Mr Barry Potton

Sutton House Nursing Home

Inspection report

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Tel: 01482784703

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This comprehensive inspection took place on 31 January 2018 and was unannounced. At the last comprehensive inspection on 6 and 7 June 2017, the service had an overall rating of 'Requires Improvement' and a rating of 'Inadequate' in Safe. We had found concerns with medicines management, staffing numbers and overall governance of the service. Since the last inspection, the registered manager has kept the Care Quality Commission (CQC) informed and when requested, sent us an updated action plan.

Sutton House Nursing Home is registered to provide personal and nursing care to a maximum of 38 people, some of whom may be living with dementia or have physical disabilities. It is situated in the village of Sutton, close to local amenities. The home has three floors serviced by a passenger lift and stairs with single occupancy and shared bedrooms on the first and second floor. There is a large lounge area, a small quiet lounge and a dining room all situated on the ground floor. There is a garden at the front and the side of the building.

Sutton House Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager. A registered manager is a person who has registered with the CQC 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.

We found improvements had been made in the quality monitoring of the service delivered to people. The audits and checks highlighted when issues required addressing and were followed up by relevant staff. There were surveys, questionnaires and meetings in order for people to express their views.

There were improvements in the management of medicines and stock control was more effective. This meant that people received their medicines as prescribed and there were no delays when new prescriptions were issued.

Staff knew how to safeguard people from the risk of harm and abuse. They had completed safeguarding training and knew how to raise concerns and who to speak to about them. We saw people had assessments to help guide staff in how to minimise risk and keep people safe.

Staffing numbers had increased and were consistently maintained. There was a comment from health professionals about the difficulty in locating care staff, general oversight in the dining room and exiting the building at a peak time in the morning. Staff were busy supporting people to get up or administering medicines at this time. However, the registered manager told us they would resolve this by adjusting ancillary staff deployment at this peak time.

Staff recruitment was robust and employment checks were in place prior to new staff starting work. Staff had access to a range of training, supervision and appraisal which helped them to feel confident when supporting people's needs.

People told us staff were kind and caring and their privacy and dignity was maintained. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice. People were treated as individuals and their rights protected.

We found people's health care needs were met. They had access to community health care professionals when required and referrals to them were made in a timely way.

People's nutritional needs were met. The menus provided choices and alternatives and special diets were provided. Staff supported people to eat their meals in a sensitive way and the lunchtime experience was a calm and sociable event.

There were activities provided seven days a week to help prevent isolation and encourage social interaction. Although there was an outside area for people to sit in during the warmer weather, there were plans for this to be improved to makes it more secure.

The provider had a complaints procedure displayed in the service. People felt able to raise concerns and staff knew how to manage them so they were resolved as quickly as possible.

The environment was clean and safe. Staff had personal protective equipment and there were procedures for infection control. Equipment used in the service was checked and maintained. There was a business continuity plan to guide staff in dealing with emergencies such as utility failures or floods. Each person who used the service had a personal emergency evacuation plan although these were included in their care file. The registered manager told us they would ensure a copy was included with an emergency pack to provide information to professionals if required.

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 safe. While improvements have been made we have not rated the this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

There had been improvements in the management of medicines and people received them as prescribed.

There was a robust system of staff recruitment to enable checks to be made before staff started work. Improvements had been made in staffing numbers and there was sufficient staff employed to meet people's needs, although deployment of staff on the ground floor between 8.30 and 9.30am could be improved.

People were protected from the risk of harm and abuse by staff training and knowledge of policies and procedures. Risk assessments were completed when people had identified issues of concern. These helped to guide staff in minimising risk.

The environment was clean and safe.

Is the service effective?

Good

The service was effective.

People were supported to make their own decisions. When they were assessed as lacking capacity to do this, the provider and registered manager acted in people's best interest and consulted with relevant people.

People's health and nutritional needs were met. There was a range of community healthcare professionals to advise and provide treatment and the meals provided to people met their nutritional needs.

