Barchester Healthcare Homes Limited

Friston House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was carried out on 03 and 06 October 2017. The first day of our inspection was unannounced.

Friston House provides accommodation, residential and nursing care for up to 81 older people. The home comprises of three units. The main building has two floors and accommodates people with residential needs with early onset dementia on the ground floor; and people with nursing needs on the first floor. There is a separate 'Memory Lane Unit' for people who live with dementia and nursing care needs. The home has a garden and courtyard areas available for all of the people.

On the day of our inspection there were 80 people living at the home. People had a variety of complex needs including people with mental health and physical health needs and people living with dementia. Some people had limited mobility, pressures ulcers and some people received care in bed.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been off work for some time. The deputy manager had been managing the home until August 2017, which is when the provider had put in place a peripatetic general manager.

At the last inspection on 25 August 2015 the service was rated Good overall and Requires improvement in Safe. We had made a recommendation in the Safe domain that prescribed thickening powders were kept locked away to prevent accidental ingestion.

At this inspection we found that that there had been improvements to the storage of thickening powders. However, activities to meet people's individual needs to help keep people active and stimulated had deteriorated. We made a recommendation about this.

Most staff had undertaken training relevant to their roles. Some staff required updates and training relevant to meet people's health needs. We made a recommendation about this.

Some people experienced care which was task led. We made a recommendation about this.

Medicines were well managed. Medicines were stored and administered appropriately. Some medicines were prescribed on a 'when required' basis. There was guidance in place for each person's when required medicine.

Staff had a good understanding of what their roles and responsibilities were in preventing abuse. The safeguarding policy gave staff all of the information they needed to report safeguarding concerns to external

agencies.

The provider followed safe recruitment practice. Essential documentation was in place for all staff employed. Gaps in employment history had been explored to check staff suitability for their role. There were suitable numbers of staff deployed on shift to meet people's assessed needs. Some people told us about delays to calls bells being answered. We made a recommendation about this.

The premises were well maintained, clean and tidy. The home smelled fresh. Areas of the home had been decorated to help people orientate in their environment. More improvements were planned.

Staff were supported to gain qualifications and were supported in their roles. They had received regular supervision meetings.

Meals and mealtimes promoted people's wellbeing, meal times were relaxed and people were given choices.

Staff had a good understanding of the Mental Capacity Act 2005 and supported people to make choices. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority by the management team.

People received medical assistance from healthcare professionals when they needed it. Staff knew people well and recognised when people were not acting in their usual manner. Feedback from healthcare professionals was positive.

People were supported to maintain their relationships with people who mattered to them. Relatives and visitors were welcomed at the service at any reasonable time.

Staff were cheerful, kind and patient in their approach and had a good rapport with people. The atmosphere in the home was calm and relaxed. Staff treated people with dignity and respect.

People's care was person centred. Care plans detailed people's important information such as their life history and personal history and what people can do for themselves. People were supported to be as independent as possible.

People's views and experiences were sought through surveys and meetings. People were listened to. People and their relatives knew how to raise concerns and complaints.

There were quality assurance systems in place. The management team and provider carried out regular checks on the service. Action plans were put in place and completed quickly. Staff told us they felt supported by the management team.

The management demonstrated that they had a good understanding of their role and responsibilities in relation to notifying CQC about important events such as injuries, safeguarding concerns and deaths.

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.

Staff had a good knowledge and understanding on how to keep people safe from abuse.

Risks to people's safety and welfare were assessed and managed effectively.

The home was clean, tidy, smelt fresh and had been well maintained.

There were enough staff employed to ensure people received the care they needed and in a safe way. Effective recruitment procedures and practices were in place and being followed.

Medicines were well managed and were securely stored.

Is the service effective?

Good

The service was effective.

Most staff had attended training they needed, training was on going. Staff received supervision and said they were supported in their role. Nursing staff received appropriate support and clinical supervision.

Staff were aware of the Mental Capacity Act 2005. Where people's freedom was restricted Deprivation of Liberties Safeguards were in place.

Meals and mealtimes promoted people's wellbeing. People had choices of food at each meal time which met their likes, needs and expectations. People with specialist diets had been catered for.

People received medical care from healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring.

People received consistent care and support from staff they knew very well. Staff were aware of people's personal preferences and life histories.

People were supported by staff who were kind and caring. People's privacy and dignity were maintained whilst promoting people's independence.

People were supported to maintain relationships with their relatives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were not always person centred to meet people's needs in order to keep them stimulated.

People's care plans contained important information about them and what they needed help with. People's care had been reviewed regularly.

People and their relatives knew how to raise concerns and complaints. The complaints policy was prominently displayed in the home. People and relatives had opportunities to feedback about the service through surveys and meetings.

Is the service well-led?

Good

The service was well led.

Effective systems were in place to monitor the quality of the service, action taken to address areas of concern was timely.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

The staff received good support from the management team. Meetings were held regularly.

Friston House

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.

We undertook an unannounced focused inspection of Friston House on 03 and 06 October 2017. The first day of our inspection was unannounced.

