Four Seasons (No 10) Limited

Murrayfield Care Home

Inspection report

77 Dysons Road
Edmonton
London
N18 2DF

Tel: 02088840005
Website: www.fshc.co.uk

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 21 and 22 November 2017 and was unannounced. At the last inspection on 18 and 19 October 2016 we found the service was in breach of six regulations as stipulated by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that people were not supported by care staff in a person centred way. Care was not delivered in a way which was appropriate, met people's needs and reflected their preferences. The provider did not ensure that appropriate activities were organised and provided to people, which encouraged autonomy, independence and involvement within the community. People were not supported by care staff with dignity and respect. Care staff did not put person centred care into practice or provide care that ensured people were treated with dignity and respect. Care staff did not interact with people unless they requested attention.

The provider was not protecting people and was not doing all that was reasonably practicable to mitigate identified risks associated with people's care and support needs. The provider failed to ensure that people were appropriately supported with their nutritional and hydration needs in order to maintain their health and well-being. The provider did not ensure that all areas of the home and equipment used by the service were clean, suitable for the purpose for which they were to be used and properly maintained.

Quality assurance audits that were being completed were not effective as they did not highlight concerns and issues around the home which had been identified on inspection. Where issues were identified there were no action plans in place on how these issues were to be addressed and resolved and there was also a lack of evidence that staff were supported to fulfil their roles and responsibilities through regular supervisions and appraisals.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve each of the key questions to at least good. During this inspection we found that the service had made appropriate improvements to the issues that we identified and were also able to evidence sustainability of improvements that had previously been made.

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

Murrayfield Care Home accommodates up to 74 people in one purpose built building. Within the building there were three floors, each of which had separate adapted facilities. One of the units specialises in providing nursing care to people and the two other floors specialised in providing care and support to people living with dementia and physical health needs. At the time of this inspection there were 73 people using the service.

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

The service had made significant improvements in the fabric and condition of the home. The home was clean and improvements had been made to food preparation areas and other specific areas around the home. However, we did note that sluice rooms had not been kept locked and secure where required.

The service had implemented a number of checks to ensure the appropriate completion of fluid intake charts and to ensure people were appropriately hydrated. However, the effectiveness of these checks were inconsistent across the home because charts had not always been checked appropriately.

Some care staff were able to demonstrate a basic understanding of safeguarding and the steps they would take to report any concerns but this remained inconsistent with some care staff unable to demonstrate a clear understanding of safeguarding and whistleblowing.

Care plans contained appropriate documentation confirming consent to care had been obtained and care staff were clearly able to explain their understanding of the MCA and DoLS and how this impacted on the care and support that they delivered.

We observed positive and caring interactions between people and care staff. However, further improvements needed to be made especially around people's mealtime experiences.

Significant improvements had been made to people's care plans. Care plans were detailed and person centred and also contained a life history booklet about the person which gave detailed background information about the person, their likes and dislikes and information about their interests.

During this inspection we observed that although improvements had been implemented to ensure a daily schedule of activities was delivered, outside of this schedule, care staff did not always take the initiative to deliver any additional activities or interaction.

Improved systems were in place to monitor and check the quality of care provided. We received consistently positive feedback from people, relatives and staff regarding the management structure in place and the support they received.

The service had policies and procedures in place to ensure the safe management and administration of medicines. Previously the service had encountered significant issues with medicines which had resulted in enforcement action. However, during this inspection the service demonstrated that they had successfully sustained the improvements in the way that medicines were administered and managed.

People's care plans identified and assessed risks associated with their health, care and medical needs and appropriate guidance was available to care staff in order to reduce or mitigate the risk in order to keep people safe and free from harm.

Records seen confirmed that staff received regular supervisions and annual appraisals as well as regular training to enable them to deliver safe and effective care.

We received mix feedback from people and relatives about staffing levels within the home. However, during

both days of the inspection we observed appropriate staffing levels to be in place. Staff did not seem to be rushed and people's needs were met appropriately.

Appropriate recruitment processes and checks were in place to ensure that only staff safe to work with vulnerable people were recruited.

Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. Where safeguarding concerns were raised, the service was able to demonstrate the actions they took and the improvements made to ensure lessons were learnt.

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 supported this practice.

The senior management team were accessible to people, relatives and staff who spoke positively about them and felt confident about raising concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Risk assessments in place identified and provided guidance to staff on people's risks and how to reduce and/or mitigate identified risks.

Medicines were managed and administered safely.

Robust safeguarding policies were in place. However, not all care staff were able to demonstrate a clear understanding of safeguarding and whistleblowing.

The service followed robust recruitment processes to ensure appropriate recruitment of staff.

Appropriate staffing levels were observed throughout the inspection.

Accidents and incidents were recorded, investigated and analysed to ensure lessons were learnt to prevent any further re-occurrences.