Staff had access to a range of training, supervision and support to ensure they felt confident when caring for people and meeting their needs.

Is the service caring?

Good

The service was caring.

People told us staff supported them in a kind and caring way. We observed this during the inspection.

People's privacy and dignity were maintained and their individuality promoted. They were provided with information in accessible formats.

Confidentiality was maintained and personal records stored securely.

Is the service responsive?

Good

The service was responsive.

People had assessments of their needs completed prior to admission and the information was used to prepare plans of care. Staff told us they had sufficient information to be able to care for people.

Care was delivered to people in ways that met their preferences, likes and dislikes. People received end of life care and relatives were supported through this process.

People were able to participate in a range of activities to help prevent isolation and promote social interaction.

There was a complaints procedure on display and people felt able to raise issues. The provider and registered manager took action when concerns were raised with them.

Is the service well-led?

Good

The service was well-led.

There had been improvements in the quality monitoring of the service delivered to people. Audits had improved and helped to identify issues to be addressed and people's views were sought via meetings and questionnaires.

People, their relatives and staff told us the service was well-managed and the culture within the service and organisation had improved.

The registered manager provided support and guidance to the staff team. All staff spoken with told us they could raise issues and these would be addressed.

Sutton House Nursing Home

Detailed findings

Background to this inspection

We carried out this comprehensive inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The comprehensive inspection site visit took place on 31 January 2018 and was unannounced. The team consisted of three adult care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert-by-experience had expertise in caring for an older relative who lived with dementia.

The provider had completed a Provider Information Return (PIR) prior to the inspection. 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 checked the PIR and also our systems for any notifications that had been sent in as these would tell us how the provider managed incidents and accidents that affected the welfare of people who used the service.

Prior to the inspection we spoke with local authority safeguarding, contracts and commissioning teams, and also health commissioners about their views of the service.

During the inspection, we observed how staff interacted with people who used the service throughout the days and at lunchtime. We spoke with three people who used the service and six people who were visiting their relative or friend. We spoke with the registered manager and the deputy manager (both qualified nurses), the nurse in charge of the shift, a senior care worker, four care workers, an activity coordinator, a cook and maintenance personnel. We also spoke with two visiting health care professionals and received further information from another health professional following the inspection. Following the inspection, we spoke with the provider.

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 five care files which belonged to people who used the service. We also looked at other important documentation relating to them such as 10 medication administration records (MARs) and monitoring charts for food, fluid, weights and pressure relief. We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held.

We looked at a selection of documentation relating to the management and running of the service. These included four staff recruitment files, training records, the staff rota, minutes of meetings with staff and people who used the service, quality assurance audits, complaints management and maintenance of equipment records.

Requires Improvement

Is the service safe?

Our findings

At this inspection, we found the provider had made the required improvements and was now meeting the regulations in this area. While improvements have been made we have not rated the this key question as 'Good'; to improve the rating to 'Good' would require a longer term track record of consistent good practice.

At the last comprehensive inspection, we had concerns that people did not always receive their medicines as prescribed due to stock management. There were also some recording issues and some people's medication administration records were difficult to follow. At this inspection we found improvements in the way medicines were managed. We saw medicines were administered safely to people in line with their prescriptions; this included both oral medicines and the application of topical products such as creams. A small number of people had medicines prescribed 'as required' for anxious or distressed behaviour; we saw these medicines were used appropriately. We observed staff administer medicines to people and this was completed in a patient and sensitive way. There were colour-coded body maps to identify creams and where these were to be applied. Staff kept good records of the administration and application of medicines. We saw staff ordered medicines in a timely way and stored them safely. People spoken with told us they had no concerns about their medicines and they received them on time.