The inspection team consisted of two inspectors, a specialist advisor who was a trained nurse with a background of dementia care and complex care and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for older family members.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. A notification is information about important events which the home is required to send us by law. We also reviewed information supplied to us by the local authority following a contract monitoring visit.

During the inspection we reviewed 12 people's records and a variety of documents. These included people's risk assessments, daily records and five staff recruitment records. We also requested information by email from Healthwatch (Healthwatch is an independent organisation who listen to people's views and share them with commissioners and regulators to make local services better), a local GP, the community nursing team, End of Life facilitators from the hospice, a specialist Parkinson's disease nurse, the falls team and from local authority commissioners to obtain feedback about their experiences of the service.

Some people were not able to verbally express their experiences of living in the home. We observed staff interactions with people and observed care and support in communal areas. We spoke with 11 people who lived in the service. We also spoke with nine relatives who visited the service and 16 staff including, care staff, senior care staff, a handyperson, a cook, nurses, the deputy manager, the peripatetic general manager and a senior general manager who supported the management team. We also spoke with the regional operations

director.

We asked the peripatetic general manager to send additional information after the inspection visit. The information we requested was sent to us in a timely manner.

Good

Is the service safe?

Our findings

At our last comprehensive inspection on 25 August 2015 we made a recommendation. We recommended that prescribed thickeners were appropriately stored to ensure people were safe at all times.

At this inspection we found that risks to people's safety had been mitigated because prescribed thickening powders were stored appropriately.

People told us they felt safe. Comments included, "I suppose I feel safe, I like being here"; "Yes, I definitely feel safe. It's great in here"; "I feel safe here" and "Yes, I do feel safe here and with the staff". We observed staff maintaining people's safety by reminding and prompting people to use their walking aids such as sticks and frames. Relatives also told us their family members were safe. One relative told us, "She is safe. We couldn't cope at home. I visit every day".

Health and social care professionals told us people received safe care and treatment. One healthcare professional said, 'During my visits overall I have observed the care to be safe and effective'. Another healthcare professional told us, 'On the whole I do find that the residents receive safe, effective care'.

People continued to be protected from abuse and mistreatment. Staff had completed safeguarding adults training. Staff understood the various types of abuse to look out for to make sure people were protected from harm. Staff knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The management team knew how to report any safeguarding concerns and had done so in a timely manner.

The provider had continued to follow safe recruitment procedures to ensure that staff employed to work with people were suitable for their roles. Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Employer references were also checked. One of the staff files had a large unexplained gap in employment history of 24 years. This had not been documented as picked up through the employment screening checks. We spoke to the management team about they advised this had been picked up during screening and gave reasons for the gap. During the inspection the reason for the gap was recorded. Nurses were registered with the Nursing and Midwifery Council and the management team had made checks on their PIN numbers to confirm their registration status.

The management team assessed people's individual needs and used the information to assess the levels of staffing required to meet the needs of people using a 'DICE Tool'. DICE is the provider's assessment tool which is used to calculate people's needs and staffing numbers to meet these needs. People's needs were reassessed on a monthly basis. When there were changes to people's needs, these were communicated to

the management team so the DICE tool could be updated. We observed that there were suitable numbers of staff deployed in the residential unit and within the Memory lane units on the ground floor. The DICE tool showed that the home has a very small variance of 2.3 hours per day between actual staffing planned and expected staffing needed. This deficit was managed by activities staff and the management team assisting at core times such as meal times and when a crisis happened. For example on the second day of inspection, a person had fallen first thing in the morning. The deputy manager assisted the care staff to manage the situation and coordinate with the paramedics. During the afternoon another person fell, whilst independently mobilising. The peripatetic general manager assisted the care staff with protecting the person's dignity whilst the deputy manager called for an ambulance.

People gave us mixed feedback about whether there were enough staff to respond to their needs. Feedback included, "Staff are on the go all the time"; "Sometimes they come quickly when I call"; "Only sometimes they seem a bit short-staffed"; "If they aren't busy, they help sometimes"; "There seems to be enough staff about"; "Sometimes staff seem a bit hurried"; "They do respond when I ask for something"; "They seem short-staffed"; "There have been some staff changes"; "Generally there are enough staff about"; "There is always someone around"; "I think they would respond quickly"; "There's no problem with staff numbers"; "There are not enough staff"; "If I call them, they come and as soon as they can"; "There have been lots of changes of staff for the last two months" and "Staff do respond quite quickly when I call". People's comments corresponded with some of our observations.

On the top floor there were two nurses deployed on shift as well as five members of staff to support the 34 people living in this part of the home. People in this part of the home had higher nursing care needs. Most of the people on this unit were cared for in bed. Those that were able to get out of bed needed assistance of two staff to enable them to safely transfer. We observed that the level of contact people received from staff in this area of the home was task orientated. There were some delays to meetings people's care needs. One person had contact with staff when they answered their call bell, but there was no spontaneous or planned engagement without them ringing the call bell. One person on the top floor told us about concerns in relation to staff responding to their call bell. They told us that staff answered the bell quickly but said we are just with another person at the moment and we will be back. The person said that they would have to call again repeatedly because no one came. They said, "There are not enough care staff and they are rushed off their feet". We passed this information on to the management team and they met with the person to discuss their concerns with a view to resolving them. A healthcare professional told us, 'There are times that call bells seem to ring for a very long time before being answered and on occasions have needed to find staff to change bedding etc for a resident that I have been asked to examine and have been told that they were "next". This tends to be more on the nursing floor than the residential floor.' Another healthcare professional told us, 'Sometimes the call bells ring for a long time before being answered'. We observed this happening in practice during the inspection. However, when we investigated the person who was pressing the call bell had staff with them attending to their needs. The person kept pressing the bell because they were becoming anxious about having care and support from a staff member they knew well alongside a new staff member. The nurse on duty took over from the new staff member and this helped the person to calm. The person's relative told us, "[Person] doesn't like new faces, it takes her about a week to get used to new people".

