Saltwood Care Centre Ltd

Saltwood Care Centre

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection was unannounced and took place on 13 & 14 September 2016. The service is a nursing home for up to 66 people. The service supports mostly older people living with dementia, physical disability and sensory impairments who also require nursing care. At the time of inspection there were 59 people in residence a few of whom were in hospital. People have their own bedrooms these are located over four floors accessed by a main shaft lift, ensuites are provided in many of the rooms.
This service was last inspected on 30 June 2015 when we found the provider was not meeting the regulations in regard to the management of medicines, storage of equipment, management of complaints, maintaining peoples care records, analysing feedback from relatives, using an effective quality monitoring system, and ensuring there were enough suitably trained staff. We asked the provider to send us a plan of action for addressing these shortfalls which they did. This inspection looked at whether the action plans had been implemented fully and improvements maintained.

The service did not have a registered manager in place. The registered manager had just left prior to the inspection and an interim manager was providing support. A registered manager is a person who is 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.

At the previous inspection we had highlighted that the quality monitoring systems in place were not adequate to give assurance to the provider that the service was providing good quality care. Since then an improved range of quality monitoring had been implemented to inform the interim manager and provider about how well the service was performing, however the shortfalls identified at this inspection indicate that some of the audits were not being completed robustly to give an accurate assessment of some areas to enable the provider to make improvements.

There had been improvement in the management of medicines but there were shortfalls where the dating on opening of all boxed and bottled medicines had not been extended to non prescribed and 'as required' medicines. Records of administration of prescribed creams were transferring to an electronic system and during this period paper records were not well completed and there was a risk during this period the frequency of administration needed was not happening, similarly protocols for the administration of 'as required' medicines lacked sufficient detail.

The decorative state of the laundry area made it difficult to keep clean and there was a risk of compromising good infection control standards. Sluices were left unlocked when not in use, this posed a risk of people accessing chemicals used in the sluice but harmful to their health. In all other respects the premises were clean and well maintained.

Staff had received fire training and understood fire procedures and the evacuation of the building, they attended occasional fire drills and we have recommended the provider seek further advice in regard to

some of these arrangements.

At inspection there was no one on an 'end of life' care pathway. We have recommended that the provider implement a recognised end of life care model which they agreed to do at inspection.

People told us they felt safe and liked the staff that supported them. Most relatives told us they had no concerns about the service with a few saying they had some niggles but these did not detract from the overall good standard of care and support provided to their relatives. They felt confident in the quality of care but thought some aspects of communication from staff could be improved upon.

Staff were able to demonstrate they could recognise, respond and report concerns about potential abuse. They treated people with kindness and respected their privacy.
Since the last inspection staffing levels had been reviewed and a dependency tool was used to assess numbers of staff needed, this was kept updated monthly or sooner if some needs changed significantly. The interim manager recognised there was a need to look also at how staff were deployed to make more effective use of all those already on duty and this is an area for improvement. Recruitment processes ensured only suitable staff were employed. Staff received induction and a range of training to give them the knowledge and skills they needed. Staff felt listened to and supported, with opportunities to talk about their work performance and development.
People ate a varied diet that took account of their personal food preferences. Their health and wellbeing was monitored by staff and appropriate referrals were made to health professionals and support given to attend appointments when needed. People were supported to maintain their independence for as long as possible and at a pace to suit them.

Staff were guided in the support they gave to people through the development of individualised plans of care and support that also included improved information about how health needs were to be supported such as Diabetes. Risks were appropriately assessed to ensure measures implemented kept people safe. People were encouraged by staff to make everyday decisions for themselves, but staff understood and worked to the principles of the Mental Capacity Act 2005 (MCA) where people could not do so.

The complaints process had been reviewed and people and relatives told us they found staff approachable and felt confident of raising concerns if they had them. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The interim manager understood when an application should be made and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

People said their needs were attended to by staff when and if they required it. People were supported to maintain links with the important people in their lives and relatives told us they were always kept informed of important well being changes.

People and relatives were routinely asked to comment about the service and improvements had been implemented to ensure feedback was collated and analysed to inform service development, this information was still to be published for people and relatives to see and there were plans for this to be added to the quarterly newsletter.