Is the service effective?

Good

The service was effective. Care staff were regularly supported in their role through training, supervisions and appraisals.

Care staff understood and provided care and support according to the key principles of the Mental Capacity Act 2005.

People were provided with sufficient food and drink and were supported where required.

Care plans were developed in partnership with people, relatives and healthcare professionals.

Is the service caring?

Good

The service was caring. People had developed caring relationships with certain care staff. People and relatives confirmed that they were treated with dignity and respect.

Care staff knew people well and had a good knowledge and

understanding of their needs, wishes and choices. People were seen to be involved in day to day decision where possible.

Is the service responsive?

Requires Improvement

The service was responsive, however, further improvements needed to take place before this key question could be rated as 'Good'.

Although there was a schedule of activities no effort or initiation was driven by care staff to deliver any other type of activity or stimulation outside of this schedule.

Care staff were generally responsive to people's needs. However, further improvements needed to be made especially around people's mealtime experiences.

Care plans were detailed, person centred and responsive to people's needs. Care plans were reviewed regularly.

All complaints and feedback from people, relatives, visitors and health care professionals were recorded and responded to appropriately.

Is the service well-led?

Good

The service was well-led. The service had made significant improvements since the last inspection to ensure that people received safe, effective, caring and responsive care and support.

A number of audits were carried out by the regional manager, registered manager, deputy manager and nurse unit leads to ensure that identified issues or concerns were immediately highlighted and addressed.

There was a clear management structure in place and people and staff spoke positively of the senior management team.

Murrayfield Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 21 and 22 November 2017 and was unannounced.

This inspection was carried out by three inspectors and a specialist advisor nurse. The inspection team was also supported by two experts by experience who spoke to people and visitors and made observations throughout the inspection. An expert by experience is a person who has
personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection, we reviewed the information that we held about the service and the providers including notifications affecting the safety and well-being of people who used the service and safeguarding information received by us. We reviewed the Provider Information Return (PIR) which the provider had sent to us. A PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also looked at action plans that the provider had send to us following the previous inspection in October 2016.

We looked at care records for 16 people living at the service to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for nine members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including staffing rotas and quality assurance processes, to see how the service was run.

During the inspection, we obtained feedback from 15 people and 13 relatives. We spoke with the registered manager and deputy manager, the regional manager, three registered nurses, 11 care staff, the chef, the handyman and an activities coordinator. We spoke with three visiting healthcare professionals.

Good

Is the service safe?

Our findings

People and relatives told us that they felt safe living at Murrayfield Care Home and with the care and support that they received from care staff. Comments from people included, "I feel safe", "I feel safe knowing staff are around" and "Safe? Oh yes. Staff are brilliant." Responses from relatives when asked if they felt their relative was safe living at the home included, "Oh god yes!", "I feel [relative] is safe now. There were issues in the past with medicines but these have been sorted" and "Absolutely safe."

At the last inspection in October 2016 we found that although the unit managers and senior care staff demonstrated a good understanding of safeguarding and knew the actions to take if abuse was suspected, some care staff were unable to demonstrate any understanding of what safeguarding was. Care staff could not describe the various types of abuse and until the inspectors further prompted what it meant, were they then able to tell us the actions that they would take if abuse was suspected.

During this inspection we found that although the provider had consistently tried to train and refresh all care staff on their knowledge around safeguarding and whistleblowing not all staff could articulate the definitions of safeguarding. However, most staff were able to demonstrate their understanding and the actions they would take if concerns were noted. Care staff told us, "To safeguard residents from abuse and harm. I would go to the RM or whistle blow" and "To protect residents from anything coming. To protect from abuse. Our staff group is lovely. Everything is fine. Report straight away to the manager or nurse in charge." However one care staff response included, "Yes helping you improve. Shouting, kicking, something. Report to nurse or manager."

One member of care staff did not know what 'whistleblowing' meant and did not understand that concerns could be reported to external professionals such as the Care Quality Commission (CQC) or the police. We highlighted these concerns to the regional manager, registered manager and deputy manager who assured us that continuous improvements in this area were being implemented through regular training and supervision.

The provider had a safeguarding policy in place which gave information about the different types of abuse and staff members' roles and responsibilities when identifying and reporting suspected abuse. The service had received a number of safeguarding concerns since the last inspection especially around the time when the registered manager was away on leave. We highlighted our concerns to the regional manager, around the management of the home in the absence of the registered manager. The provider confirmed that they would ensure for the future that adequate and appropriate management cover was in place to ensure the safe management of the home.

In relation to the safeguarding concerns, the service had appropriately notified CQC of all safeguarding matters and had always provided further information about the concerns, their investigation findings and the outcome of their findings with actions or learning to take forward. During this inspection we met with a healthcare professional who was visiting to investigate and review a safeguarding concern that had recently been reported. They told us, "In relation to safeguarding concerns, there is always a sign of improvement.

