Care Quality Commission

Lilian Faithfull Homes

St Faith's Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

This inspection took place on 1 and 2 April 2015 and was unannounced.

At the last inspection on 28 July 2014 we asked the provider to take action to make improvements to the guidance provided for staff in relation to some medicines. The registered provider told us they would meet these legal requirements by 30 November 2014. We found these actions had been met, although this guidance needed to be more personalised.

During this inspection one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. This related to a lack of accurate record keeping. You can see what action we told the provider to take at the back of the full version of the report.

The service predominantly cared for older people who live with dementia and could accommodate up to 69 people. At the time of the inspection 65 people in total were cared for.

There was a registered manager although they had resigned and were due to leave soon after the inspection. A registered manager is a person who has registered with

Summary of findings

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 recruitment process for a new home manager had already begun.

People's consent was sought prior to care or treatment being provided. Where appropriate people's mental capacity was assessed and people who lacked mental capacity were protected under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff understood the principles of the Act and adhered to its code of practice. However, staff had not understood how to effectively record this process on the documentation provided.

Arrangements for the management of medicines were improved. However, the guidance recorded for the use of some medicines lacked detail. These medicines had been prescribed to be used "when required". Clearer guidance (protocols) for their use, in relation to the person it had been prescribed for, would help define the parameters in which these should be used and improve consistency in how they are administered.

People were kept safe because staff knew how to recognise abuse and report incidents or allegations of abuse. Staff were aware of who to contact if they had concerns about other staff or the service generally. Robust staff recruitment practices kept people safe from those who may be unsuitable to care for them. A continued good investment in staff training and support ensured staff delivered people's care safely and with knowledge. Accidents and incidents were responded to quickly and monitored to try and prevent reoccurrences.

People's human rights were upheld and people were not discriminated against. People's dignity and privacy was maintained. Staff cared for people with compassion and understanding, promoting independence and supporting their retained skills where possible. People were treated as individuals and their care was personalised to meet their needs and capabilities. People who mattered to those who were being cared for were included and made to feel welcome.

People received the support they required to eat and drink. Health related risks were identified and managed well. People had access to appropriate health care and adult social care professionals who also helped to support their physical and mental health needs. People were supported to attend health related appointments.

People were involved in the planning of their care and in making day to day decisions. Where people were unable to do this their family and other representatives were involved on their behalf. Care records however did not always reflect people's individual needs and sometimes lacked up to date guidance for the staff.

The service needed to recruit a new activities co-ordinator but people were still being supported to join in social gatherings and take part in activities.

People and their relatives knew how to make a complaint if they needed to. Any concerns and complaints were taken seriously, investigated and responded to.

Improvements had been made to the service by the registered manager. However, shortfalls in effective communication had failed to identify that some senior staff had required additional support to carry out their responsibilities. A lack of understanding of what was required to be in place had resulted in some shortfalls. The registered provider's system for quality monitoring was generally robust and an initiative taken by the newly appointed Chief Executive Officer to independently quality monitor the service's systems and processes led to the shortfalls being identified. The provider's senior management team had recently started to take specific action to determine the extent of the shortfalls. Some actions had already started to address the shortfalls others had been planned. Despite these issues staff told us they felt well supported by the immediate senior staff team in the home and we did not evidence any adverse effects on people's care or wellbeing.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Risks to people were identified and managed.

The management of people's medicines had improved although guidance available to staff for the use of medicines prescribed to be used "when required" was not overly personalised.

People were protected from abuse and their human rights were upheld.

There were enough staff to meet people's needs. Staff recruitment practices were robust and protected people from those who may harm them.

Good

Is the service effective?
The service was effective.

People's rights were protected under the Mental Capacity Act (2005) because staff sought people's consent before delivering care and treatment and where consent could not be provided, this care was delivered lawfully.

People received appropriate support with their eating and drinking and were provided with a diet that helped maintain their well-being.

People's health care needs were met.

People received care and treatment from staff who were well trained and supported to do this effectively and safely.

Good

Is the service caring?
The service was caring.

People were cared for by staff who were caring and compassionate and staff treated people as individuals.

Staff understood the concept of person centred care and were supported to ensure this took place.

People's dignity and privacy was maintained.