We have made two recommendations:

We recommend that the provider seek guidance from an appropriate competent source as to the frequency of fire drills for day and night staff and make adjustments to current frequencies as required to ensure these

meet the requirements of fire legislation Regulatory Reform (Fire Safety) Order 2005.

We recommend that the provider consult with a competent person regarding the implementation of the Gold Standards Framework for end of life care.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we 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?

Requires Improvement

The service was not always safe

Further improvements were needed in the management of medicines. Fire procedures and evacuation plans were in place but the frequency of staff fire drills needed review. The laundry was in need of redecoration and sluices were not routinely locked to protect people from harm.

There were enough staff to support people safely but staff deployment needed review. Recruitment processes ensured that only suitable staff were employed.

The premises were well maintained and where improvement was needed upgrading was happening or planned. Staff understood how to recognise and respond to abuse people could be subject to. Accidents and incidents were monitored, analysed and actions taken in respect of emerging issues.

Is the service effective?

Good

The service was effective

Staff were supported through individual planned supervisions and staff meetings were in place. Staff received training to give them the right knowledge and skills to understand people's needs and support them safely.

People ate a varied diet that took account of their preferences. Peoples health needs were monitored and they were supported to access healthcare appointments.

People were supported in accordance with the Mental Capacity Act 2005 (MCA) and they were consulted about their care and support needs.

Is the service caring?

Good

The service was caring

People were treated with kindness and staff supported them to maintain their privacy and dignity.

People received good support at the end of their lives and the service was implementing end of life training to ensure consistent practice was followed by staff. People's end of life wishes were known and acted upon.

Staff promoted people's independence and ability to do more for themselves.

Staff supported people to maintain links with their relatives and representatives. Relatives felt they were kept informed.

Is the service responsive?

Good

The service was responsive

People referred to the service had their needs assessed to ensure these could be met. Care plans were individualised and took account of people's capacity, needs, support preferences and things that were important to them.

People were provided with a programme of weekly activities they could choose to participate in or not.

People and relatives told us they felt comfortable raising issues with staff and were confident these would be addressed.

Is the service well-led?

Requires Improvement

The service was not consistently well led

Quality assurance audits were not completed robustly to provide an accurate picture of service quality.

People and their relatives were asked to comment about the service on a regular basis, and their comments influenced service development. They spoke positively about the service and the quality of care people received.

Policies and procedures were kept updated to inform staff. Staff said they felt listened to and were given opportunities to express their views in regular staff meetings.

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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 13 & 14 September 2016 and was unannounced. The inspection team comprised of three inspectors.

Prior to the inspection we 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. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

At inspection we met and spoke with many of the people who lived in the service and observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported. We spoke in more depth with twelve people who use the service and one visiting relative. People who were unable to speak with us kept to their rooms so we were unable to use 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 did however observe one person receiving assistance from a staff member to eat their meal.

We spoke with the interim manager, one of the providers, five Registered nurses, six care staff and six members of the domestic and maintenance team, and two relatives. After the inspection we received feedback from eight relatives and five health and social care professionals who spoke positively about the service and raised no issues of concern.

We looked at six people's care and health plans and risk assessments, medicine records, six staff recruitment

training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe and felt able to speak with staff about their support, people said staff usually responded well to call bells but said on occasion they did have to wait. Some people in the rehabilitation unit said that at times they felt there were not enough staff, and staff said there were peak times when the unit was full when it meant they could not respond to everyone as quickly as they wanted. People in the rehabilitation unit commented "staff come but it depends on what they are doing as to how quickly they arrive, it can be quite long and I am unable to walk without help". Another said staff come as quickly as they can but I often have to wait, whereas others reported that staff responded quickly to call bells.

Only one relative and health professional commented that they thought at the busiest times more staff were needed. Others thought staffing levels were enough. Other health and social care professionals spoke positively about the service comments included: "The home is always clean and comfortable, I have always been able to find a member of staff when needed", another said "generally the care home provides good, safe and timely care and interventions for all its residents, particularly on the rehabilitation floor where patients are cared for in a way that gives them the best chance of returning home".