We also had concerns about staffing numbers at the last comprehensive inspection. The registered manager told us staffing numbers had increased since then and rotas confirmed this. We found there were sufficient staff on duty to support people's assessed needs; however, there was a comment from a visiting professional about a perceived staffing issue first thing in the morning, when they visited to provide treatment to people. The issue was about a lack of care staff in the lounge area and dining room to oversee people who were eating breakfast. They also commented on the length of time it took to find staff to let them out of building. At this busy time, staff were supporting people to get up and dressed and senior staff would be administering medicines which would account for the perceived lack of staff. We discussed with the registered manager how staff deployment could be resolved with the use of ancillary staff. The registered manager agreed they could be visible in the lounge and dining room to oversee people's support and answer the door until the activity coordinator arrived at 10am or staff support upstairs had been completed. Another health professional said, "When I have visited, there always seems to be enough staff available and they are able to support people in their care."

People told us staff attended to them quickly although one person said they sometimes had to wait so would go try to go to the toilet independently which could pose a risk. We saw staff had arranged for a sensor mat to be strategically placed in the person's bedroom to alert them when they mobilised by themselves. Comments included, "There's never a time when I am waiting; I don't use the call button much" and "I sleep through the night so can't say about night staff; I feel staff are always busy though." Relatives said, "I think so [sufficient staff]. The call bell is answered within seconds during the night; it's brilliant", "There are plenty of them around", "Staff do the best they can; I am here every day so do most things for him" and "There's always carers around when I visit."

Staff had received training in how to safeguard people from the risk of harm and abuse. They knew the

different types of abuse and how to protect people; staff knew how to raise concerns with the registered manager or the local safeguarding team. Comments included, "I would inform the senior on shift or [Name of registered manager], and they would definitely report it. [Name of registered manager is very approachable and poor practice would be picked up. I'm proud of what we do." There was a system in place to manage people's personal allowance held for safekeeping in the service. This helped to protect people's finances.

People told us they felt safe living in the service. Comments included, "My room is safe and homely, and I have all my own pictures up", "There is no reason that would nullify the safety side" and "Yes, I have no front door to lock and I have my own little room." Visitors also felt their friend or family member was safe and well-looked after. They said, "Yes, the building is secure and staff are stringent", "I feel my mother is secure and safe" and "As safe as she is ever going to be; she tends to walk off without her frame, so does fall." The person advised that staff had placed a sensor mat outside their room to alert staff if she is going to walk about on her own. Other comments included, "Yes, I think nobody is going to harm him", "She feels safe here and looks after her own handbag as she is concerned that belongings may go missing", "Very safe; there are no issues" and "Somebody is there all the time; he can't get out and can't hurt himself."

People had risk assessments completed on admission and when issues occurred. The care files evidenced risk assessments in areas such as falls, moving and handling, nutritional intake, choking, skin integrity, bed safety rails and distressed or anxious behaviour. The risk assessments were kept under review.

We checked files for new staff and saw recruitment was completed safely. Employment checks were in place prior to staff staring work at the service. These included application forms to assess gaps in employment, references and a check with the Disclosure and Barring Service (DBS). DBS checks helps providers make safer recruitment decisions and includes a police check. There was a system in place to look at Nursing and Midwifery Council (NMC) information for qualified nurses to see if there were any conditions placed on their registration.

The environment was a clean and safe place for people. Accidents and incidents were recorded and the registered manager used the information to minimise risk of reoccurrence. Staff knew how to prevent and control the spread of infection and used personal protective equipment appropriately. Equipment used in the service was maintained and maintenance personnel showed us their system for identifying and addressing when issues needed attention, for example, light bulb renewals and repairs to items. Fire equipment such as the alarm system, emergency lights and exits was checked weekly and fire extinguishers checked annually. Staff had completed personal emergency evacuation plans (PEEPs) for each person, which were held in their individual care folders. We spoke with the registered manager about ensuring a copy of each PEEP was available in one separate 'grab file' for staff or emergency services to use if required. Hot water outlets were monitored and thermostatic valves were in place to avoid the risk of scalding. Electrical and gas appliances were serviced.