Specific support was given to the people who mattered to those that received care. Staff helped people maintain relationships with those they loved or who mattered to them.

Good

Is the service responsive?
The service was not always responsive.

Requires Improvement

Summary of findings

People were involved in making decisions about their care and in reviewing their care. Where people were unable to do this their representatives did this on their behalf. Care plans however, lacked personalisation and the care delivered was not always in line with the written care plan.

People had opportunities to socialise and partake in organised activities.

People's complaints and concerns were taken seriously and the information used to help improve the service.

Is the service well-led?

Requires Improvement 

The service was not always well-led.

Records had not been accurately or sufficiently maintained.

Some senior staff had required better support to meet some of their responsibilities. Communication arrangements had not been effective enough to identify this as a need and to address it.

People and staff felt supported by and able to approach the management staff. People were encouraged to be involved in decisions made about the running of the service.

St Faith's Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 April 2015 and was unannounced. It was carried out by three inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service. This included information sent to us by the provider about significant events.

During the inspection we spoke to 23 members of staff. We spoke with four people who used the service and two relatives. We reviewed the care records of seven people. These records included their care plans, risk assessments and medicines administration records. We also reviewed a selection of other records relating to nine other people. These included records of weights and repositioning and food and fluid intake charts. We reviewed the recruitment, training and support records of 12 members of staff. We also reviewed a selection of records relating to the management of the service. These included a selection of audits, maintenance records, policies and procedures and accident and incident records.

Good

Is the service safe?

Our findings

Stair gates (the management team refer to these as garden gates) were seen in use throughout the care home. These were placed at each person's bedroom door way. Staff told us they were used to prevent people entering bedrooms that were not their own. They told us this practice kept the very frail, who were sometimes cared for in bed, safe from others who may unintentionally harm them. One relative said, "When (person's name) moved in she didn't like people coming into the room". We did not see risk assessments in place for the safe use of these stair (garden) gates when inspecting people's records. However, the management team subsequently confirmed that these were in place and provided a selection of these for us to see.

Assessments were carried out in relation to people's risk of developing pressure ulcers by using a recognised assessment tool. Depending on the outcome of the assessment people were provided with different types of pressure relieving equipment and appropriate care. For example, one person had been provided with a pressure relief mattress and staff were repositioning the person to alleviate pressure from their skin. A similar situation was found for another person where their skin had begun to be at risk of pressure ulcers developing; it had started to become red. Staff again had taken appropriate action to reduce the risk.

We reviewed the use of pressure relief mattresses in relation to 11 people. We were told by a nurse that the mattress pressure was set according to the person's weight. This was adjusted by turning a simple dial on the mattress pump. We found seven mattresses; five were being used by the person when we visited them, which were incorrectly set in relation to the person's weight. The setting was corrected by the nurse that accompanied us. We found the settings dial could be easily turned and it was felt by the nurse that this was possibly inadvertently happening when staff brushed passed the end of the bed where the dial was located. We were informed that none of the five people on their beds, or any of the others using these mattresses, were showing increased levels of poor skin integrity. This had therefore not had a negative impact on people's skin which was also being closely monitored by the staff. We were subsequently informed by the management team that arrangements would be put in place to regularly check the mattress settings.

Following the last inspection on 28 July 2014 we found the provider did not have robust enough systems in place to ensure some people's medicines were administered appropriately. We found the arrangements for the management of medicines were generally good during this inspection. Some additional guidance for staff regarding people's medicines prescribed to be used 'as required' could have benefitted from more detail. For example, protocols for the use of laxatives did not give specific guidance to staff as to when they should start to consider the administration of a laxative in situations when they were unsure if a person had used the toilet. This was fed back to the management team and the improvement of these protocols and relevant care plans had been delegated to the member of staff who was co-ordinating the general improvement of care plan content. Care staff were however aware that they needed to report to the nurse if they suspected a person of becoming constipated. Care records supported the fact that this was happening and people's toilet habits were being monitored.

On the day of visiting two people's medicine cupboards we found the storage temperature to be in excess of the medicine manufacturers ideal temperature. This issue had been identified in other people's bedrooms by staff and been addressed by relocating the medicines storage cupboard. We were told that the same would be done for these cupboards.