At the previous inspection we highlighted that medicines were not always well managed. At this inspection the medicine policy and procedure had been updated. Medicine Administration Records (MAR) viewed were well completed and unused medicines were being disposed of appropriately. Prescribed boxed and bottled medicines were now dated upon opening, but this practice had not been extended to those medicines which were given 'as and when required'. Protocols in place to inform staff when 'as required' medicines needed to be given to the people concerned lacked sufficient information to ensure this could be undertaken consistently by staff and avoid a risk of over or under dosing by different staff. Cream charts for administration of topical prescribed and 'as required' creams were not always completed everyday; this was partly due to the transfer of these records to an electronic system and not all staff were using the same system when administering creams during this changeover and there was a risk skin integrity for some people could be compromised if application of creams was sometimes missed. The failure to ensure that all medicines are managed safely and as directed is a breach of Regulation 12 (2) (g) of the Health & Social care Act (HSCA) 2008 (Regulated Activities) (RA) Regulations 2014.

In other respects medicines were well managed. Arrangements for ordering and receipt of medicines were working well, storage was clean, tidy and secure there was good stock rotation, medicines that needed to be kept more securely were stored and administered to the required standards, a separate register was maintained and a random check of medicine quantities showed the register to be accurate for these medicines. A drug fridge was in place for medicines requiring lower storage temperatures and a record of medicine storage temperatures was maintained. Administering staff were medicines trained and their competency reassessed annually. Covert medicine was administered to one person and the GP and relatives had been involved in this decision in the person's best interest.

At the previous inspection we recommended that sluices were kept locked when staff were not in attendance. At this inspection sluices were unlocked on every floor and accessible to people if they chose to

enter, sluices were clean and tidy, but some soiled clothing baskets were stored in there ready to go down to the laundry, also chemicals used for disinfecting commodes were easily accessible to people if they chose to take them and placed them at serious risk of harm.

The laundry area although well-equipped was in a poor state of decoration and was not on the future plans for upgrading. Tiles were missing on walls; roof windows were in need of repair and stuffed with towels to reduce leaks and drafts, there was debris behind washing machines and tumble driers from previous building and repair works making the flooring in these areas difficult to clean and harbouring dust. Although there was a good separation of clean from soiled laundry, laundry staff had received infection control training and were provided with protective clothing the current state of the laundry compromised good infection control standards. An infection control audit was conducted every six months and this should highlight any shortfalls in practice and the actions taken to address them, but had not shown the laundry to be an area in need of attention to warrant adding to the development plan.

The failure to ensure the laundry was properly maintained and clean or that sluices were kept secure from people in the home is a breach of regulation 15(a-e) of the HSCA 2008 (RA) Regulations 2014.

In all other respects the premises and gardens were well maintained, a maintenance team was on site to address any repairs and implement development plans for upgrading of the premises. Servicing and testing of all equipment was undertaken to ensure this was safe and in good working order. Cleaners worked each day to regular cleaning schedules and had daily weekly and monthly tasks to complete to ensure that a good standard of cleanliness was maintained throughout the service. Staff were provided with protective clothing for when supporting people with personal care.

Business continuity and emergency plans were in place to inform staff in the event of occurrences that stopped the service. Staff had received fire training, fire risk assessments were in place and all staff knew the evacuation procedure and assembly point. One fire drill had been undertaken in the last nine months and there had also been informal training with staff in regard to the use of evacuation equipment but we reminded the interim manager of the need to ensure that all nursing and care staff had undertaken practice drills so they knew the actions to take in the event of a fire. Individual personal evacuations plans (PEEPS) were in place for people; these took account of their specific needs should they need to be evacuated.

We recommend that the provider seek guidance from an appropriate competent source as to the frequency of fire drills for day and night staff and make adjustments to current frequencies as required to ensure these meet the requirements of fire legislation.

At the previous inspection we had raised concerns at the lack of appropriate storage for equipment used to support people, the provider took action to address this and the amount of equipment located in bathrooms and corridors was significantly reduced and impacted less on people accessing these areas.