The service is very transparent and I haven't come back to find the same issues here."

Care plans provided detailed information on people's identified risks associated with their health, care and medical needs. This included clear guidance to staff on how these risks affected people and the steps to take to monitor and support people in order to reduce or mitigate any risk identified. Identified risks and corresponding risk assessments covered bed rails, falls, pressure sores, choking, epilepsy, challenging behaviour and the use of call bells. Risk assessments were reviewed on a monthly basis or sooner where a change in a person's condition was identified.

At the last inspection we found that where people were assessed as being at high risk of dehydration and the person's fluid intake needed to be monitored, recording was inconsistent. Fluid charts did not give information on how much a person should be drinking per day and charts were not totalled at the end of each day. During this inspection we found that improvements had been made to the way in which fluid charts were completed. We looked at a total of nine fluid intake charts. Most of these had been completed and totalled correctly and where people's fluid intake had been below the recommended daily intake, appropriate actions had been taken which included regular monitoring and where required, referrals had been made to the appropriate healthcare professional. Periodically throughout the day we also noted that a senior carer or unit lead was required to check the chart and initial to confirm these had been completed as required.

However, we did note that for two fluid charts the total fluid intake had been calculated incorrectly which meant that people's recommended daily intake may not have been achieved as care staff had incorrectly totalled the daily amount. We highlighted this concern to the registered manager who confirmed they would address this issue immediately.

At our last inspection we observed poor standards of cleanliness in various areas of the home. This placed people at risk due to not maintaining the premises and facilities to a safe standard. At this inspection we found that significant environmental improvements had been made to the home. All areas of the home were clean. Where mal-odours were noted very early in the morning, these disappeared as the day progressed. Certain identified areas at the last inspection, such as the unit kitchens and dining rooms had been re-decorated. Cleaning schedules were in place for night staff with a list of cleaning duties to be completed. Some gaps in recording on the cleaning schedules were identified and these were pointed out to the registered manager. A team of cleaning staff were also visible throughout the day in all areas of the home.

At the last inspection we found bottles containing chemicals and medicinal items had been left accessible in bathrooms and shower rooms. All these items were in easy reach of people especially those living with dementia who may not have understood what they were and mistaken them as something to drink or eat. At this inspection we found that this was no longer an issue. We walked round the home and looked at all bathrooms and shower rooms and found them to be clean and accessible. There were a number of bathrooms that continued to be used as storage areas for hoists, wheelchairs and laundry trollies. However, the registered manager confirmed that the availability of appropriate storage areas continued to be an issue.

At the last inspection we also found that sluice rooms located around the home were unlocked even though a sign was situated on the doors stating that the sluice room must be locked at all times. A sluice room is where used disposable items such as incontinence pads and bed pans are dealt with, and reusable products are cleaned and disinfected. This meant that people living at the home could access the room at any time and this was a potential cross infection risk. At this inspection we noted that this continued to be an issue. All sluice rooms except one that we looked at were unlocked and accessible. We informed the registered

manager about this during the inspection.

The service continued to administer and manage medicines safely. People received their medicines as prescribed. Medicines storage areas were noted to be clean and secure. Sufficient stock levels of medicines required within the home were held securely and where medicines needed to be disposed of, there were procedures in place to ensure this was done safely and appropriately.

The process used for ordering people's monthly medicines to ensure that these were received on time and making sure people had their medicines when they needed them were clear and understood by all staff involved with this process. We looked at a sample of Medicine Administration Records (MAR) for 14 people who used the service.

There were appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed. Records showed people were receiving their medicines when they needed them, there were no gaps on the MAR's and any reasons for not giving people their medicines were recorded.

Controlled drugs were stored and managed appropriately. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

A number of people received medicines which were disguised in food or crushed. When medicines were being administered covertly to people we saw there were the appropriate agreements in place which had been signed by the GP, family and pharmacist.

When medicines were prescribed to be given 'only when needed', or where they were to be used only under specific circumstances, there were protocols in place which were tailored to the individual and provided guidance to staff on how these medicines were to be administered. Records showed that all qualified staff had completed medicines management training and that medicines competency assessments had been completed for those staff who administered medicines.

Throughout both days of the inspection, the inspection team observed there to be sufficient numbers of care staff available around the home. Care staff did not seem rushed and were able to attend to people's need in a timely manner. Rotas seen for the days of the inspection, confirmed that the stated number of care staff were present in the home. However, we received mixed feedback from people and relatives about the staffing levels at the home. Comments from people included, "I recommend more staff for the period up to breakfast as people are not always up and have clean pads and therefore not ready for breakfast" and "When I ring the bell, they come." Feedback from relatives included, "Whenever we go there, there is always staff available. Plenty of staff around", "Oh yes always staff around" and "When they [care staff] are not too busy they will pop in and talk to [relative]. At weekends there is not enough staff."