The passenger lift had caused some difficulties in recent months and had required several call outs from engineers. The registered manager told us the provider has sought quotes to look at a full refurbishment of the lift. After the inspection, we spoke with the provider who described the work that had taken place on the control panel and plans to install coded locks to the lift which can only be operated by staff. They confirmed refurbishment will take place in April 2018 if these measures do not resolve the issues.

Good

Is the service effective?

Our findings

At the last comprehensive inspection, we had concerns that the pace of staff training was too slow and some staff did not have the skills required to support people's needs especially in relation to managing behaviours which could be challenging to others. At this inspection training records showed all bar very new staff had received training considered essential by the provider. These covered topics such as safeguarding, moving and handling, infection control, first aid, fire, health and safety, dementia awareness, communication, nutrition, confidentiality, mental capacity legislation and equality and diversity. Care staff told us they received sufficient training and felt confident in meeting people's needs. Most nurses had received clinical training in catheterisation, venepuncture, wound care and the use of syringe drivers for palliative care. They also said they had received formal supervision meetings; some staff had attended more meetings than others. All staff spoken with stated they felt supported in their role. Records confirmed staff had completed competency checks in specific areas such as medicines administration, continence care, pressure area care and record keeping.

We noted the induction records for some staff were more comprehensive than others. However, it would have been difficult to audit the records in the time available as they were all together in one file and not in any particular order. There had not been any administration support for the last three months and the organisation of the records had not been a priority. However, staff confirmed they had completed supernumerary shifts during induction and were mentored by more senior staff.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was acting within the MCA and had made appropriate applications for DoLS to the local authority. There were eight people who had DoLS authorised and several more people were awaiting assessment. All staff had received training in MCA and DoLS, and in discussions, they had a good understanding of their responsibilities.

In discussions with staff, they described how they assisted people to make their own decisions, for example where they would like to spend their day, where to eat their meals, the times of rising and retiring and what activities to participate in. People told us they were supported to make their own decisions and staff asked for their consent prior to carrying out care tasks. Comments included, "Yes, I asked for a shower this morning and got one. I eat my breakfast in the dining room but the rest of my meals in my own room", "I choose

bedtimes", "Yes, they ask me if I'll take my tablets" and "I choose when I get up and where I eat; nobody tells me what to do." A relative said, "It seems to be common practice to ask her; they always ask her if they can give personal care."

People's care file showed us they had access to a range of community health care professionals and attended hospital appointments when required. Comments from health professionals included, "They chased up specific equipment in a timely way", "Staff contact GPs when appropriate and refer to district nursing when needed" and "The staff always contact us when they experience any problems with residents. Staff are receptive to advice and follow instructions when given." One health professional told us they had to remind staff about the creams applied to a person's legs.

People told us staff contacted their GP when required. Comments included, "I've seen a doctor once since I have been here and an optician. I've seen a chiropodist once but I do my nails myself" and "I see a doctor when needed and a district nurse sometimes; I've also seen a dentist, optician and chiropodist." Relatives said, "All doctor or hospital needs are met and we are informed of all treatments" and "They tell me if they have called a doctor in, I have never had to ask. He has got some cream that they put on his knees and they let him rub it in."

People told us they liked the meals provided to them and they could ask for alternatives. Comments included, "They brought up liver to eat the other day and I told them I don't like it so they brought me another meal." Relatives said, "She used to struggle to eat but since she has been here it is great. The meals look well-presented; they look lovely." They also added the person's husband visited regularly and pays a small amount to have his dinner here which he always enjoyed. Other relatives said, "The food is brilliant; they eat sufficient and there is always a choice. They were under the dietician but have now been discharged", "He is eating alright; the food is fine. I had Christmas dinner here and it was fine", "Mum has maintained a healthy diet in line with her health needs and is fitter and healthier since coming here" and "He is putting weight on; I think he is getting enough."