People's needs were being met by sufficient numbers of staff, although at times, for example, when providing personal care to people, staff were not always able to be as responsive to other people's needs as they usually were. The registered manager considered the staffing numbers to be sufficient. The deputy manager alerted them to concerns about staffing numbers or skill mix and they altered the staffing numbers accordingly. Staff told us they believed the staffing numbers were usually satisfactory. Staff comments included, "We could always do with more, but usually there are enough staff" and "I think we have enough staff to provide safe care that meets people's needs". People told us staff responded to their needs. One person said, "It makes such a difference when staff attend

Good

Is the service safe?

quickly" they told us that staff generally did. They also said, "At night, I know they will be here quickly". Another person said, "In the evenings the staff are not around so much but when I ring my call bell they come straight away".

People told us staff were available to meet their needs. There were however two different times, on two different units when staff were busy attending to people's personal care needs, behind closed doors. They were therefore unable to supervise those who were using the communal areas. During this time one person had required attention and had begun to get distressed. Once a member of staff had been located and informed, by a visitor on this occasion, the person was attended to. In this situation people were not put at risk, but it potentially meant, at busy times, staff were not always able to be as responsive as needed.

People were protected against abuse because staff had been trained to recognise this and report it. The provider's policy and procedures for protecting people from abuse linked in to with the County Council's wider protocols for safeguarding people. The service appropriately shared information with relevant agencies in order to safeguard people. Staff told us they knew how to and would feel confident in, raising concerns they may have about other staff or the service generally. They had good support to do this within the company but also knew how to contact other agencies if they needed to.

There were effective arrangements in place to manage and monitor accidents and incidents that occurred to people. A system was in place to help identify emerging trends, such as time, place, type and frequency of accident or incident. This was so that new actions could be taken or existing actions altered to try and prevent reoccurrences.

Staff recruitment records showed, with the exception of one, that robust processes were in place to check potential staff before they started work. The service's recruitment policy was dated February 2014 and the relevant manager told us this would be reviewed this year. The service was advertising for care staff and one nurse. Appropriate staff disciplinary arrangements were in place. One staff member's records contained confirmation of an investigation, a disciplinary hearing and the disciplinary penalty. In this case further training was needed. The staff member's training records confirmed that the required training had been completed and a follow up staff support (supervision) session had been completed. This confirmed that the additional learning had been beneficial.

There were strategies in place to manage untoward emergencies and ensure the regular monitoring of safety systems. The use of a robust risk management process maintained people's generally safety. One relative considered their relative to be "very safe" when living in the care home.

Good

Is the service effective?

Our findings

When talking with people about their health needs and if they considered the staff met these one person said, "They're very helpful, I think they're quite good. Some have a better understanding of my needs than others". Another person said, "Some staff wash me thoroughly others do not. It depends on who you get". A third person said, "The staff are very good". One relative said, "The staff are really friendly, and I feel that (person's name) is well cared for". Another relative said, "What I have observed is very thorough. I wouldn't hesitate to recommend".

People's consent was sought before their care or treatment was provided. We spoke with four people who told us staff sought their consent before providing their care or treatment. These people's records however did not reflect this practice. This was feedback to the member of staff who had been allocated the job of improving how consent was recorded in people's care records. They had already identified this and actions to address this had already been planned. Staff told us where people could not provide consent or make decisions about their care and treatment they had been assessed as lacking mental capacity to do this. The records we reviewed demonstrated this to be the case. Staff understood that care and treatment sometimes needed to be provided in the person's best interest. Senior staff were often involved in this decision making process. They understood that to do this lawfully the Mental Capacity Act (2005) and its code of practice had to be followed.

The registered manager confirmed that there were no authorisations in place under the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be lawfully deprived of their liberty when there is no less restrictive way of ensuring they get the care and treatment they need. The Care Quality Commission monitors the implementation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People's levels of supervision and control had also been reviewed in relation to clarification of the DoLS legislation by the Supreme Court in March 2014. This clarified what may constitute a situation whereby someone can legally have their liberty taken away. We were told that no referrals for authorisation under DoLS needed to be sent to the local authority (the local supervisory body for DoLS) following this review.