The provider had safe recruitment processes in place to ensure staff recruited and employed were safe to work with vulnerable adults. A number of checks and assurances were required including criminal record checks, written references, proof of identity and confirmation of nurses Nursing and Midwifery Council registration and validation. The provider also used a computer system which was linked to the police and the immigration department and checked the legality of documents that were submitted by potential employees as part of their identity verification.

The provider recorded all accidents and incidents through an electronic system. All information relating to an accident or incident was recorded on the system with details of the person, details of the incident or

accident that had taken place, the actions taken, any investigative action taken and any lessons that were learnt. Where a person had sustained a serious injury or the incident was of a serious nature the registered manager, regional manager and other senior managers would receive an immediate alert on their mobile phone, allowing them to take immediate action where necessary and to identify areas for improvement and lessons learnt following the incident. The registered manager reviewed all accidents and incidents on a daily basis and also produced management reports on a monthly basis to review all accidents and incidents for trends and patterns in order to implement improvements to prevent re-occurrences where possible.

Records confirmed that all care staff had received food hygiene training. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed. This included cleaning schedules, specific food preparation areas for meat and vegetables, records of cooked food temperatures and food storage temperatures.

Good

Is the service effective?

Our findings

People and relatives were complimentary of the care staff that supported them and felt that they were adequately skilled and trained to carry out their role. One person told us, "I have to admit the staff are really good." Another person commented, "I think they're very experienced." Relative's feedback included, "It's a mix bag. I suppose I take it from the interaction [relative] has. I am confident with the nurses", "The permanent staff are skilled and trained" and "I certainly find them skilled and trained."

At the last inspection we found that when speaking to care staff that they had limited understanding and awareness in certain topic areas such as the Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS), safeguarding and whistleblowing. During this inspection we found that the provider had put in place specific processes to ensure that staff received regular refresher training and were, on an ad-hoc basis, assessed on their knowledge of these topics. Care staff we spoke with were able to demonstrate their understanding of the MCA and DoLS and how these impacted on the care and support that they provided to people. However, as reported on in the 'Safe' section of this report, some care staff we spoke with were still not fully able to explain what safeguarding and whistleblowing was.

One care staff told us, "Sometimes we have people with certain conditions, so to make sure we look after them properly we have to assess their capacity to make certain decisions and we make these in their best interest." A second care staff stated, "If someone can't make decision we help them. Consent, of course." A third care staff explained, "Sometimes people can be difficult, aggressive, inappropriate, difficult to attend. We have to ask them first. Apply the choices."

All newly recruited care staff attended a two-day induction programme which covered areas such as orientation to the home, health and safety, residents and policies procedures. Care staff were then required to attend training in mandatory topics such as safeguarding, moving and handling, basic life support, fire awareness and health and safety. Records confirmed that all staff received training in the mandatory topics as well as additional topics such as dementia care, first aid awareness, MCA 2005, food hygiene and infection control.

Care staff's feedback about the training that they received was positive. Comments included, "Dementia, face to face, e-learning also. Hoisting was both in person and online", "Good. I feel like I have settled in quite quickly. E-learning, moving and handling, dementia experience with the goggles on. It makes you realise what they go through" and "We spent a lot of time after the formal training just meeting people and spending time with them. It helped to get to know them and it was really important they got used to us being around and comfortable with us being in their home."

Care staff told us and records confirmed that they received regular supervision and an annual appraisal. We were told that they felt appropriately supported their role. One care home assistant practitioner told us, "I am having one a week at the moment due to the nursing programme but generally I have supervision every two to three months. We talk about issues around daily practice and legislation."

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The 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 that the service was meeting the requirements of the MCA 2005 and the Deprivation of Liberty Safeguards.

Where any person living at the home lacked capacity, we saw evidence that a mental capacity assessment had been completed and a Deprivation of Liberty Safeguard authorisation had been made to the local authority. Where authorisations had been granted, this was documented within the care plan including details of any conditions that had been set. The registered manager held an overview of each person who had been granted an authorisation and the date it was due to expire so that re-authorisation could be requested.

Records showed that where a person lacked capacity to make a specific decision, a multi-disciplinary approach had been taken in order to reach a decision which was in the person's best interest. Where risk assessments were in place in relation to the requirement of bed rails, we saw that a best interest decision had been made on behalf of the person, especially where they lacked capacity, and that the decision had been discussed with the relatives. Where a decision to administer covert medicines had been made we saw evidence that the family, GP and pharmacist had been involved in the decision making process. This had been appropriately recorded within the persons care plan. We also saw records of best interest decisions that had been made in relation to a person's ability in using the call bell or where a 'do not resuscitate' authorisation was in place.