We found people's nutritional needs were met. People who used the service had their nutritional needs assessed on admission to the service. The assessments identified the type and texture of diet they needed, whether any support was required when eating their meals and whether any equipment such as plate guards or adapted cutlery would assist them. A risk assessment was carried out and people were weighed in line with this, either weekly or monthly. The menus provided choices and alternatives to the main meals on offer. Catering staff said, "If we get asked by people for a request we try to do it and we have asked them about the new menu and they seem to be happy with choices." The cook had information about people's dietary requirements and was knowledgeable about the preparation of different textured meals. We observed people were offered a range of snacks in between meals such as biscuits, cakes, yoghurts, crisps, milk and fresh fruit. Tea and coffee and a selection of juices were available throughout the day.

We observed the lunchtime experience for people and saw this had much improved from previous inspections. The lunchtime was calm and informal; people were served at the same time and received the support they required in a sensitive way. Some people chose to eat their meals in the large or small lounge and tables for this use were provided. People who chose to eat their meals in their bedrooms had these delivered to them on a covered tray to help keep them warm. Staff were attentive during the meal and made sure people had had sufficient to eat and drink before clearing away plates.

We saw the environment was appropriate for people's needs. Corridors were wide and had grab rails to assist people. There were specialised baths or shower rooms and a range of moving and handling equipment. The registered manager told us how they were making the environment more dementia friendly.

For example, the new carpet in the lounge was a plain colour as it was recognised patterned carpets could pose a distraction for people living with dementia and contribute to falls. Signage throughout the ground floor had improved with pictorial signs on the toilets and doors to the lounge and dining room, and also on notice boards for activities and meals. There were no photographs to assist people living with dementia to more easily locate their bedroom; this was important as all the bedroom doors were painted white. There was also no clear signage to remind people where the lift was on each of the floors. This was mentioned to the registered manager to address.

Good

Is the service caring?

Our findings

People told us staff cared for them well and protected their privacy and dignity. Comments included, "They are helpful", "Staff are good; I'm happy with my room", "This place is comfortable, very pleasant", "They are okay; they do the job", "It's not bad at all, nobody bothers me; it's a happy place" and "If you ask them for anything, they help." A comment from one person about a specific incident was mentioned to the registered manager to address.

Visitors and relatives said, "I think she is settled, happy, cared for, clean and well-fed", "Mum says she really likes it here and she is well-looked after. They are always friendly and talk to me and Mum. They are on the ball with everything", "They are warm, friendly, caring, compassionate and all seem dedicated" and "They are content here; there are good staff here. Mostly they have empathy and compassion; most carers are excellent with them." Other comments included, "Excellent staff; I cannot commend the staff enough", "Staff are respectful of all mum's needs" and "Mum refers to the carers as her friends; one carer recently crocheted a shawl for her."

In discussions, staff described how they promoted people's privacy and dignity by closing doors and curtains during personal care, keeping people covered and knocking on doors before entering bedrooms. We saw shared bedrooms had privacy curtains separating the two beds and there were privacy locks on bathroom and toilet doors. We saw staff accompany people out of the lounge to use the toilets but we never overheard staff ask them if they wanted to go to the toilet, which showed us staff were discreet about this. People were appropriately dressed and had shoes, slippers or slipper socks on, and their hair had been neatly brushed. We saw two people who required nail care which was mentioned to the registered manager to address. When we checked one of the people's care files, we saw staff had attempted nail care on several occasions but had been unsuccessful. The registered manager told us they would try again to address this or seek professional advice.

Professional visitors to the service told us, "Yes, I have seen good examples of privacy and dignity", "Staff are always caring towards their residents and family. Privacy and dignity is maintained at all times" and "Staff have been very kind. In shared rooms, curtains are pulled across when carrying out personal cares."

Training records showed that all bar new staff had completed equality and diversity training and staff were aware of the need to treat people as individuals. Comments included, "We have a rapport with people so they open up and talk to us. We don't judge people and all colleagues would have to work in this way." The provider had a policy and procedure entitled, "Equality, Diversity and Inclusion", which provided staff with information and expressed a commitment to respecting people's individual life choices and ensuring that support delivered to them was not discriminatory. There were attempts to make information more accessible to people with the use of signage and large print.