People were protected against the risks of receiving support from unsuitable staff, because recruitment checks undertaken ensured staff selected were safe and had suitable qualities and experience to support people safely. Checks had been undertaken with regard to criminal records, proof of identity and previous conduct in employment and character references.

A review of the staffing rota over a three week period showed that staffing levels were stable and reflected the numbers of staff on shift on the days of inspection. There had been some recent turnover of staff leaving through maternity leave and there was some use of agency to cover gaps in shifts. Staff and most people told us that there were always enough staff available to provide people with the support they needed,

analysis of the call bell response times showed that whilst there was an occasional wait of approximately eight minutes the majority of calls were dealt with within three minutes. A dependency tool was used to assess people's individual dependency needs and those for the service as a whole this also took into account the difficulties of the environment; information gathered from these assessments informed the interim manager as to how many staff were needed to support people safely.

During the daytime shifts there was the interim manager, deputy manager, three registered nurses and 13 to14 health care assistants who worked a mixture of shifts between 8 am until 8 pm, which reduced to 5 Health care assistants and seniors at night. The interim manager was aware that some floors within the service required higher staffing because often people there required more than one staff member to support them. The interim manager felt there was enough staff to support people but considered that the way staff were deployed might need to be reviewed to make them more effective and more flexible to respond to issues on other floors if they were free and this is an area for improvement.

Staff had received safeguarding training that helped them to understand, recognise and respond to abuse, and helped them to protect people from experiencing abuse. Staff were confident of raising concerns either through the whistleblowing process, or by escalating concerns to senior staff, managers or the providers. Staff understood and were confident they would take issues to other agencies if they felt they were not being addressed within the organisation.

Risks people may experience within the environment or as a result of their own health conditions or behaviour were assessed. Measures were identified to reduce the risk of harm occurring and these guided staff on how to support people safely. Risk information was kept updated and reviewed from time to time to re-evaluate how effective risk reduction measures were or whether further amendments and changes were needed to reduce risk levels further.

Incidents and accidents were recorded and action taken to seek appropriate advice and support for people with for example, increased falls, or incidents of behaviour.

Good

Is the service effective?

Our findings

People told us that staff always ensured they received appropriate attention when they were unwell including calling the GP to see them. They enjoyed the food they received, comments included: "Food is good, I am always happy with the choice", "Food is lovely, I am putting on weight". There is always a good choice of food"

Relatives said they felt that staff kept them informed about any health issues or needs their family member experienced. Another said "they always make sure he gets a cooked breakfast because that's his preference",

A health professional said from their observations overall care given was good, staff were proactive in dealing with people and adaptable to each ones needs, they said staff followed interventions for each person and followed instructions recorded on people's individual plans. They said staff communicated well with the multi-disciplinary team and in regard to onward referrals. Another said "If I find discrepancies during my review i.e. care plans, around wound management etc. I will discuss with the manager and the RGNs and I have found that all my recommendations are acted on in the first instance."

The Provider Information Return informed us that the provider was working to implement a supervision schedule of four times annually for all care and nursing staff,. A planner was in place to ensure all supervisions were scheduled in and records showed that staff were receiving supervision; a new system in which RGN's took more responsibility for the supervision of HCA's was also being implemented. Supervision meetings provided opportunities for staff to discuss their performance, development and training needs. All staff said they felt supported and felt able to bring issues to discuss at supervision sessions but felt the style of the management team was such that they could discuss issues at other times also because they were easily approachable. A system for the annual appraisal of staff was in place.

HCA staff ensured that air mattress settings were correctly set, and people who needed support around their skin integrity were monitored and turned where necessary. People at risk of falls, pressure ulcers or poor nutrition were assessed and procedures implemented to reduce the risk of harm occurring. People who had diabetes had detailed care plans in place to guide staff in how to support them. Relatives said they felt happy that their family members health needs were attended to.

New staff were supernumerary on the rota for the first three shifts during which they shadowed other staff and completed on line training. They were expected to complete a probationary period before they were made permanent in their role, performance reviews of their progress were undertaken during their induction/probationary period which lasted 12 weeks. This ensured that the interim manager was confident that they had the right competencies and had learned and put into practice the skills they needed to support people safely. The provider currently used their own induction programme but this was under review currently with a view to implementing a more interactive induction that followed a nationally recognised induction programme and enabled staff to complete the 'Care Certificate'. The Care Certificate was introduced in April 2015 by Skills for Care. These are an identified set of 15 standards that social care

workers complete during their induction and adhere to in their daily working life.