Care staff understood the need for obtaining consent from the person that they supported and throughout the inspection we observed care staff asking people's consent and offering them choice and options around meal preferences or if they wished to wash their hands or wear a food protector at meal times. However, at the last inspection we noted that care plans did not evidence that consent to care and support had been obtained from the person or where the person was unable to consent, that a relative or advocate had consented on their behalf. At this inspection we found that this issue had been addressed. All care plans that we looked at evidenced that consent to care had been obtained from the person or their relative. People and relatives confirmed that care staff always sought consent before undertaking any support task. One person stated, "I feel in control of my care."

At the last inspection we observed poor practices in relation to people's mealtime experiences as well as the way in which people were supported to remain hydrated and maintain a healthy and balanced diet. We observed people were left for long periods of time, waiting for a meal, without a drink, people who required assistance with their meals were left waiting until everyone else had been served, people were not always offered a choice of meal, especially where people required a pureed meal due to swallowing difficulties and pictorial menus were not being used even though senior managers stated that they were.

During this inspection we found that the service had made significant improvements in trying to improve the whole mealtime experience for people and ensuring that people were supported appropriately with their

meals. On both days of the inspection we observed people had received their meals in a timely manner and care staff were available to support people with their meals where required. People were generally not left waiting for their meal apart from one occasion, on the first day of the inspection, where one person was served their meal at 13:40 as care staff seemed to have forgotten to serve them.

We saw that people were offered a choice of drinks throughout the day and at meal times and we were also told by the registered manager that people were served a choice of drink in the morning whilst people were in their rooms waiting support with personal care. We observed one person, who was brought into the dining room from their bedroom, had a drink in their hand.

We observed people being offered a choice of meals, even though they had selected their choices on the previous day. We saw that where people, once served, did not want the meal that they had chosen, this was taken away and alternative options were offered. We saw pictorial menus available for people to use to make their selection. However, the pictures on the menu were small and people may have found it difficult to see what the meal was. We highlighted this to the registered manager who accepted this and agreed to re-visit the menus.

Pureed meals were presented in an appetising way. People were able to choose their meal of choice and preference. Throughout the inspection we saw that meals looked appetising and people overall seemed to enjoy the meal that they were offered. We received mixed feedback from people and relatives about the quality of the food that was provided at the home. Comments from people included, "Food is not too bad. They give us a menu", "The meals are not great here though and they haven't got a clue. A Spanish omelette is scrambled eggs according to them", "I like the food" and "Food is alright." Relatives' feedback included, "Food is okay there", "The worst part of the home is the food. It's completely hit and miss. One day is never the same as the next" and "[Relative] has always the food. She eats well."

On the first day of the inspection, members of the inspection team sampled the food that had been prepared for people which also included a pureed meal. We found the food to be appealing and no concerns were noted with the flavours of the food.

The service carried out comprehensive pre-admission assessments to ensure that they understood and were able to meet people's health, care and medical needs. The holistic assessment not only looked at standard care needs such as mobility, nutrition and medication needs but also covered areas such as human behaviour needs, cognition, psychological and communication needs. Assessments were completed with the person and in partnership with involved relatives and health care professionals. Where people were assessed to have specific health care needs which required the use of specialist equipment, the service ensured that the equipment was ready an available in time for the person's admission. Care plans were reviewed on a monthly basis to ensure that they were current and reflective of the person's needs. One person told us, "I tell them what I want, it's up to me if I have a complete bed wash or just wash specific areas."

People's weights were checked and monitored on a monthly basis. Where weight loss or excessive weight gain was noted, charts were completed to monitor food intake as well as appropriate referrals made to help ensure that people's nutritional needs were met. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

A variety of staff, including unit nurses, senior carers and care staff were able to explain the processes involved when referring people to a variety of health care services where specific needs or concerns had

been identified. This included referrals to dieticians, speech and language therapists, physiotherapists, continence services and the mental health team. Records seen confirmed that referrals were made in a timely manner and people were seen by the appropriate professional where required. One visiting health care professional told us, "I am not worried about the care here. They follow the plans I make and consult me when needed."

Care plans recorded and detailed visits that people received from visiting health care professionals included podiatrists, GP, chiropodists and opticians. People and relatives were happy with the support that they and their relative received in relation to their healthcare and were confident that any identified concerns would be addressed immediately. One relative told us, "If there are any concerns with [relatives] health they would call the GP."

The home was clean and odour free. Since the last inspection the home had undergone re-decoration and environmental improvements to ensure that the home was suitable to meet people's needs. All areas of the home were accessible by people including the garden and outdoor spaces. Appropriate decoration and signage had been used around the home especially on the dementia unit to support people living with dementia in order to meet their needs and promote their independence. People were seen to be able to access the outside smoking areas as and when they so wished.

Good

Is the service caring?