We recommend that the provider reviews call bell response times and feedback from people to ensure that there are sufficient staff deployed in each area of the home.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. For example, risk assessments were in place for moving and handling people. Moving and handling risk assessments detailed

what size sling a person needed. We observed staff following risk assessments during the inspection. Risks relating to people's skin integrity were well managed. Recent wounds and or bruising was recorded on a body map and photographed, these were documented and there was evidence that risks were being managed through use of specialist equipment, regular repositioning and through application of barrier creams. On the first day of our inspection we did not always find care plans and risk assessments in place in relation to specific medical conditions or specific medicines such as Warfarin. Warfarin is an anticoagulant, this is a medicine that stops blood clotting. There are associated side effects and risks from taking Warfarin such as increased risks of bruising. However, the care plans and risk assessments were in place on the second day of the inspection.

Incidents and accidents had been appropriately recorded and monitored by the management team. The provider's monitoring system meant that additional checks were carried out by the provider's clinical governance team to check the data received in relation to accidents and incidents and provide additional clinical assistance where needed. Where accidents and incidents had occurred, appropriate action had been taken. For example, people had been referred to the Parkinson's nurse for review and assessment as well as safeguarding referrals made. This meant appropriate action had been taken to mitigate the risk of further accidents and incidents.

The medicines round was carried out by a nurse who had undergone relevant training within the nursing units and by a trained member of senior care staff within the residential unit. People told us, "I take my medication when they give it"; "I do get my medication from the nurse, she watches me take it"; "They do make sure I have my tablets" and "Any medication I need, I get". Medicines administration records (MAR) were clear and accurate. We checked the medicines records and found that people had received the medicines they had been prescribed. Each person's MAR included a photograph. Staff only signed the MAR once the medicine had been administered.

Protocols were in place to provide information and guidance for staff in relation to as and when required (PRN) medicines. This guidance detailed how each person communicated pain, why PRN medicines were needed, the reason for administration, the frequency, and the maximum dose that could be given over a set period of time. Staff responded to people's requests for pain relief promptly. We observed one person use their call bell to tell a nurse they were in pain and they requested pain relief. The nurse went to get the person's pain relief immediately and administered this is a timely manner. People who had fallen during the inspection were offered pain relief once the paramedics had finished assessing them for injuries.

The medicines storage areas had been temperature checked daily to check that medicines were stored within suitable temperatures. Medicines storage areas had air conditioning units fitted to ensure that the room was kept at a constant cool temperature.

The use of anticoagulants was clearly managed, so people received regular INR blood tests. The international normalised ratio (INR) is a measure of how long it takes a person's blood to clot. The INR will be used to determine the dose of warfarin the person needs to take. Procedures were in place to ensure that people who had pain patches applied to the skin had these applied to different areas of the body as recommended by the manufacturer. This reduced the risk of skin irritation from pain patches repeatedly administered to the same site. People who were diabetic were effectively monitored. Records evidenced that people's blood sugar levels were checked by staff as per guidance provided by health care professionals. Where a person's blood sugar level had been high staff had taken action and reported this to the diabetic nurse and sought advice.

People and relatives said the service was clean and it was clean on both days of our inspection. Cleaning

schedules were in place and the team worked hard to ensure that any odours were dealt with promptly. People told us, "It's usually quite clean here" and "It's quite clean here". All staff had received infection control training. There were suitable supplies of personal protective equipment available and these were used appropriately by staff. Sluice rooms were available for dealing with used continence pads and bed pans. The laundry was well managed to ensure that soiled and clean laundry were kept separate. Washing machines washed soiled clothing at the required temperature to ensure it was clean and hygienic.

The service had been well maintained. Systems were in place to protect people from the risks of fire. Fire tests had been carried out frequently. Fire evacuation equipment was available on the top floor of the home to aid safe evacuation of people who would be unable to use the stairs safely. Fire drills had been carried out frequently with night and day staff. Staff we spoke with knew their responsibilities in an emergency situation and confidently talked through the procedures. Records showed that emergency lighting had been tested regularly. Any repairs required were generally completed quickly. Gas and electric installations and equipment had been checked. The hoists, slings and lifts had been serviced. Water testing had been carried out as well as regular legionella testing.

Good

Is the service effective?