Staff felt well supported however, some were not sure about the frequency of their supervision (staff support) sessions or what they were supposed to receive. One member of staff said they received "good" support and another said they received "brilliant" support from senior staff. One member of staff said, "I don't think I've had an official supervision or appraisal session but I feel so well supported. There's always someone to ask, and I'm sure I would be told if there was an issue with my work".

People had access to health care and adult social care professionals when needed. People were supported to attend health related appointments, although many had very supportive family members who helped with this. The service had good arrangements with local GP surgeries which ensured people's health related problems were sorted out quickly. People had access to additional health services such as chiropody, dental and eye care services. The provider had arrangements in place for a private Physiotherapist to visit the home for 12 hours per week. For a separate charge, people could access their support and expertise. One person said, "The Physio gave me a lot of confidence".

People were cared for by staff who were well trained. One member of staff from an agency said "staff are very professional here. It's not always the case in other places". The provider had continued to invest in staff training and support. Over half the staff delivering care had completed a recognised qualification in care. The provider supported all staff to achieve recognised qualifications or to improve their knowledge in other ways. All staff, whatever their role, were expected to attend training in basic subjects, which were updated at regular intervals. These included subjects such as health and safety, safe moving and handling and dementia awareness. The service's main training record showed staff were keeping up to date with their training requirements. The pre-inspection information from the provider told us that the content of training courses is continually updated to reflect changes in legislation and the provider's policies and procedures.

All staff completed induction training before they worked in the home. This covered all the above subjects as well as others. The training also looked at the provider's policies and procedures. 'On the job' training and support was then provided and the probationary period for all staff was six months. During this time competency observations were completed and recorded. These would remain on-going

after the probationary period. Staff were not confirmed as permanent employees until they had completed the required training and submitted their induction work folders. One staff member's probationary period had been extended until they completed the required training. One member of staff told us the support and training they had received had been "really, really good". Another member of staff said, "I am really enjoying it". This member of staff was shadowing a more senior and experienced care assistant. The provider was aware of the new Care Certificate requirements (launched in March 2015 which all new care workers must hold within 12 weeks of starting work).

Additional training was provided in subjects such as syringe driver use, care of the dying with dignity, care of the person artificially fed and Parkinson's Disease awareness. This helped staff meet people's more specific health needs. Some staff had completed courses that enabled them to support other staff. These included the dementia link worker course and coaching for team leaders. Senior staff were provided with leadership and development courses. Training for supporting people with challenging behaviours had just been planned and was due to be delivered in the near future.

People received the support they required to eat and drink. The service employed additional staff whose sole job it was to help people eat their food, make choices about their food and have access to drinks. Care staff also carried out these tasks and we observed some very sensitive and caring support being provided at mealtimes. People's abilities to feed themselves varied according to what skills they had retained. GPs were kept aware of alterations in people's appetites and weight. Where additional calories were needed food was fortified with milk powder, cream and butter. Snacks could also be provided at various times of the day. A relevant care plan in each person's care file was completed and gave staff guidance on what support the person required in this area. One person could not tolerate certain foods and needed their food cut up and this had

been recorded in the appropriate care plan. We saw this person struggling with their lunch because their food had not been sufficiently cut up. The nurse that rectified this situation was going to follow this up with the particular member of staff who had delivered the person's meal.

People made choices about their food by completing a menu in advance but where needed, staff also supported them to make choices at the meal time. One member of staff showed us pictures of different meals they sometimes used to help one person make a choice. In some cases the options were put in front of the person to help them make a decision. Where people required an assessment of their swallowing reflex a referral was completed and they were assessed by a speech and language therapist. This assessment determined how they should be fed and the consistency of the food that should be provided. For example, two people's care plans stipulated that pureed food must be provided and a thickener used in their drinks. The support provided to these people was in line with their care plans.

Good

Is the service caring?

Our findings

People told us the staff were exceptionally caring and kind. When talking about the staff one person said they gave them all a "gold star". They said, "They (the staff) are always respectful towards me. They insist on closing my curtains when I am using the commode". This person's bedroom looked over the garden and a road. Another person said, "They (the staff) work very hard but they bother to ask me how I'm getting on". When asked if staff were respectful to them this person said, "Oh yes, definitely". Another person told us staff pass by their bedroom door and say "hello, how are you". This person said, "They are interested in me, isn't that nice". A relative said, "They have been absolutely excellent. They are very patient".

