Dovestone Estates Limited

Wray Common Nursing Home

Inspection report

Wray Common Road
Reigate
Surrey
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Tel: 01737240563

Date of inspection visit:
21 December 2017
05 January 2018

Date of publication:
15 February 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Wray Common Nursing Home is a care home providing accommodation and personal care for up to 55 older people, who may also be living with dementia. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The accommodation at Wray Common Nursing Home is set over two floors with lounge and dining areas on each floor. The upper floor is fully accessible via two lifts. On the first day of our inspection 49 people were living at the service. On the second day two people had been discharged from hospital and there were 51 people living at the service.

This inspection was carried out over two dates, both of which were unannounced. The first inspection was undertaken early morning on 21 December 2017. This was because we were responding to some concerns we had received about the way people were being cared for. We then returned to the service on 5 January 2018.

The home 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 assisted us with our inspection.

We last carried out a comprehensive inspection of this service on 14 April 2016 when we rated the service as Good.

This inspection was brought forward in response to concerns we had received about the care being provided at Wray Common. Due to the nature of the concerns that were raised, we carried out a focused inspection of the service early in the morning on 21 December 2017. We focused on Safe and Well-Led at this inspection. Following the first inspection date, we spoke with the registered manager to discuss our findings. The second inspection visit was carried out to look at the other key questions that we inspect on – Effective, Caring and Responsive.

Although people received responsive care, we found records relating to people were not sufficiently well maintained and that people were not always being cared for by an adequate number of staff. Although the provider carried out pre-employment checks for care and clinical staff, we found that non care staff had not undergone a police check to ensure they were suitable to work at the service.

People's risks had been identified, however action taken by staff to satisfy themselves that people were kept free from potential risks was not always carried out. People lived in an environment that, although clean, posed potential infection control risks.

Medicines management procedures were not always followed in line with best practice and the legal requirements in relation to obtaining people's consent were not being adhered to. Quality assurance processes in relation to care records and the monitoring of the service being provided were not robust. This included a lack of routine audits on areas such as medicines.

People felt safe living at Wray Common Nursing Home and staff were aware of their responsibilities to ensure that if they had any concerns about the way people were being cared for they should raise this. In the event of an emergency people's care would continue in the least disrupted way possible.

Staff received training to carry out their roles and as such relatives and professionals felt staff were competent. However, we found that staff had not always been given the opportunity to meet with their line manager on a one to one basis. The registered manager was aware of this and addressing it.

People enjoyed the food that was provided to them and told us they could eat their meals in the place of their choice. People had access to health care professionals as and when needed and when people moved into the home staff assessed their needs in order to help ensure they could provide appropriate care. Staff worked in conjunction with external agencies to provide suitable and responsive care to people.

People were cared for by staff who were kind, attentive and respectful to them. People and their relatives gave us very positive feedback in relation to staff and the way that they treated them. We observed gentle, caring interactions between staff and people and it was clear staff knew people and their family members well. People had the opportunity to participate in a range of activities and where they chose to spend time in their rooms they had interaction from dedicated staff.

In the event that people or relatives felt the need to complain they told us they would not hesitate to speak to the registered manager or staff. We saw any complaints received by the service were addressed.

People, staff and relatives felt involved in the service and we heard that people felt the service was well managed. Where ideas and suggestions had been raised these were listened to and relatives told us the registered manager was approachable and managed the home well. Staff told us they felt supported and valued by the registered manager and enjoyed working in the home. The registered manager was aware of their statutory duties in relation to registration with CQC and as such had notified us of any significant events. The registered manager had a clear vision for the service and the care they wished to provide and they worked closely with external healthcare professionals and agencies.

During our inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made three recommendations to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Staffing levels were not always sufficient to meet people's needs promptly.

Risks to people were not always appropriately assessed and managed.

Good medicines management processes were not always followed and people lived in an environment that posed risks due to a lack of suitable infection control procedures.

Appropriate recruitment checks were not always carried out to ensure suitable new staff were employed.

Staff understood their roles and responsibilities in safeguarding people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow the legal requirements in relation to consent.

Although staff received training, they had not always had the opportunity meet with their line manager for supervision.

People were provided with food they enjoyed.

People's needs were assessed when moving into the home and staff followed guidance from external agencies and professionals.

People had access to healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People had warm and positive relationships with the staff who supported them.

Staff treated people with dignity and respect.

People were involved in making decisions about their care and staff understood the importance of respecting people's choices and individual preferences.

Is the service responsive?

Good

The service was responsive.

People's end of life wishes were sought and recorded.

People received responsive care.

Where people had a reason to complain they could follow the provider's complaint policy.