Our findings

People told us their health needs were well met. Comments included, "I can see the doctor if needed"; "I get my toenails cut regularly"; "I can see the doctor, he always comes when I needed it"; "I get my hair done and my toenails cut"; "Without question they would call the doctor to me [if unwell]"; "They do organise my toenails to be cut"; "I get the healthcare services as I need them" and "I do see the chiropodist and the district nurse". Relatives told us "She [family member] does see the chiropodist and she has been to the dentist a couple of times" and "If there is a problem, like her teeth, they do get in touch".

Health and social care professionals gave us positive feedback about the service which evidenced that the home refer people through to them when required. One health care professional told us that sometimes staff contact them for advice but if they are asked to monitor the person for a longer period of time the staff contact the out of hours GP service or the person's GP. One healthcare professional told us, 'I feel mainly the staff on duty are competent but sometimes lack the confidence to make decisions and contact services to confirm the treatment they know should be given. This can result in some unnecessary visits by myself and other services'. Another healthcare professional said, 'Friston are quick to seek advice from our team however there have been occasions when other services i.e. Secamb [South East Coast Ambulance Service], GP are called at the same time and it ends up being a case of whoever arrives first deals with the situation'.

People were able to access external healthcare professionals as required, and any changes to their care as a result were incorporated into their care plans. For example, one person was noted to be at risk of choking, and staff made a referral to the speech and language therapy team. The advice regarding use of thickened fluids was incorporated into the person's care plan, and staff were observed to offer the person thickened fluids. All healthcare professional visits or interactions were clearly recorded within people's care plans. The use of fluid thickeners was managed safely. Thickeners were safely stored with restricted access. Staff used the correct prescribed thickener for each person, and referred to the handover sheet and care plan to ensure that this was the case.

Staff were observed to manage behaviour that others may find challenging with sensitivity and care. One person had presented with this type of behaviour on several occasions in the past, staff had documented each episode. The person had been referred to the local mental health outreach team, and a viable program of support was put in place. This included one to one care for this person, records were seen which confirmed that this care was being provided. The number of incidents had noticeably decreased as a result, which improved the quality of life of the person and those people they shared the home with.

People received medical assistance from healthcare professionals when they needed it. Staff recognised when people were not acting in their usual manner, which could evidence that they were in pain. Pain assessments had been carried out and evidence showed that people had received pain relief when it was required. Staff had sought medical advice from the GP when required. Records demonstrated that staff had contacted the GP, ambulance service, dementia specialists, palliative care nurses, tissue viability services, hospital and relatives when necessary. People had seen an optician on a regular basis to check the health of their eyes. Where people had lost weight, this had been quickly addressed with support, food supplements

and referrals to GP's and dieticians as required. People's weight records were regularly maintained to enable nurses and staff to monitor people effectively.

The handovers between staff going off shift and staff coming on shift were documented. This included information about any medical concerns and the emotional wellbeing of people who lived in the home. This ensured that information was passed on and documented appropriately.

People were supported by staff who were qualified and trained to meet these needs. Registered nurses were available who had qualifications in adult nursing. Systems and procedures were in place to provide support to nursing staff in order to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. Systems were in place to support the nursing staff achieve revalidation. Specialised training courses were available to nursing staff to enable them to learn or refresh nursing tasks such as catheterisation and compression dressings.

The nursing team were made up of nurses who had general nursing background and learning disability nursing backgrounds. Most nurses and care staff had received appropriate training to carry out their roles. This included statutory mandatory training; moving and handling, safeguarding and equality and diversity training and specialist nursing training such as use of syringe drivers, wound care and venepuncture. Venepuncture is the collection of blood from a vein which is usually done for laboratory testing. Our discussions with staff and our observations of practice confirmed they understood most people's care needs. However, one nurse working in one area of the home confirmed they had not received training and guidance around nursing people who were living with Parkinson's disease. They told us the care staff had not received this training either. A person had recently moved to the home with this diagnosis. The person had shared how they felt staff did not understand their condition sufficiently. They gave examples of being given food that they found difficult to eat by themselves as they had difficulty picking it up. Training records seen for two nurses on Memory Lane unit showed that they had not received refresher or update training on dementia care or managing challenging behaviour for over two years. This meant that staff would not have had the most up to date training in these subjects, which were significant within a dementia unit.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with Parkinson's disease and dementia care.

Staff told us there was a varied programme of mandatory and developmental training available at the service. Training topics included customer care, prevention of choking, falls prevention, tissue viability, health and safety, first aid, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, and fire safety. Staff said that their individual training records were updated online once they had completed a training course, and that they received reminders when they were required to attend a refresher course. The electronic training record for all staff showed that the organisation's training target of 85% completion had been met in all mandatory and statutory training topics.

Staff confirmed they received regular supervision and annual appraisals. One staff member said, "I have had three supervisions since being here". They had worked at the home for approximately eight months. Another staff member shared, "I should have six [supervisions] a year, I have more". Nurses received clinical supervision from the deputy manager. The deputy manager also acted as a mentor for student nurses as well as sitting on fitness to practice panels at Christchurch university. The deputy manager explained they always tried "Developing staff and encouraging additional training" They shared that they always looked to develop nurse's skills. They kept up to date with best practice by attending nursing home forums, liaising with the GP, liaising with NHS England, Clinical Commissioning groups and specialist nurses as well as lots of research and reading.