There were notice boards in the service to provide information to people such as the daily menu in pictorial as well as word format, and activities arranged for the week. There was a notice which reminded people the fire alarm was tested each week on a specific date. Service user guides were available which gave

information about what people could expect when living at Sutton House Nursing Home; there was also information about how to make a complaint. Initially, we noted the date displayed in the dining room was incorrect but this had been adjusted when we next checked at 2.30pm.

During the Short Observation Framework for Inspection (SOFI) and general observations throughout the day, we saw staff spoke with people in a kind and caring way during their interactions. It was clear staff had developed caring relationships with people who used the service and knew their needs well. For example, we saw two care staff assisted a person from a wheelchair to a dining chair; they chatted with them, offered to put on a clothes protector and asked if they wanted poached egg on toast for breakfast, which they did. Staff chatted to people about their relatives and when they would be visiting. They gave explanations prior to tasks such as moving and handling or repositioning equipment for them. We observed staff were sensitive when adjusting people's clothing or placing blankets around their knees. We overheard one care worker tell a person who used the service that they had inspired them to start crocheting; this was pleasant for the person and helped to raise their esteem and self-worth.

People's care files provided information about their preferences, likes and dislikes and we saw staff were aware of these and acted upon them in day to day interactions with people. For example, some people had specific chairs they liked to sit in, some people chose to remain in their bedrooms which was respected and some people requested specific snacks which were accommodated.

The registered manager had information about advocacy services and told us one person had received support from an independent mental capacity advocate. Relatives also provided support to people who used the service and acted as advocates for them.

The service had a visit from the Lord Mayor recently and the registered manager arranged for one person who was having their birthday to meet him. There was a photograph of the meeting and the person was really pleased and felt it was a special occasion.

Staff were aware of the need for confidentiality and personal discussions and phone calls were held privately. Care files were held securely in the nurse's office and staff personnel files were held in the registered manager's office. Computers were password protected and the provider was aware of the need to be registered with the Information Commissioners Officer when personal information was held electronically.

Good

Is the service responsive?

Our findings

At the last comprehensive inspection, there had been an occasion when a person was admitted without full knowledge of their needs and we made a recommendation to address this. At this inspection, we saw the registered manager had ensured the statement of purpose had been adjusted to include the requirement of a full assessment (including receipt of those completed by other professionals) prior to admission in order to make sure needs could be safely met.

We saw people who used the service had an assessment of their needs completed prior to admission. The assessment we looked at for a new person admitted to the service was thorough and included information about the full range of their needs. The registered manager confirmed they ensured assessments completed by health and social care professionals were received and used to form a judgement about whether Sutton House Nursing Home was the most appropriate place for the person. Assessment information was also used to formulate plans of care.

The plans of care we saw reflected people's assessed needs and provided guidance for staff in how to meet them. Three months prior to the inspection, we had received information about shortfalls in one person's care plan records and the checking of a wound care site. We received further information from the local authority that these issues had been addressed.

We saw people's care files had information about their preferences for how care was to be delivered, their likes and dislikes and social histories. The information helped staff to see people as individuals and not just the recipients of care tasks. In discussions with staff and from observations, it was clear that they knew people's needs well and had built up caring relationships with them. Staff said, "A couple of the ladies don't like male carers or vice versa and this is respected; you get to know people as individuals quite quickly." People's bedrooms were personalised with their own small items, such as ornaments, pictures and photographs. We saw there was a portable, pictorial communication board which was used to help people who struggled to find words; this helped people to make their needs known and could be used in a discreet and sensitive way.