Observations confirmed that the people staff cared for mattered to them. They valued the relationships they had with the people they cared for and where able to do so, people reciprocated this. Staff we spoke with had a real passion for supporting people who live with dementia. Simple acts of caring were seen such as stroking the hair of a person who was frail and in bed and tucking another person in with their blanket. Interactions with people were supportive and encouraging. Moments of distress were managed by the use of a sympathetic and reassuring tone of voice or by just sitting by the person. Where this did not initially work, staff returned later to support the person when they knew the person would be able to engage better with them. Staff were seen putting their arms around people and providing an appropriate level of comfort. Staff were also seen having fun and laughter with people.

Staff saw people as individuals and this was reflected in the individualised care we saw delivered. Senior managers were committed to providing person centred care and they supported the staff to be able to do this. It was clear in the way staff delivered people's support that the person came first and the diagnosis of dementia came second. One senior member of staff told us that all staff training was aimed at ensuring that people were treated as individuals and that their human rights were upheld. The pre inspection information from the provider told us the service linked in to local and national forums which promoted person centred care.

The document 'This is Me' (designed by the Alzheimer's Society) was used to find out information, predominantly from family members, which helped the staff understand the person better. We spoke with one person who was able to tell us some of their experiences but they also found it difficult to articulate these. The 'This Is Me' document had been fully completed by family members, with the person's knowledge. It helped to get down on paper this person's life history, past events, things that had been important to them before they had become ill, including their preferences. This helped staff deliver this person's care in an individualised and personalised way. The person told us "staff know what I like and don't like". They confirmed that specific preferences were supported by the staff. For example, this person had a set time they preferred to go to bed and they told us staff stuck to this time most evenings. They also told us, "I like to be kept busy and the staff help me do that". This was achieved by staff helping the person set up their own activities and by making sure everything was near to hand so they could be as independent as possible.

Things that mattered to people were acknowledged and incorporated into their care. One person had been asked if they preferred male or female staff to care for them. They told us they had said female staff and they told us only female staff delivered their personal care. This was also the case for one other person which was confirmed by a relative. Another person told us they had been following the recent politics and said, "They (the staff) helped me organise my postal vote". They ensure I get my daily paper which keeps me going all day". This person's bedroom looked well lived in with items in many places. The person said, "The staff know that I know where everything is and that I like it like that".

People who were unable to freely communicate or engage with things going on around them also received the same level of concern and kindness from the staff. For example, one person had classical music quietly playing on their radio whilst they were poorly and in bed. A member of staff told us the person had been "very involved" with classical music when they were well and said "so we make sure it is on the radio for (name of person)".

People who were able to be independent in some areas of their daily activities told us staff helped them to do this. A simple but important example was discussed with staff and the person involved. Staff had been concerned about the risks involved in supporting one person to be independent with one particular task. The person told us it had been really important to them to be able to carry out this task for

Good

Is the service caring?

themselves. Staff had worried about the person's safety when doing this, but had realised that it really mattered to this person to be able to do this for themselves. Staff therefore organised an assessment of the person's physical and mental capability around this task. They had discussed their concerns with the person; the risk verses the person's independence. The person told us they were aware that staff had worried about them but also showed us how they carried out this task. A senior member of staff told us "it would have been easier to have not acknowledged the importance of this to (person's name) but that is not how it works here".

Staff interactions were never belittling or degrading and staff showed great patience with people. Where explanations were needed or where choices needed to be established, staff spent time doing this verbally or using other forms of communication. For example, gestures or showing a person something they could associate with what was being said. One member of staff was seen trying to explain to a person that it was time for a drink. This was done through the use of simple words but also by taking a cup up towards their own mouth and then pointing to the person. The person then answered and agreed they would like a cup of tea.

Visitors were able to visit without restriction. They were welcomed at the reception and were on friendly and relaxed terms with the care staff. They were able to ask for updates on their relative's health and wellbeing and staff gave time to provide this.