Staff were supported to gain qualification and carry out training to help them develop. One staff member was a care practitioner and undergoing the provider's care practitioner programme. This programme had been developed to upskill senior care staff so they could take on additional responsibilities to support the nurses. This included; medicines, tissue viability and wound management, continence, physiological assessment and care planning and leadership and supervision of the care team.

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 2005. 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 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff understood the requirements of the Deprivation of Liberty safeguards (DoLS), and documents seen demonstrated that the appropriate procedures had been followed. There was restricted entry and exit to and from the Memory lane unit, via use of keypad codes unknown to the people who lived there. Staff confirmed that all people in the unit had received a mental capacity assessment, to determine whether or not the person could make their own decisions about leaving the unit. Records seen within people's care plans showed that the mental capacity assessment was conducted as part of the two stage process, and included the involvement of the person's next of kin or advocate, as well as their doctor or healthcare professional. This was to ensure that any decisions taken about the person's liberty or their care would be made in the person's best interests. Care records showed that consent was sought in a lawful manner. We observed people making choices and being involved in decisions relating to their care and support throughout the inspection. People told us "They do involve me in my care"; "You can go to bed when you want to" and "I can do what I like, I do have choice".

People and relatives gave us positive feedback regarding the food. Comments included, "The food's quite good"; "There's always a drink to be had"; "The food's brilliant"; "I eat everything, there's enough variety"; "You can have a drink anytime"; "The chef's good in here"; "The food's perfectly acceptable"; "There is enough choice and portions are big enough"; "The food's nice"; "The food seems good" and "Portions are big enough and there is a nice choice". Several people living on the top floor told us that their feed was cold when it was delivered to them. One person said, "Food up here arrives cold because they have to feed twenty plus people first". We raised this with the management team. They took immediate action to rectify this. records showed that they visited people on the top floor to check that the improvements had been made and they put in place monitoring to ensure this did not happen again. One relative told us that that the staff made sure their family member drank plenty as they were prone to urinary tract infections.

Catering staff and care staff communicated effectively about the nutritional needs of people. The chef attended the daily meeting held for all department managers, which provided up to date information about any changes in nutritional or dietary needs of people. There was evidence that the chef was aware of the specific dietary needs of people: a dietary information record for each person was seen in the kitchen, detailing who required specialist diets or formulations for their food. The information record also provided information on any speech and language therapy (SALT) referrals, as well as the person's preferred or recommended portion sizes, food likes and dislikes, allergies and malnutrition universal screening tool

(MUST) score. The information record identified which of the people at the home had an increased choking risk, and detailed the control measures catering staff should employ to manage the risk (for example, pureed or soft food). The catering staff reviewed risks and took actions to ensure these were well-managed. For example, the chef told us that all cooked food was checked with a probe thermometer during and after cooking to ensure the temperatures remained within the recommended ranges, and records seen confirmed this. The service had been visited by the environmental health officer a year ago, and had received a rating of 5 out of 5 for the kitchen arrangements. There was suitable storage for packaged, fresh, chilled and frozen food, and temperatures for all fridges and freezers were checked daily.

We observed the lunch service in all dining rooms. Most people upstairs had their meals in their own rooms. It was clear that people were encouraged to make their own choices. There were two options for a main meal, and staff were observed asking people which option they preferred. Staff also encouraged people to make their own choice from the available drinks by showing them all the options. Where people did not want the available options, alternatives were offered, and provided. The meal options matched those on the displayed menu in the dining room. People were encouraged to eat and drink independently, and specific aids such as dual-handled beakers were in use to support this. People who were unable to eat their meal independently were supported by staff. It was noted that staff sat down next to the person they were supporting, and interacted positively with people during the meal. Some people in the Memory Lane unit who required support to eat had to wait for some time before receiving their food; up to thirty minutes after the beginning of the lunch service. Staff also told us that on busy days the lunch service could take up to 90 minutes to complete. Staff had up to date information relating to people's dietary needs as these were documented on handover sheets. We observed staff referring to these during the inspection to ensure that people received the appropriate meal.

The ground floor of the home had been redecorated. Corridors were themed in colours and each person had a picture of themselves on their door, along with a room number and their name. Toilets and bathrooms were signposted. This enabled people to navigate around the home with greater ease. It also helped staff to lead people who were confused about their environment to the right room. The upstairs of the home had not yet been decorated in the same way to help people navigate.

Good

Is the service caring?

Our findings

People we spoke with said the care delivered was good and most thought the staff were kind, caring, helpful, attentive and respectful. Comments included, "Staff are always quite pleasant"; "They are caring to people here"; "The staff are very caring, they are pretty good here"; "Sometimes they are rushed, but they do spend time with people" and "They treat me as part of the place". Although staff interactions with people were observed to be kind, positive, respectful and caring, it was noted that there was little opportunity for staff to spend time with people who lived on the top floor and Memory Lane unless they were performing a specific task. Two staff who worked on the Memory Lane unit told us that recent staff changes had resulted in less time for them to interact with people in activities. A healthcare professional told us that on occasions they have needed to find staff to change bedding for a person that they had been asked to examine. They were told that the person was "Next". We also observed this happen during the inspection as we reported to staff that one person required some care and support. This evidenced that some people's care was task driven rather than responsive to people's needs.

