enjoyed the activities. One said, "They ask, what shall we do today, you can draw or paint or play games". Another told us, "The quizzes give everyone a chance to have a laugh together". Two people told us about a recent garden fete where they enjoyed a visiting brass band. Others spoke about a forthcoming trip to a local garden. Most people were members of the '100 club' which was open to residents, relatives and staff. The key aim of the club was to raise money for activities but there was also a monthly prize draw. On the day we visited people were enjoying sitting in the garden. One person told us, "This is a very nice place. We have a woodpecker. They redid the gardens last year, we have nice new plants".

Throughout our inspection we observed that care staff had limited time to interact with people on a social level and that activity staff were key in providing stimulation and social contact. The main activity coordinator was due to leave shortly after our visit. We discussed with the registered manager what arrangements were in place to ensure that this support continued through to the appointment of a new activity coordinator. She told us that the other member of activity staff had increased their days and that additional external entertainers had been booked. The provider was recruiting to fill the vacancy.

People told us that they could raise concerns. One person told us that she felt able to speak to any of the staff. Concerns raised by people had been responded to. One person had shared that they felt their medication came too late and that this made them anxious. The registered manager had suggested to this person that the night staff could administer their medication at an earlier time. A second person shared with a care assistant that they felt rushed by night staff. The care assistant had completed a feedback form on behalf of this person which led to discussions with the night staff and an apology to the person. In response to a relative's concern that they were not informed promptly about a minor injury, the registered manager carried out an investigation and provided a response and apology to the family. A commissioner told us, 'From experience (registered manager and deputy) always appear to know what is going on with the residents and will always respond to any comments'.

People knew how to make a complaint. Information on how to complain was displayed in the home. This explained how to make a complaint and the anticipated timescales for response. We looked at a sample of complaints to see how they had been addressed. We found that they had been responded to in line with the provider's policy and that action had been taken to try to minimise the chances of a repeat event.

Good

Is the service well-led?

Our findings

The provider encouraged feedback from people and their relatives. The registered manager visited people in their rooms. She said, "I like hands on. It's nice and it gives them time to chat with me". One person confirmed, "Matron always comes to see us, she's very nice". This gave people an opportunity to discuss any concerns or issues directly with the registered manager. A new tablet computer was available in reception for people and visitors to leave feedback. This tablet was also used by care and activity staff to complete feedback surveys with people. The results of the surveys from July and August 2016 had not yet been analysed. Of all the responses (10 people, 19 relatives and 2 professionals), 40 percent rated the home as 'outstanding', 52 percent as 'good' and eight percent as 'adequate'. The registered manager told us, "We keep trying to work different ideas on how to get feedback".

The service promoted a positive culture, to seek feedback and to respond to concerns. Feedback from the majority of people and relatives was positive. One relative told us, "We have no quarrels, staff are hugely pleasant. I cannot find fault with the home". Some people shared concerns with us because they felt there was a lack of flexibility in the 'routine' of the home which did not always meet with their needs and preferences. You can read more about this in the 'Caring' section of this report. These concerns had not been raised through any of the provider's existing ways of seeking and receiving feedback. We shared this feedback with the provider and deputy manager, and later discussed it by telephone with the registered manager. They responded openly and demonstrated a willingness to respond and make changes. A meeting had been arranged with all team leaders to discuss their views and any feedback they had received from people. The registered manager also planned to carry out a survey entitled, 'How can we do things better?' to try and capture the concerns and act quickly to make improvements.

People had been involved in decisions relating to how the service was run. There was a residents' committee. Two people using the service attended these meetings to represent people's views. We saw that these meetings covered developments to the premises and planning for outings. As a result of this committee a new shower wet-room had been created.

There was a system in place to monitor the quality of the service and to make improvements. This system had proved to be effective at identifying issues and delivering improvements. We noted, however, that the training qualification for the registered manager and deputy to deliver moving and handing training to staff had expired in 2015. Although we did not identify any impact from this in the way staff supported people to move around the home, it presented a risk that staff may not be up to date with current best-practice. We raised this with the registered manager. She told us that she had spoken with the provider and that they were booked to attend a revalidation course in early October 2016.

Audits of medication, recruitment, complaints, infection control, nutrition and the premises had been carried out. Where areas of improvement were noted, these had been addressed. For example, the nutrition audit had identified that people should be supported to wash their hands before meals. This had been communicated to all staff and wipes were offered to people before their meals were served. The infection control audit identified that additional trolleys for dirty linen were required and these had been purchased.

Any immediate requests such as for maintenance tasks were logged and quickly addressed. This included repairing taps, replacing lights and testing the safety of new electrical equipment.

A review of accidents and incidents from April 2015 to April 2016 grouped incidents into categories to help identify any patterns or trends. External audits had also been completed by the pharmacy and fire service. The recent audit by the fire service had identified some areas of action which were being addressed by the provider. On an annual basis, the audits of the service were reviewed by a representative of the provider. In 2015 there had been a suggestion that care plans should be stored in people's rooms to ensure that they had access to the information. This had been done.

The registered manager and provider met on a weekly basis to discuss the running of the home. The meetings included a discussion of any incidents, safeguarding, complaints, audits, the staffing rotas and recruitment. Any immediate updates for staff were shared in handover or via the electronic care records system. Messages could be targeted to specific staff or groups of staff who were required to confirm that the message had been read and understood. Examples of when this system had been used were to communicate a best interest decision not to admit one person to hospital and to follow up with a named staff member when a gap on the MAR chart had been identified.

People spoke positively about the registered manager. One told us that registered manager and deputy, "Sort things out". Another said, "She's like a matron in a hospital but she is kind". Staff felt able to raise any concerns with management. One said, "If I have any problems I can go to her and they are addressed". Another told us, "Matron comes down and speaks to everyone".

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People had not been fully involved in planning their care and treatment to ensure that it was appropriate, met their needs and reflected their preferences. Regulation 9 (1), 3(a)(b)