The staff training record showed that staff had completed all their essential training updates in for example, food hygiene, fire safety, moving and handling, safeguarding, mental capacity, health and safety, control of substances harmful to health COSHH and the needs of people with Dementia. The interim manager confirmed that wound care, diabetes and infection control had also been booked for staff to attend. Additional training was available in other specialist areas and Registered General Nurses (RGN's) had recently received syringe driver training. All staff received moving and handling training from a trained trainer on site; staff competency to use equipment and support people safely was observed and assessed as part of this training. A new training provider/system was being introduced which would provide Health Care Assistants (HCA's) and other staff with more e-leaning and interactive group sessions, staff competency would be tested through completion of independently marked tests. The provider has encouraged the qualified training of care staff and out of 33 daytime HCA's and seniors 26 had achieved NVQ level two or three, out of 11 night time HCA's and seniors 5 were qualified to NVQ level two or three.

Staff had received training in the Mental Capacity Act 2005 (MCA). This provides a legal framework for acting and making decisions on behalf of people who lack the mental capacity to make particular decisions for themselves. Staff sought consent from people for their everyday care and support needs. They understood that when more complex decisions needed to be made that people lacked capacity to decide for themselves, relatives, representatives and staff would help make this decision for them in their best interest. The majority of relatives spoken with confirmed they were asked to sign their relatives care plan and were consulted about their care and support needs. The registered manager was aware of actions to take when best interest meetings needed to be held for example, necessary health interventions. Restraint was not used and staff were not trained in the use of physical interventions. Care plans made clear people's individual emotional expressions of behaviour and this helped staff understand the behaviour and the simple strategies they should use to de-escalate this to keep everyone safe.

Staff supported people with their health appointments. People were referred to health care professionals based on individual needs. Staff were vigilant in checking people's wellbeing and whether there was an emerging health related need. People's weights were taken on a regular basis and any weight loss was alerted to senior staff. There was a wide range of equipment available to support peoples care needs and where this might be deemed restrictive for example bed rails, if the person lacked capacity relatives were consulted about the use of this equipment in the person's best interest. The provider and management team were proactive in looking for more appropriate equipment that may better suit some people and minimise harm occurring for example specialist mattresses to reduce the risk of pressure ulcers.

We spoke with both cooks who were aware of what made up a balanced diet and the need to sometimes fortify people's meals and the importance also of protein within the diet. The kitchen only used fresh fruit and vegetables and this was delivered daily. Menus were developed from peoples initial food preferences they were asked about on entering the service and also feedback from surveys, resident meetings and a monthly food audit. Two choices were available for main meals but if people did not want these other choices could be offered. People ate either in the dining room or in their room, a Bain Marie was used to transport food from the kitchen to the dining area and meals were plated up from there directly to the table or sent to people's rooms. The service had responded to concerns from people that portion sizes were too big which could put them off their food by introducing smaller plates; people with larger appetites could ask for seconds if they wanted. A new electronic records system was enabling the service to discontinue paper fluid charts in favour of a live electronic record this enabled the interim manager and other staff to monitor the amount of fluid people were drinking, should this be less than the level set for an individual, the system had the facility to alert staff so they could monitor the person more closely.

One member of staff was responsible for ensuring people had drinks throughout the day and were encouraged to eat. The cook worked with the staff member to develop "food for thought days", this was when a person shared their favourite meal and the memories this evoked for them, the meal was then placed on the menu for other people to choose if they wanted. This had proved very popular with people. Picture menus were used both paper and electronic; this was helpful for some people who had small appetites so they could select what they wanted. We observed the lunch period. Many people chose to come to the dining room for lunch and these were set with cutlery glassware and condiments. People sat in companionable groups some chatting amongst themselves. Staff offered assistance to people as needed and this was undertaken discreetly.

Good

Is the service caring?