We recommend that registered person's review interaction, care and levels of support to ensure people receive care which meets their individual needs.

Relatives gave us mostly positive feedback. Comments included, "Generally the care is okay and she is well cared for, well fed and warm"; "Staff are lovely"; "Staff are very patient with residents, especially the new ones"; "The carers are so nice to him and others"; "The staff are very caring, and supportive, beyond what I would expect"; "The nurses stand out beyond anyone else as far as being caring and concerned" and "Staff are kind, you can't beat them". Two relatives gave us less favourable feedback, "I had to ask them to change and make her bed" and "They don't encourage her to have a wash or do her teeth". One person's relatives reported an issue which had happened on 01 October 2017 in relation to their family member not being treated with dignity and respect. We reported this to the management team and they immediately started an investigation.

Staff were observed to knock on bedroom doors, and await a response before entering. Personal care was only carried out in private rooms, and not in communal areas. People told us "Staff do give me respect"; "I am given respect, they always knock"; "I do feel independent here"; "Staff seem respectful"; "Yes, I feel I am encouraged to be as independent as I can be" and "I think the management does encourage me to be as independent as I can be". Relatives told us "Staff are kind and caring, staff knock [on her door] and she is treated with dignity and respect. Sometimes she waits longer for personal care because she refuses care from some people" and "Staff knock before coming in. They give privacy and only help if needed".

Staff were clear how to maintain people's dignity when supporting them with their personal care. People's curtains and doors were closed. Staff told us they ensured people's choices were respected. One staff member detailed how they offered people two or three options. They said, "I try to help them remain as independent as possible'. They gave examples such as giving the person their flannel and prompting them to use it on the areas of their body they could reach. Another staff member said they "Make sure they are comfortable, talk them through what they are doing". They shared how they tried to encourage and prompt

the person later on if the person didn't want their personal care. We observed one person who lived upstairs become increasing upset because they didn't want care from a particular staff member who was new and shadowing experienced staff. The person's wishes were respected and a nurse stepped in to help with the person's care because they knew them well. Relatives confirmed this was normal for their family member to react in this way.

We observed staff kindly and calmly supporting people who were confused and disorientated about the time and where they were. For example, one person frequently walked around the home looking for their mum. Staff helped them to look and offered gentle distractions to help the person and reassure them. We checked the person's care plans and this was an agreed strategy to help the person. Another person became increasing anxious about where they were and walked around the home calling their relatives name and asking for help. Staff responded each time and offered reassurance about when they would see their relative and offered drinks and snacks which helped the person calm.

Some people told us they had been involved in making decisions and planning their care. They were asked how they want to be cared for and about their likes and dislikes. Care files evidenced that people and their relatives had been involved with planning and reviewing their care.

People were listened to by staff. We observed one person told a staff member they were cold. The staff member went and got a cardigan from the person's room with consent. We observed staff checking with people whether they were happy to go into their room to put laundry away. Staff called people by their preferred names. We observed staff members checking with people that they were comfortable and pain free.

End of life care was managed well. There were clear end of life care plans in place for those that needed it. The service worked closely with the facilitators for end of life from the local hospice. People and their relatives had been involved in discussions and decisions about whether they wished to be resuscitated or not and the evidence of these discussions were appropriately recorded. The staff team took pride in supporting people with dignity to the end of their life. Healthcare professionals told us, 'The residential floor are very good at responding to peoples changing needs and my experience of their End Of Life care is impeccable' and 'When I have visited end of life residents and discussed the risks and benefits of medication to manage residents symptoms as they approach end of life'; 'Staff are very proactive in contacting end of life facilitators [redacted] when a residents end of life needs change' and 'They have contacted us so we can visit to verify [a death] in a more timely manner causing less stress to family and other residents'.

People's bedrooms had been decorated to their own tastes and personalised with pictures, photographs and items of furniture.

Relatives explained that they visited their family members at different times of the day and they were always made to feel welcome. We observed that relatives visited throughout the day. They spent time with their family members in communal lounges, the dining room, people's own bedrooms and during activities. People said, "For me, it's a very friendly place, very comfortable for me" and "I'm generally happy here".

Staff had a good understanding of the need to maintain confidentiality. People's information was treated confidentially. Personal records were stored securely. People's individual care records were stored in locked offices to make sure they were accessible to staff. Staff files and other records were securely locked in cabinets within the management and administration offices to ensure that they were only accessible to those authorised to view them.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with gave us positive feedback about the activities. Comments included, "I do know activities happen, I choose to be on my own in my room"; "You can be involved in the entertainment if you want"; "They'd always help you if you needed it"; "I find I get the care I need"; "We do have activities; sing/songs, music, art sometimes and we get visiting players"; "It's my choice about going to the activities"; "They seem to cater for everything and everybody"; "There's enough to do"; "If I wanted to join in things [activities] I can"; "Staff always help me when I need"; "There is always someone here to ask, if you need to"; "There's enough to occupy me" and "I entertain myself and therefore I don't go to many activities". One person told us they were very happy with their life, they enjoyed writing poetry and shared one of their poems with us, they assured us that the activities staff visited them in their room regularly.