Our findings

People and relatives told us that care staff were caring, kind and respectful of them and the way in which they wished to be supported. Comments from people included, "I have to admit the staff are really good", "Care is excellent", "Carers are pretty good and they are caring", "I've been absolutely floored by the kindness of the staff. They feel like family" and "This feels like home now. They [care staff] are a loving, caring team." Feedback from relatives included, "Staff are brilliant and caring", "Staff were very caring", "Love and kindness is all that I see" and "Most of them [care staff] are pretty friendly."

At the last inspection in October 2016 we observed very little interaction between people and care staff. We saw people were ignored, particularly when they made a request or were calling for attention. Care and support provided to people was not person centred but was more focused on
the tasks that needed to be completed. During this inspection we observed significant improvements in this area. We observed positive and caring interactions between people and care staff. Conversation and banter between people and care staff was seen to be friendly, jokey and informal.

We saw that people and relatives had built and developed positive relationships with other people living at the home, the nurse and care staff team and senior managers. One person told us, "This is the best care home I've been to." Relatives told us, "The atmosphere is just right. We are pleased we came here" and "I think it's [home] excellent. She [relative] could not have gone to a better place. We have a wonderful relationship with the home." We observed staff communication with people was warm and friendly, showing caring attitudes whether conversations were outwardly meaningful or not. One care staff told us, "I love them all. You see them every day and the bond grows. Staff do have attachments and the residents have their favourites."

People and relatives told us that care staff knew them and their relatives well and care was provided in a way which respected their choices, preferences and wishes. One person said, "I feel in control of my care." One relative told us, "They follow the care plan. It takes two staff and it is always two." In one person's room we saw a document called, 'This is Me' which clearly stated how to approach and care for the person.

People and relatives confirmed that they were always treated with respect and that care staff always protected their privacy and dignity. One person when asked about their privacy and dignity said, "Oh yeah! I rely on them." A second person replied, "Respectful, yes!" Responses from relatives included, "Yes, they are. [Relative] can be aggressive but they [care staff] manage that. They have the greatest patience and understanding" and "Yes, I do believe they are." Care staff demonstrated a clear of understanding on how they respected people's privacy and dignity. One care staff explained, "When giving personal care ask their [person's] permission, shut the door and also get to know their background as people might have different cultures."

Care staff understood the importance of promoting people's independence in order for them to continue to remain as independent as possible even whilst living at the home. One care staff told us, "We never take for granted what people can and can't do. We let people take their time, let them do things for themselves and

support them where required." Care plans also recorded people's level of independence. One care plan noted that the person required minimal assistance with personal care as they liked to be independent. We observed care staff enable one person to independently eat their meal in a way that they preferred even though the person was unable to see or hear the care staff.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection people's feedback about the activities that were organised within the home was negative. Most of the activities listed on the activity board did not take place. Throughout the last inspection we saw very little interaction, activity or stimulation that was initiated by care staff that were on duty. People were always seen to be taken to the lounge and positioned to watch television throughout the day. Care staff did not appear to be caring and responsive to people's mental and emotional well-being.

During this inspection we observed that the provider had worked with the care staff team to improve these areas. An activity board in each area of the home outlined daily activities that had been scheduled. We saw these noted activities taking place during the inspection. However, we found that other than these scheduled activities, care staff initiated very little activity or stimulation whilst on duty. We did observe some examples of care staff interacting with people and initiating activities such as reading a newspaper, colouring and chatting with people. However, we also continued to observe some people sat in a room watching television with care staff sitting in the room watching with them. There was very little in terms of organised, guided activities such as games, jigsaw puzzles, quizzes or exercise sessions.

We were told by the registered manager that they had implemented a gentleman's club as an activity and on the first day of the inspection, this was one of the scheduled activities. However, we observed that the gentleman's club involved a group of men sitting in front of the television watching an old military movie, with the care staff sitting in one corner of the room with minimal interaction taking place. One person told us, "I have been to the gentleman's club once. I'm afraid I didn't go again."

On the second day of the inspection, an entertainer had been scheduled for the afternoon entertainment. We observed 23 residents in the lounge with two relatives. Most appeared to enjoy the music and sang along and moved to the rhythm.

At the last inspection we observed that care staff did not put person centred care into practice. When we asked care staff about what they thought person centred care meant they were unable to explain this to us. During this inspection we saw that the provider had worked with the care staff team in order to make improvements.

We saw that people were placed at the centre of the care that they received and care staff approached people in a person centred way, giving them the opportunity to make decisions and choices on how they received their care and support. People were asked if they wanted to clean their hands with wipes prior to their meal being served and whether they wanted to wear a clothes protector. We heard care staff asking people questions such as, "Would you like a drink?", "Can I put that across your lap?" and "Lunch will be here soon guys!"