The registered manager explained that a lot of time was spent supporting those who mattered to the people who received care. They told us that many family members, at some point, found visiting their relative who lived with dementia, difficult. One member of staff described it as being a "hard journey for the person left". To help provide this support and promote a better understanding of dementia generally a registered mental health nurse had been specifically employed. Their role, as well as providing care, was to provide more specific advice to staff and to support and educate family members on what was happening to their relative. This support was also available from other staff who had taken further qualifications and courses in dementia care. They were able to explain to family members, from a sound knowledge base, why their relative did certain things and why their behaviour sometimes altered and could be upsetting. One relative told us they had been supported by staff to adjust emotionally to their close relative's admission. They told us it had been a difficult decision for them to make as they knew their relative would really rather be living in their own home.

Requires Improvement

Is the service responsive?

Our findings

People's care records, included care plans and were kept secure. Staff understood the need for confidentiality and we did not observe any conversations held about people's care in public areas. We spoke with four people who told us they were able to tell staff how they wanted their care provided and that the staff listened to them and followed their requests. Two of these people told us that staff always asked them if they were happy with their care and if they wanted anything altered. All four had been involved in the decisions made about their daily care. However, one person told us they knew they had care plans but no-one had ever reviewed these with them, but they were happy with the care that had been provided to them. Records showed that where people were unable to engage in the planning and reviewing of their care, their representatives were and had been given opportunities to act on their behalf. One relative confirmed they had been fully consulted by staff about how their relative's care would be provided. Records showed representatives were also updated with changes in their relative's care or health.

Care delivery was personalised and it met people's needs however, care was not always delivered in line with people's care plans because these were sometimes not up to date or lacked personalisation. Where the information and guidance held about people's needs and care delivery is not fully up to date there is potential for people not to receive appropriate care and treatment. Staff told us they did read people's care plans but received the guidance they required about people's care, predominantly from daily staff hand over meetings and from the practical support they received from senior care staff. They also told us they knew how people liked to be cared for because they knew them well and because they spoke to people about how they wanted their care delivered. Where this was not possible they learnt from family members and in how the person's reactions. Where care plans and other care records do not hold up dated information and guidance for staff there is a potential risk that people will not receive appropriate care and treatment.

People were being supported to socialise and links were established within the local community. The service was carrying out recruitment for a new activities co-ordinator in order for people to receive more personalised and meaningful activities. In the mean-time a member of staff from a sister home was providing some activities and arranging social events. People visited the local community and there were opportunities for the local community to be involved with the service. Entertainment was organised, as were trips out. The registered provider had recently purchased a new mini-bus which could be booked by the staff when needed. Care staff also provided some activities to smaller groups and individuals within their own units. For example, care staff supported three people to partake in exercises with a ball on one unit.

People had the opportunity to raise their concerns and complaints about the service. There was a complaints policy and procedure which people received information about when they were admitted. The complaints procedure was visible within the service and the registered manager operated an open door policy. Two complaints had been received since the last inspection in July 2015. These had been acknowledged, investigated and responded to appropriately.

Information received from people's complaints was reflected on and used to improve the service. Following one complaint a reflective group had been set up to identify points of learning. These were formulated into actions to help avoid a reoccurrence of the issues that were raised. We discussed some of the actions taken with the staff. Learning had taken place and staff managed the area of care that had been complained about differently. This had helped to protect people from a reoccurrence but records kept in relation to this care needed to improve.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with knew who the registered manager was and found him to be approachable and easy to speak with. One person told us they would be quite happy to talk to him about anything that worried them. Staff told us he was visible around the care home and they would have no problem in speaking with him about any problems they may have. This sentiment was extended to other senior management staff which included the Chief Executive Officer (CEO) and the Director of Care.

We found people's records did not always contain an accurate recording of the best interest decision making processes taking place. Care plans and risk assessments were not always recording accurate information about people's care and treatment. Documents had been made available for staff to record best interest decisions but those we reviewed were incomplete, partially completed or incorrectly completed. Care plans lacked personalisation and sometimes also sufficient guidance for care staff. For example, people's life histories and preferences had been gathered and recorded but this information had not always been used to help inform people's care plans. One person told us they preferred female care staff to deliver their care but this preference had not been incorporated into the person's personal hygiene care plan for staff guidance.