Our findings

People said they were happy with the care they received comments included "I am very happy here the girls are lovely", another also said they were very happy and the only improvement they thought could be made was to have resident meetings more often, a third person said they liked resident meetings because if they wanted to raise something they felt more comfortable doing so in a larger group.

Relatives said that they were mostly consulted about their relatives care and were very satisfied with the way in which this was delivered by staff. Their comments included "The top floor (Rehabilitation unit) was excellent, "staff are brilliant", "my relative is very well looked after she has been in bed for several years but has no bed sores, we are very happy with it, it's peaceful there". Another said "nothing is too much trouble if he wants to go outside they get him out with a hat and sun cream".

Staff showed that they had a good rapport with people; they were kind and helpful responding quickly to people's requests for support or expressed need where possible. We saw many examples of positive interactions between staff and people, for example medicines administration and assisted meal taking for people with limited capacity, this was undertaken in a respectful manner with the individual staff members involved were seen and heard explaining what they were doing and preparing each person with a covering of paper towel or an apron so that no medicine or food dripped onto their clothing; they were encouraging and gentle in their explanations to people who could not themselves vocalise their wishes.

In the conservatory area we saw that staff were considerate in asking people where they would like to sit, where they wanted their wheelchair positioned, or if they wanted a door open. They offered refreshments and chatted with people about that afternoon's activity- a church service. Religious services were held at the service for those who wished to attend.

We saw staff explaining and informing people about medical visits and also aspects of their care for example, physiotherapy exercises so people knew what was happening. Staff were observed watching some people in respect of their mobility or where they might be going in the service to ensure they were safe.

People's care plans contained information about the important people in their lives and important events they needed to be reminded about. Staff were familiar with their life stories and had built up relationships with them. Relatives said they were always made to feel welcome whenever they visited.

A number of people we spoke with told us what they did for themselves and what help they needed from staff so that they could remain independent for as long as possible.

Bedrooms were of various sizes and all single occupancy as a result of upgrading of bedrooms facilities a number were now ensuite. People were encouraged with family or staff support to personalise their bedrooms and many seen had personal effects such as photographs, pictures, flowers, small personal possessions, and books. Some people had also brought in items of their own furniture. People could have televisions and telephones in their bedrooms but this was a personal choice.

People were provided with a user guide in their bedrooms which was in large print and informed them about the terms and conditions of living in the service, and some of the routines that would make settling in easier to understand.

A notice board in the dining room showed the day, date and weather, this was clear and understandable and helpful to people struggling to retain such information so they did not become confused or lose track of time and the days of the week. People had access to daily newspapers to keep them informed of local national and worldwide events.

In discussion with the interim manager and activities person it was clear that plans were underway for improving signage around the service for those people with cognitive impairments.

No one at the service was considered to be in need of 'end of life care' at the time of our inspection, but staff in the service had worked closely with the local Hospice team who told us that although the service was not currently using any specific recognised model of end of life care they were happy with the care they had seen delivered to people at end of life. Several relatives spoke positively about their relatives having been admitted for end of life care but as a result of the quality of care they had received in the service, they had lived beyond what medical professionals had stated. The provider informed us at inspection that they were arranging for staff at this service to receive training to deliver the Gold Standard Framework for End of Life care and arrangements for this to happen were in hand.. The Gold Standard Framework applies to all conditions and in all settings to ensure that everyone at the end of their life receives appropriate and individualised care that places them at the centre and takes account of their wishes and preferences and we recommend this be progressed. Peoples end of life wishes were discussed with them and /or their relatives where possible and recorded in their plan of care to ensure that these would be fully respected when needed.

We recommend that the provider progresses consultation with a competent person regarding the training and implementation of the Gold Standards Framework for end of life care.

Good

Is the service responsive?

Our findings

People said: "I can go to activities if I want but I am a bit of a loner, I have what I need, I have no complaints about the service", another said "I have a few niggles but I think it would be really picky to complain as I am very well looked after, but I would complain if I felt the need to".

Relatives commented: "I chose this place for my husband because I had received excellent care when I was there for rehabilitation. I was told my husband was end of life when he went there but he has greatly improved since going there". Another said "they do special things there for people like barbecues and strawberry teas". Another said" they talk to me about her care records".