Throughout the inspection we carried out a number of observations at mealtimes to see how people were supported with their meal where support was required and the level of interaction and responsiveness to people's needs as recognised and provided by care staff. We found that since the last inspection care staff

had made improvements to the ways in which they cared and responded to people's needs, however, we noted further improvements were required.

Care staff respectfully greeted and spoke with people whenever they were passing through the lounge or dining room and always made sure that people were offered a drink or snack. On the ground floor and first floor care staff interactions especially at mealtimes were positive. People were involved in day to day conversations with care staff about the weather, Christmas and visits from their relatives. People were also observed to be supported with their meal in a timely manner.

However, on the second floor, which is the dementia unit, we observed care practices and interactions that were not always responsive to people's needs. We observed very little interaction between people and care staff when they were supporting them with their meal. We observed two staff members engaging in a private conversation whilst one of them was supporting a person with their meal. We observed one member of care staff who was supporting one person with their meal in their room did not engage in any conversation with the person or did not even tell them what they were doing. One nurse, who wanted to explain one person's eating habits to the inspector stated, "This one likes to eat with her hands."

Care staff were able to tell us their understanding of person centred care. One care staff told us, "The way that you provide care is in a way that is tailored to them [people]. The level of care is specific to the person."

We provided feedback to the registered manager about the positive and negative observations that we had noted. The registered manager explained that the issues identified were related to care staff attitudes and the culture within the home and that they were actively working with care staff as a team to address these attitudes and culture within the home.

At the last inspection we found that care plans did not always have a life history booklet completed about the person and information about the person had not been reflected within the care plan. During this inspection we found that the service had addressed this issue. All care plans that we looked at contained a detailed life history document which included information about the person's background, their life, relationships and their health.

Care plans were found to be detailed and person centred and gave information about people's likes and dislikes, choices and preferences. The care staff team knew the people they supported and demonstrated knowledge and awareness of people's likes and dislikes and how they wish to be cared for. Care plans were reviewed and updated where required on a monthly basis.

People's cultural, spiritual and sexual needs were also recorded as part of the care planning process. Most care plans provided details about people's cultural and spiritual needs and how they were to be supported to meet those needs. However, in relation to sexuality the care plan combined personal hygiene needs with sexuality in the same document. There was no record of discussions around sexual identity or expression in any of the care plans we looked at. We spoke with a care worker about this. They told us sexual identity and equality had been discussed very briefly in their induction but not in relation to the specific nature of this home environment. In addition they said the focus was largely on how to identify sexual abuse rather than how to support sexual identity. We brought this to the attention of the registered manager who assured us that they would look at this with a view to making improvements.

Most people and relatives confirmed that they felt involved in the planning of their care, however, not all people and relatives we spoke with had seen their care plan. One relative told us, "We have visits from NHS and social services. They come every six months. Yes did one on Saturday. All about medication and what is

on [relative's] care plan. The nurse done it and I answered questions." Another relative stated, "I am wondering when there will be a review. I only saw the care plan when [relative] first moved in." A third relative commented, "If anything is ever wrong they will phone and tell me."

Care staff maintained daily records for each individual which included daily logs of how the person was, what they had eaten and any noted concerns or issues. A daily journal was also completed by care staff which detailed any activities the person had participated in or any visitors that the person may have had. Entries were seen to be person centred. One entry noted, '[Person] was so lovely today. She kept greeting staff every time you met or passed by her. She even helped to tidy the dining room. She was asked why she was doing it and she said she used to do it in her work before.'

However, we noted one false entry that had been made by a member of care staff about how much a person had eaten at lunch time. We had observed that on the first day of the inspection the person had not received any lunch by 13:47. We highlighted this to the nurse on the unit who advised that she would have biscuits and coffee later on. However, when we reviewed the daily notes on the following day a record had been made stating that she had quarter of a portion of potato at 13:20. This had not been the case. We fed this back to registered manager and regional manager who confirmed that they would look into this matter.

We observed staff handover on the first day of inspection between the night staff and day staff. The team of nurses and care staff walked to each person's room where a brief handover was given about the person, any significant changes and areas of concern to be monitored. Handover records were also kept and contained a brief summary of the person and any significant information about the person that care staff were to be aware of.

End of life preferences and wishes were noted in the advance care planning section of the care plan. The section was generally only completed for those people who had a 'do not resuscitate' authorisation on file or for those who had expressed their views on the care and support that they wished to receive. However, we found that not enough detail was always available in terms of people's cultural and spiritual needs and requirements. The registered manager responded positively by stating that this would be area that they would like at to improve.