People told us they were well-looked after and staff knew how to care for them in an individualised way. Comments included, "My son visits regularly; I feel I get looked after." Relatives said, "There's been a massive improvement since she has been in here; she is eating more, getting out of bed more and is generally more alert", "All needs are met. They can be awkward and they [staff] are really patient with her; I visit most days", "My mum was bedridden and could not communicate at first; she is unrecognisable and this is due to the care given" and "I think it is now; I'm happy with everything." One visitor told us how staff knew their relative well and were able to calm them when they became distressed. They were also pleased they had been provided with specific information when requested.

We saw people were able to remain in the service for end of life care. One person had recently died and we checked their care file to see how support at the end of their life was recorded. There was information about equipment used such as specialised mattresses and cushions for pressure relief, the care provided on a daily

basis, preparations for pain relief and involvement of family, GP and district nursing services. Arrangements for care after death had been discussed with the person and their relatives to ensure their wishes were documented. In discussions, staff described how they supported people at the end of their life and referred to offering comfort and TLC (tender loving care), pain relief, increasing the amount of checks, sitting with people to hold their hand and support for relatives. Staff were aware of who had a 'do not attempt resuscitation' order in place.

We saw there was a range of activities for people to participate in within the service. An activity coordinator was employed seven days a week from 10am to 6pm. This helped to ensure people in the lounge and those who preferred to remain in their bedroom had the opportunity for social stimulation. The service had chickens, which people who used the service had watched hatch in an incubator, hamsters and tropical fish. People enjoyed feeding and watching the animals. An activity board was displayed in the lounge and included exercises to music, bingo, sing-a-longs, 'Name that Song', games, art and craft work, entertainers, hand and nail care, quizzes, folding towels and visits from 'Zoo Lab'. There were newspapers for people to read and church services. A hairdresser visited the service twice a week. One person told us they would like to have more trips out and others commented that the garden was not secure. The registered manager described plans to make a secure garden when the weather improves.

The activity coordinator described how they had secured audio tapes for two people and arranged cakes and banners to make birthdays special. They also showed us a dementia aid DVD with topics such as 'what's that sound', 'name the hit record' and 'name that TV tune'. The activity coordinator visited each new person to ask them what they would like to do, finds out any hobbies and asks them about their life; they also checked out what they would physically be able to participate in and what they would need support with. There was an activity file and they recorded the activities people have participated in and whether they enjoyed them or made any comments. One to one support in people's bedrooms included manicures and chats. There were photographs of a recent visit from the Lord Mayor and another from an entertainer who was an Elvis impersonator. We observed two activities taking place during the inspection and saw several people either joining in and enjoying it or smiling and watching.

Comments about activities included, "I read books, watch television, play bingo; sometimes my family visit too" and "I play bingo twice a week; I like listening to music and my son visits a lot." Relatives said, "When she is having a good day, she will join in; she likes quizzes, bingo and the singing", "Mum plays bingo, sings, takes part in activities and outings to fayres and Christmas parties", "He likes playing dominoes, throwing and catching a ball and he sings along with the artists" and "She does a lot of reading; they ask if she wants to go downstairs but she refuses."

The provider had a complaints policy and procedure which detailed timescales for acknowledgement, investigation and response. Also how to escalate a complaint if people were unhappy with the outcome of an internal investigation. There was a reminder of how to complain in the service user guide and a poster was displayed on the notice board in the entrance. We saw there was a suggestions box and slips to complete near the registered manager's office. People told us they felt able to complain and they would be addressed. Comments from people who used the service included, "I would see [Name of registered manager], but I haven't really needed to", "I don't know, everything is ok" and "I would go to the top dog in the office but I have no issues." Visitors said, "I would go to see the lady called [Name of registered manager], I have no complaints" and "I would see the nurse initially then the manager." Other visitors named the registered manager as the person they would see if they had concerns.

Good

Is the service well-led?

Our findings

At the last comprehensive inspection, we had concerns that the provider's quality assurance system was not sufficiently robust to identify and respond to concerns. At this inspection, we found improvements had been made.