A health professional told us: "We go in as often as needed they are very responsive to patient's needs, they are very proactive in ringing for advice; we are quite happy with the care we have observed there". A social care professional told us "care plans are always available for you to read, and relatives have commented to me about the activities provided".

Information about people's likes and dislikes and activities that interested them were recorded in their care plans. The service had an activities organiser who had previously been a health care assistant at the service, this meant people were comfortable with her and she knew them. The activities organiser took time to get to know people and had written their life histories with them, these were kept in care plans and in the activities care plan, they helped to develop activities that people might be interested in but also provided staff with background history that could help in the way support was delivered. The activities programme featured theme days and there were activities each afternoon, we observed enthusiastic participation by up to a group of fifteen people for quizzes and musical entertainment. During the mornings the organiser spent one to one time with people who could not or choose not to leave their rooms, to try an alleviate boredom and the risk of isolation. We observed one of these 1-1 sessions where the activities person spent time with the person polishing and painting her nails, chatting about her family, the weather and singing along to music.

Some people we met said they had or their relatives had looked at a number of services before choosing this one, others had spent time at the service in the rehabilitation unit and had liked what they experienced and saw at that time; this had helped inform their decision to choose Saltwood Care Centre to live. We discussed the pre-admission process with staff and looked at assessment information gathered about people newly admitted. Staff said that people admitted to the residential part of the home were assessed by the registered manager or deputy. The assessment gathered personal information and also what needs the person had and what level of support they required around these. The interim manager recognised this was an area that could be improved upon regarding the quality of information gathered and would be making changes. In the rehabilitation unit a detailed assessment of prospective people was sent through to the unit from the hospital, new referrals were discussed by the multidisciplinary team offering support in the unit which included a physiotherapist, occupational therapist, case manager and Registered General Nurse, they discussed whether needs could be met and if not why not, so this could be relayed back to the hospital team.

Care plans were developed from pre-admission assessment information gathered and this looked at what people needed and wanted in the way of support to live their lives. This contained information about people's morning and night time personal care routines, the equipment they needed and how this was to be used. The care plan provided guidance to staff about how to deliver peoples care in accordance with their needs and wishes and staff practice reflected this, for example where someone had a specific sleeping routine this was accommodated by staff. People's communication, nutritional, social, emotional and continence needs were also touched on in care plans to ensure they received the right input and support from staff. People with capacity or relatives with authority to do so for those without capacity could make changes to the care plan when this discussed with them by staff. Care staff maintained a daily report of people's wellbeing. The introduction of the new electronic client record system meant that the interim manager was slowly imputing peoples care plans onto the system and this would enable registered nurses and other senior staff to review and update plans as changes occurred.

Each person had a key worker but this role required review to be effective and as their importance in the lives of people they were key worker for was understated. A number of people and relatives we spoke with were unaware of who the key worker was or what support they provided that was different to other staff; this is an area for improvement.

The implementation of a new electronic records system with care staff having small iPod units to enter information into meant that daily reports were live documents written during or immediately following a task being completed with a person, this provided greater accuracy on the quality and quantity of support provided to individuals throughout the day.

At the previous inspection we raised concerns that there was not an appropriate system in place to ensure all concerns and complaints received were acted upon. Since then the provider had taken action to address this. A complaints procedure was displayed for people to view and people were informed that they could refer their complaint to the ombudsman if they were dissatisfied with the response received from the service. Individually people were provided with copies of a 'service user guide' which they kept in their room and contained a personal copy of the complaints procedure for their information. Relatives said they felt confident of raising concerns with the registered manager or other staff if they had them and said they found staff approachable and open.

A complaints log was maintained by the registered manager for recording of formal complaints received. The Provider Information Return (PIR) informed us and the registered manager confirmed that 29 complaints had been received in the last 12 months of which 28 had been resolved these were recorded in the complaints log with evidence of the investigations undertaken. People were also provided with opportunities through resident meetings to express any matters of concern which would be reported to the registered manager. A review of the latest meeting showed no particular issues of concern arising.

Requires Improvement

Is the service well-led?