A complaints policy was available and processes were in place for receiving, handling and responding to comments and complaints. Information about how to make a complaint was on display in the home and the majority of people and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. One person told us, "I haven't got any complaints, I might go to [nurse] then go higher if wasn't happy." A second person said, "I would speak to [nurse] if I had a problem or any nurse." Relatives comments included, "They [management] have always been receptive. They have always addressed my concerns", "I would go to the nurse or ring the home to make an appointment. I know the route to take" and "We know who to speak with and we are assured that they would attend to our concerns."

Good

Is the service well-led?

Our findings

People and relatives were able to tell us who the registered manager was and confirmed that she was visible around the home and approachable at any time. One person told us, "She is visible and approachable." Another person stated, "Flexible, well organised team that get the job done." One relative said, "The manager is quite cooperative, any complaints she resolves. She's nice and she listens and supports." A second relative told us, "[Registered manager and deputy manager] are really responsive, no problems there."

Care staff were also positive about the registered manager and the support that they received. Comments from staff about the management of the home and the registered manager included, "There have been improvements in terms of staffing levels since the new manager has come. More teamwork. She [registered manager] is a good leader", "I like her. I think she is very by the book and strict", "We get on really well" and "Managers are supportive."

At the last inspection we found that the service did not promote a positive culture within the home. Senior managers were not aware of the negative culture and generally poor care and interactions that we observed within the service throughout the inspection until this was pointed out to them. At this inspection we found that the senior management team were very committed to ensuring that the home provided a safe, effective, caring and responsive service and that the necessary and on-going improvements were made where required. During this inspection we found that senior managers were keen to engage with the inspection process and were aware of and agreed with the minor concerns that we had identified.

At the last inspection we found that the provider had not implemented any of the improvements as outlined in their action plan. In addition, the management did not have oversight of how people were supported and cared for within the home until this was highlighted to them as part of the inspection. During this inspection we saw that the registered manager, deputy manager and nurse unit leads undertook a variety of online and manual daily, weekly and monthly checks and audits to ensure that people received good quality care. This included audits that looked at health and safety, care plans, medicine management, pressure ulcers, bed rails, housekeeping and mealtime experiences. Where issues or concerns were found these were logged and details of actions taken were recorded.

In addition to these checks the regional manager compiled an overview of the registered manager's findings from their checks and audits and then completed a comprehensive audit of the home. An action plan was then developed based on the findings where the registered manager was required to detail the actions taken to make the improvements and by when.

The provider had a clear vision to deliver high-quality care and support. Care staff were able to describe the values as set out by the provider which they were to follow in the day to day delivery of care. One member of care staff explained, "We are committed to our residents. We put our residents' best interest before anything else."

There was an open and transparent culture at the service. Relatives told us that the service always communicated with them about their relatives especially where significant incidents or accidents had occurred or where their relative had been taken ill. They also found that the unit nurses and leads were always approachable and gave them the desired information about their relative.

The service worked in partnership with other agencies to support care provision. We noted that that the service maintained positive links with a variety of healthcare professionals including the Care Home Assessment Team (CHAT). The CHAT visited people regularly who had complex health needs or who were at risk of deteriorating and also liaised with the wider multidisciplinary team and supported care staff and nurses to coordinate care.

Care staff told us and records confirmed that they were supported through a variety of processes including supervisions, appraisals and team meetings. Team meetings were held every four months. Topics discussed included, improvements, how do we work together to sustain improvements, training, policy of the month and team working. In addition to team meetings the service had also set up a number of committees covering health and safety and clinical governance. These were held to discuss training, management and safeguarding. Care staff told us that staff meetings were informative and that their ideas and suggestions were listened to.

Relatives told us and records confirmed that relatives meetings were held every four months. These meetings gave relatives the opportunity to discuss topics such as staffing, key workers, care planning, activities and food. During the inspection we also asked to look at minutes of meetings involving people living at the home. The registered manager told us that the resident meetings were combined with relatives meetings. However, the minutes that we saw did not evidence this. We asked the registered manager about how people were given the opportunity to give their feedback and make suggestions particularly around activities and the planning of meal menus. We were told that the activity co-ordinators held informal discussions with people; however, these were not recorded. The registered manager confirmed that for future residents meetings would be held and recorded formally.

The service had systems in place to monitor quality through surveys that people, relatives and visiting professionals could complete. This was an electronic quality survey. The regional manager and registered manager explained that they asked people, relatives and visiting professionals who visited the home to complete a questionnaire on the home's iPad and they did this so that feedback could be obtained on an on-going basis. We were informed that between 1 October 2017 and 30 November 2017, the service had received a total of 248 responses. This information was then recorded on the home's system and any necessary action required was taken to rectify any issues. Feedback received from people, relatives and visiting professionals was overall positive.

All staff members also had the opportunity to complete a staff survey, through the iPad. Staff were able to complete these questionnaires anonymously. Results of completed questionnaires seen were positive. In addition to this care staff were asked to complete an annual survey. This exercise had just recently been completed and the provider was in the process of compiling the results.