Relatives said and "There is a good programme of activities, but she's not interested"; "There are very few activities, no outings and she has not been taken out"; "He gets all the care he needs"; "He's not really interested in the activities" and "Mum has been here 11 months, in all that time the minibus outside has been out twice in the summer due to lack of drivers".

Although people gave us positive feedback about activities, our observations showed this was not everyone's experience. Information about activities on offer was displayed on the various notice boards around the home. This included one to one activities such as manicures, as well as group activities including exercise, musical entertainment, quizzes, baking and crafts. The activity coordinator told us that there was a wide range of activity available at the home, and all the people had an activity assessment and evaluation within their care plan. This took account of the person's preferences. We checked people's care records to check that their hobbies and past times were listed. We found that some people's had not been completed. There was no evidence that this information was used to create meaningful activity for people.

There was a small team of activities coordinators to help people engage and participate in activities, one of these members of staff was on sick leave. This meant that activities on the schedule did not happen as they had been planned. The activities that did take place were only offered to a small portion of the people. On one of the days of inspection we observed a staff member brought a small group of three people into the quieter lounge on the ground floor at 10:35 to read and review the daily newspapers. On bringing people into the room the staff member explained she had to go off and do something and would be back soon. We observed one of the people left the room after 10 minutes of waiting telling the others they were going to watch television. One person actively read the paper and followed stories reading headlines out loud and one person sat at the table watching other people for 15 minutes before picking up the newspaper to read. The staff member returned at 11:10. The activities schedule detailed that activities staff were allocated 30 minutes on the top floor of the home to provide one to one activities. There were 34 people living on the top floor of the home. Providing one to one time within 30 minutes would allow less than one minute for each person. This is not quality time and cannot be classed as an activity. We spoke with the management team about this. The peripatetic general manager told us they planned to improve activities for people living in the home.

Within the Memory Lane unit there were reminiscence items that people could touch, hold and wear. Fiddle mitts and blankets were seen which are designed to provide sensory, tactile and visual stimulation for a person living with dementia or people with cognitive impairments. Memory Lane had a sensory room, which contained several items including board games, lights, musical instruments and tactile and other items designed to stimulate. We did not see this room used by any person during the inspection and staff did not have the time to take people in there to engage them. One person had declined group activities, but preferred to attend communion. This was recorded within the person's evaluation of activities on a regular basis.

External singers came to the home to sing for people. There was photographic evidence of entertainers working with people who were cared for in bed.

We recommend that registered person's review activities following good practice guidance to ensure people have access to activities and hobbies to meet their needs.

Care records contained an initial assessment of needs prior to admission, followed by a care plan. The initial assessment included a detailed medical history and current medical needs. There were risk assessments in place which covered a variety of areas including moving and handling, and falls.

Care plans demonstrated that people had risk assessments which determined their risk of malnutrition and choking. The risk assessments were linked to care plans which identified actions to be taken by staff to manage and reduce the risk. For example, a person identified as being at risk of choking or malnutrition was referred to a dietitian or speech therapist, and actions recommended were incorporated into the person's care plan. Specific information on how to safely manage a person's care was included in their care plan. For example, if a person required specific support such as enteral feeding.

Care plans demonstrated the involvement of relatives in care plan reviews, and specifically where a person required decisions to be made in their best interests. Mental capacity assessments for specific tasks or events were in place in the care plans, and included the involvement of the registered manager and the person's doctor, as well as the next of kin or advocate where possible. This was evident where a person had been assessed as not being suitable for resuscitation, or where the person's liberty had to be deprived to ensure their own safety. All care plans included a consent form which allowed staff to provide care, share relevant information with other healthcare professionals, and use photographs to document or track care.

People told us they knew how to complain if they needed to. Comments included, "No, I've never had a grumble"; "I'd go to the staff if I was unhappy about something"; "We have no complaints about anything at all"; "I've never complained"; "If I needed to, I'd complain to the management"; "No complaints at all" and "I would complain to the team leader, I have not had to do that". Relatives told us they had confidence in complaints being managed effectively. Information was on display about how to complain. The peripatetic general manager told us that there had been one complaint within the past 12 months. The complaint was raised by a person's relative who was concerned that staff had referred the person to a doctor, and commenced treatment for a chest infection, but had not informed the relative. The management team had responded to the complainant within the service's response timeframes, and outlined the actions that had been taken to ensure that this incident would not happen again, including a discussion with staff about the need for communication with a person's next of kin.

Compliments received demonstrated that people and their relatives were happy with the care they received at Friston House. Comments included 'I would like to thank your domestic staff for being so polite and helpful'; 'The staff here have done a marvellous job' and 'The care given was done with thought,

compassion, consideration and respect'.

The service received feedback from people who used the service, and their friends and family. An annual survey was sent to people and their friends and family, and the results were collated into a report. This included a benchmark of the same criteria against other care home providers nationwide. The most recent published report, covering 2016, showed that the service was above the national average for positive responses from people who used the service, but scored below the national average for positive responses from friends and family. The survey covered questions on quality of staffing, care, the quality of life of people who used the service, the building and facilities, safety, security, privacy, and access to external healthcare. Most of the criteria scored highly, but it was noted that the friends and family responses to the question of availability of staff to spend time with people, scored lower than other areas.