Care plans that lacked specific documented guidance were seen in relation to some people's pressure ulcer prevention care. This lack of guidance potentially puts people at risk of unsafe or inappropriate care or treatment. For example, it was explained to us the need for staff to reposition a person to alleviate pressure to their skin, and for staff to apply a skin protecting agent. Whilst we could evidence that this was happening in practice, none of this required guidance was recorded in the person's relevant care plans or risk assessments. We were also told by staff that care plans and risk assessments relating to people's health were reviewed monthly. The CEO confirmed this to be the provider's expectation but records did not always show this to be the case. Records for one person's pressure ulcer prevention care had also not been altered when their risk level increased and their care needs altered.

Also not clearly documented were staffs' supervision meetings. Although records, held in some individual staff files recorded a supervision meeting having taken place, it was unclear if staff had received supervision that met their individual needs. This was because records held in staff files also included attendance at staff meetings, recorded as supervision meetings. Electronic records held by the provider were not up to date for staff supervision and appraisal meetings. The provider's performance and appraisal policy stated: "each year all managers will prepare a schedule so that each member of their team is allotted an appraisal meeting or a minimum of six supervisions". Senior managers confirmed that staff were to be provided with adequate supervision sessions and a yearly appraisal. It was not therefore clear from the above records if staff had received adequate supervision sessions to meet their individual needs.

The above issues were in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Certain senior staff within the home were responsible for ensuring records were accurately and appropriately maintained. It was their responsibility to also provide staff with the support they needed to achieve this. We found that some senior staff responsible for doing this had not fully understood their responsibilities. The provider had found that these staff also required additional support themselves. Through an initiative taken by the senior management team, as part of the provider's overall quality monitoring and self-assessment process, an independent audit had been carried out on all main systems and processes in the home. This had recently identified the shortfalls found in this inspection, identified where more support was needed and given the provider enough information so they could start to address the issues.

A new position of Director of Care had also been recognised as a necessary requirement by the board of Trustees. This role would focus on and provide specific governance over all care and nursing services provided by the provided. The person identified for this role was due to take up this position imminently. The senior management team had already started to look further into exactly what the issues were in relation to the record keeping shortfalls. Actions to address these were being planned and some initiatives had already begun, for example, additional training for key staff in the maintenance of certain documents. We spoke to the member of staff who had been given the task of supporting the staff through this. They confirmed that they were already working closely with individual staff and they

Requires Improvement

Is the service well-led?

provided us with the dates of planned record keeping training sessions. The senior management team had therefore acted responsibly by taking ownership of the issues and putting actions in place to address them.

The registered manager told us he welcomed feedback from people about the services provided in order to improve them. Meetings with people and their representatives were informal but were held on a regular basis in order to get feedback and seek people's ideas for the service. For example, plans to not have a member of staff on reception and operating another system for easy access for visiting and query management at weekends were first discussed with people's representatives. New arrangements went through a trial period and feedback sought before the new arrangements were put into place. People were also involved in supporting the service. For example, several relatives were involved in organising main events such as the care home's summer fete and Christmas activities. Some had offered time and practical skills on a voluntary basis in various projects such as in the garden.

Links had been made with local community groups. One of the registered manager's visions had been that the care home should be part of the local community and not a place that people feared or had misconceptions about.

One community based group needed a place to meet and the care home needed people from the community to visit it. This joint need had resulted in a mother and toddler singing group who met regularly to sing with the people who live in the care home. We were told that this had proved to be very successful. In particular it had proved to be successful with people who lived with dementia who did not necessarily engage in other activities. There were links with local schools and children visited the care home at Christmas and at other times to sing and socialise. Children from a senior school visited people to talk to them as part of their community studies. The registered manager's vision was that young people had a better understanding of older people and in particular those who live with dementia.

The culture in the care home which included staffs' attitudes, values and general morale was monitored. This was done through group staff meetings and ad hoc and unannounced visits to the care home by the registered manager. Staff well-being was supported by regular social gatherings for staff only which were well attended. Staff told us they were "proud to work for the provider" and felt "part of an extended family". Staff told us they felt encouraged and motivated by the senior staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Accurate and complete records relating to people's care and treatment, decisions made on their behalf and staff supervision had not been maintained. Regulation 17(2)(c) and (2)(d).