Our findings

The majority of relatives spoken with said they felt informed and consulted about their relatives care and support most of the time, however some thought that communication in other areas could be improved comments included: "I am very pleased with the care but there is not much feedback" others commented "if you have an enquiry you can never seem to find someone who will deal with it themselves, they always have to ask someone else, who asks someone else and you never seem to get a response", and "I have no complaints but it is sometimes difficult to pin anyone down to get answers to things I want to know about".

A social care professional told us that communication from the home via email was good; staff were always welcoming and the home manager always helpful or would find another more appropriate staff member to answer a query. Another health professional said they had visited the service over several years and had found that the provider and staff were always willing to take responsibility for any shortcomings and took action to address these quickly.

At the last inspection there was an absence of effective systems in place to regularly monitor the quality of the service being provided. At this inspection we saw that a range of audits had now been developed such as monthly catering audits, infection control audits, care plan audits, health and safety audits, fire audit call bell audits, food surveys and surveys to people and other stakeholders and relatives these all helped to improve the provider's oversight of the service. Some of the audits within the current quality monitoring system however, had not been completed effectively and had failed to identify some of the shortfalls highlighted by this inspection which could place people at risk. The failure to ensure that quality audits are used effectively to identify shortfalls in service quality is a breach of Regulation 17 (2) (a) of the HSCA 2008 (RA) Regulations 2014.

Stakeholders were surveyed for their views about service quality; information received was analysed. People had recently been sent surveys and analysis of their comments was underway. We were informed however by the interim manager and relatives we spoke with that information previously gathered and analysed from surveys had not routinely been made available to the people completing the surveys or other stakeholders. People were therefore not able to read about the type of comments received from others or how these influenced service development. The interim manager agreed this was an area for improvement and could be added to the quarterly newsletter which all people living in the service received and brought them and their relatives up to date with happenings in the service.

There had been some recent changes within the management of the service following the departure of the registered manager. An interim manager was in place and provided experienced professional input and oversight of the service. She had already identified a number of areas where improvements needed to be made. Staff said they found the interim manager and the providers easy to talk to and approachable if they needed to raise any issues. The providers were also a visible presence in the home most weekdays and had now implemented formal quality monitoring compliance visits by an external contractor; their input will identify and improve upon any areas or shortfalls found. A service development plan for 2016 had been compiled and this incorporated areas of improvement highlighted through existing audit processes by the

providers and their staff, this was being worked through and we noted a number of improvements had already been implemented. A business continuity plan had also been developed to guide staff to take appropriate action in the event of significant unusual events that could stop the service.

Staff thought communication between staff was good and they were kept informed through handovers of changes to people's individual care and support. Changes in practice and procedure were cascaded to staff through staff meetings which were usually held monthly. The content of staff meetings showed them to have previously been very task orientated with very little recorded input from staff; we discussed this as an area for improvement with the interim manager.

Staff were seen to work in accordance to people's preferences and needs and their support was discreet and unobtrusive. The atmosphere within the service on the days of our inspection was calm and relaxed and staff were unrushed, call bells were heard now and again and staff were alert and responsive to the needs of people on what was two very hot days for example, pulling curtains to remove the sunlight from people's eyes if they were in bed, ensuring people had drinks.

Staff had access to policies and procedures, which were reviewed by a company on behalf of the provider to ensure any changes in practice, or guidance, are taken account of and implemented. Staff were made aware of policy updates and reminded to read them.

Information about individual people was clear, person specific and readily available. Guidance was in place to direct staff where needed. The language used within records reflected a positive and professional attitude towards the people supported.

The care quality Commission was notified appropriately as and when notifiable events occurred. The management team kept their knowledge and skills updated through attendance at the local care homes association meetings, forums, journals and by accessing the CQC provider website for updated guidance.

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 People who use services and others were not protected against the risks of medicines not being managed safely and as directed Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment People who use services and others were not protected against the risks associated with sluices being left unlocked when staff were not in attendance, or risks of infection control procedures being compromised through the poor state of the laundry area. Regulation 15 (1) (a-e).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People who use services were not protected against risks of unsafe care because quality monitoring and audit processes were not being undertaken robustly to highlight shortfalls in the service. Regulation 17 (2) (a)