Good

Is the service well-led?

Our findings

Observations showed that the whole management team had a presence in the home. They knew people and the staff well and helped out to provide reassurance or support when required. For example, one person was having difficulty walking so one of the team guided them slowly to where they needed to go. People told us, "It's an easy going place"; "I don't know the manager, but I know the office staff"; "I would not like it if there were staff changes"; "In the past, they were not managing well"; "We know the manager and she does have an open door attitude"; "We can't praise this place and the staff highly enough" and "I don't know the manager but I feel I can approach her with a problem".

Health and social care professionals gave us good feedback about how well led the service was. One health and social care professional said, "As a well led service I think this is difficult to say due to recent management changes. I have noticed an improvement and hope this continues" and "The residential floor seems to be extremely well managed by its staff, and the carers working there are very attentive to their residents. Nothing ever seems to be too much trouble and the residents all appear cheerful and comfortable".

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had been off work on leave for some time. The provider had put in place suitable arrangements to manage the service and provide support to the staff team.

Staff told us told us they felt well-supported by the management team. Staff told us that they were able to raise any concerns without fear of discrimination or reprisal. Staff meetings happened regularly, for both day and night staff, staff members unable to attend were provided with meeting minutes so information could be shared amongst all of the staffing complement. The peripatetic general manager and deputy manager were seen walking around the home, and had a friendly rapport with people who used the service.

The management team detailed how they supported staff to grow and develop in the organisation. One member of the management team detailed how they enjoyed mentoring new care staff. They said, "I settle them in, provide support and encouragement and watch a good heath care assistant grow". Another member of the management team shared how they mentored nursing staff to help them develop.

People were able to provide feedback in regular meetings with the management team. People told us, "They do encourage me to speak up"; "They do have a time when they ask questions"; "Overall, I feel very comfortable here"; "We have meetings when you can say what you want"; "Relatives can come to the meetings as well". A few relatives were not aware of meetings held.

Audit systems were in place. The management team had carried out audits of the service in relation to each area such as health and safety, infection control, and records keeping audits had taken place; these

highlighted some issues and showed these had been addressed with staff team. The regional manager and senior general manager for the area carried out frequent quality first checks of the service and visited the service to provide support to the management team on a regular basis. Audits undertaken showed that the service had received a quality first audit on 29 August 2017 and 04 September 2017. An action plan was put in place in relation to this audit. The actions had been addressed quickly. The provider's regulation team had carried out an audit on 15 August 2017 which followed the five domains that CQC inspect against; safe, effective, caring, responsive and well led. The audits checked records, procedures, staff understanding, observations of care and general observations around the home. An observation made in the 15 August 2017 audit was that the rating was in display in the reception area.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed their rating on their website but this was not on display in the home. We raised this with the management team on our first day. The peripatetic general manager advised it had been displayed but it must have been taken down by someone. They put a copy of the report on display to show the rating, whilst they downloaded the rating to display.

Policies and procedures were in place for staff to refer to. The policies and procedures were up to date and relevant and available on the provider's intranet system as well as paper copies when required.

The deputy manager had carried out a number of unannounced night visits to the service to check that staff were working according to the provider's policies and people's needs. Where issues had been highlighted these were dealt with swiftly and in an appropriate manner.

Staff told us they felt confident to report any concerns to the management team. Staff told us that they were aware of the home's whistleblowing policy. Staff felt confident to use this policy. Staff reported that communication was good within the home and meetings were regularly held so they could discuss concerns. Staff told us they felt supported, valued and listened to by the management team. One staff member said, "I have good support from the management. I have a good relationship and am happy to go to them for support. They listen and rectify. I feel comfortable". Another member of staff said, "I get support from the management team. [Deputy manager] will listen and she will do what she can do".

The management team held daily 'Stand up' meetings with all departments within the home to discuss the running of the home. The meetings included nursing staff, members of maintenance team, catering and housekeeping team. This ensured that the management team were aware of any issues and concerns. The peripatetic general manager told us they had an open door policy which meant that staff, people and relatives could approach them at any time to discuss any concerns. We observed people and staff all putting this into practice.

The service had an employee of the month recognition scheme for staff. The employee of the month was displayed in the hallway of the home so everyone could see this. Nominations for staff members could be made by people, relatives and by other staff. Staff were also recognised for good work by the provider. Services that were performing well received bonus points which staff could use as part of their staff care scheme.

The management team had a good understanding of their roles and responsibilities in relation to notifying CQC about important events such as injuries, Deprivation of Liberty Safeguards (DoLS) authorisations, safeguarding and any deaths. Notifications had been made in a timely manner.

The provider's website states 'Our residents, patients and their families expect great services, so our professional and dedicated team of specialists actively recruits people who are focused on continually improving the quality of life for the people in our care, to achieve our ambition of Barchester as the leading provider of care services'. Staff demonstrated they were there to provide the best quality of care to people. One staff member told us, "It is nice to try and make a difference in someone's life. I try and brighten their day; we can do little things to make a big difference".