Audits had been completed in a range of areas, for example, the environment, cleanliness, infection prevention and control, accidents and incidents, pressure relieving mattresses to ensure they were at the correct setting, food safety and medicines. In most instances there were action plans to address the issues but we could not locate some action plans although the registered manager confirmed the issues had been rectified. The registered manager completed a 'weekly manager's audit' which recorded a number of checks such as a selection of medication administration records, the signing in/out book, cleaning schedules and handover sheets. We saw some anomalies in the hot water temperature checks which were on the cool side. Following the inspection, the registered manager confirmed they had arranged for a plumber to check, and adjust if required, the thermostatic monitoring valves attached to hot water outlets.

Records had improved and new monitoring charts had been put in place. This was confirmed in discussion with a local authority representative who had recently made a visit to the service and was pleased with improvements. The registered manager told us they still inspected food and fluid charts daily to make sure staff were completing them thoroughly.

The registered manager was more aware of the need to send notifications of accidents and incidents that affected the safety or welfare of people who used the service. The Care Quality Commission had received these in a timely way which was an improvement since the last inspection. The notifications provide information so we can assess and follow up on how the incidents are managed.

We spoke with the registered manager about the culture of the organisation. They stated they were supported by the provider and felt able to talk to them or senior managers when required. They had management support meetings to discuss issues and progress. The provider and their representative completed visits to the service and recorded their findings and action required. This showed us they had oversight of the service. We saw there was a staff handbook which detailed expectations of staff and what they could expect from the provider. The provider also had a statement of purpose which detailed the vision and values of the organisation. This referred to supporting people to maintain their individuality and identity, upholding rights and freedom of choice, and promoting privacy and dignity. The registered manager told us they had an open-door policy, made themselves available to people who used the service, their relatives and staff, and tried to resolve issues quickly.

Staff all stated they felt the service was well-managed. Comments from staff included, "[Name of registered manager] is all for learning", "Management is a lot better", "It's a good team and we all get along. It's an amazing atmosphere and a home from home", "It's a happy place and the residents cheer me up", "Staff really support each other – it's one of the nicest homes I've worked in", "[Name of registered manager] took over at a difficult time and is doing a good job. The deputy manager is also very good" and "It's very well-led

which is most definitely an improvement. They are working hard to make improvements, [Name of registered manager is amazing and is always there to help and support us."

Communication within the service, between the registered manager and staff and between staff themselves, had also improved. New handover documents had been produced. One was a daily record of issues that had occurred within the service and the information was used to handover between the manager of the day or night shift. The second was a weekly record of issues for each person who used the service. They recorded when people received 'as and when required' medicines to relieve distressed or anxious behaviour, when district nurses visited to treat people or when a person had a fall. These records could also be used to inform monthly evaluations of care plans and risk assessments to check if updates were required. Staff confirmed communication within the service had improved and they told us they felt supported and able to raise concerns if required. They said, "The staff handover is good for sharing new information. If staff are off for any length of time, we go over the old handover sheets. Documentation is also much improved including observation and fluid charts." They also confirmed they attended staff meetings and we saw minutes of the last two staff meetings covered a range of topics such as care planning and monitoring charts, shift patterns, lead roles, positive feedback, plans for the environment, training and policies and procedures.

We saw there were meetings for people who used the service and their relatives; there had been two since November 2017 and topics included plans for the service, the new menus, a recent themed day when staff got dressed up in 1940/1950s clothes, the Lord Mayors visit and activities. Comments from relatives included, "They have recently upgraded the bedroom which is great", "I don't like the shared room aspect but I think they are getting rid of these", "I have been to two meetings, they tell us what is happening at the home" and "Things have improved; they now have a fluid chart so I can see what they have had." There had also been a quality survey where people could comment on the service provided to them. The analysis of the questionnaires reflected people were happy with the service they received.

The registered manager and staff team have developed good relationships with other professionals and agencies. A district nurse said, "I feel that we have a good relationship with the staff. They are able to contact us at any time for advice and support."