People had access to a range of activities.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was a lack of robust quality monitoring processes in place to ensure people received the best care possible. Records in relation to people were not well maintained.

People, relatives and staff felt involved in the service. Relatives felt the service was well managed and staff felt supported.

The registered manager was aware of their statutory duties and they were very hands on within the service and as such strove to continue to make improvements.

Wray Common 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 was a re-inspection of this service to check whether the provider was 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 an updated rating for the service under the Care Act 2014.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. In the planning of this inspection, we gathered feedback from other health and social care professionals who have recently been involved with the service.

On this occasion we did not request a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was because the inspection was brought forward due to concerns we had received.

This inspection took place over two dates on 21 December 2017 and 5 January 2018, both of which were unannounced. The first inspection commenced at 07:30am and was carried out by three inspectors. This was because we had concerns about the care people received first thing in the morning. During this visit we spoke with three people, one member of staff, three relatives, one visiting professional and two healthcare professionals. We also looked at the care records for five people, medicine administration records, 10 staff files and quality assurance processes and systems.

The second inspection took place during the day and we arrived at 09:30. The inspection team consisted of three inspectors and a specialist nursing adviser. We took an adviser with us on this occasion to look at the clinical aspects of the service.

On the second inspection day we spoke individually with five people who lived at the service, two relatives, seven staff. We observed interactions between people and staff throughout the day and joined people across the service at lunchtime to gain a view of the dining experience. We also reviewed a variety of documents which included the care records for 11 people, medicines records and other documentation relevant to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People were cared for by a sufficient number of staff to meet their physical needs, however we found there were times when staff could not respond as promptly as people should expect. On our first day of inspection the registered manager told us that there were three or four nursing staff on duty each day and 12 care staff. This reduced to two nursing staff and seven care staff in the afternoon. The registered manager was on duty each day but they told us they were supernumerary. We spoke with the registered manager about the significant drop in staff in the afternoons. They told us that they were considering reviewing the staffing levels as they were starting to admit more people with palliative care needs.

On the whole the feedback we received was that there were enough staff to look after people however we had mixed responses. One relative said, "Staff are always nearby. I have never had a problem finding staff." Another relative told us, "They have lots of staff and they are always very attentive." A third said, "Staff are always around." A further relative commented, "There are always enough staff and I see the same staff." And a fifth told us, "When we've accidentally rung the bell staff have come quickly." A visiting professional told us, "I don't usually have to wait for staff and people are always ready for me." A healthcare professional said, "There are always staff around and they are very prompt to assist me." However, some people told us staff were busy and took a while to attend to them. One person said, "Sometimes I feel they are a bit short staffed. Staff are run off their feet. If I press the bell they come but they make take a while." Another person said, "Sometimes I can wait up to 20 minutes." They added, "Staff prop you up for breakfast at 08:30 and then you have to wait and sometimes you wait for a long time." A staff member told us, "There are not enough staff. We do not have enough time with people. People want company and we don't have the time for a chat. We have routines."

We heard at times people using their calls bells and having to wait for staff to respond. We heard a call bell ringing for some time before staff responded to the person. As we approached this person's room we saw two staff come out of another room nearby. We heard one staff member say, "Who's next?" Their colleague replied, "Room xx." Neither staff acknowledged the ringing bell and we observed that it was another ten minutes before a staff member came to the room of the person who was ringing. The staff member did not apologise to the person that they had had to wait. On another occasion a person who wished to go to the toilet had to wait 13 minutes for staff. We also heard a further call bell ringing for nine minutes before staff responded. A senior staff member told us, "I will check the board when passing if I hear it (call bell). If I'm free, I will answer it. If not, I will get the staff who is allocated to that room." Another staff member said, "There are enough staff to carry out the physical care of the residents and to keep them safe, but we have to push ourselves. We have time for a smile and pop our head to say hello and goodbye when we pass by somebody's room. But we don't have to time to spend talking to people to get to know them better."

Following the first day of inspection the registered manager told us that no changes had been made to the staffing levels in the home. However, they told us the provider had agreed to recruit an additional kitchen assistant every day between 08:00 and 14:00. This would free up some staff time as they would not be involved in breakfast and lunch preparation. At our second day of inspection we found once again that staff were very busy throughout the day. We were also told that for a period of one hour only four staff were on

duty on the floor. This was because of staff lunch breaks. The registered manager told us staff would worked in pairs – two upstairs and two downstairs – but acknowledged that these were not sufficient levels and knew that there may be a risk of when staff were in one room not being able to hear someone else calling out. We were told that there were a lot of people who could not use the call bell. The registered manager told us they had raised this with the provider. A staff member told us, "Having an extra person during this period would mean that call bells were answered quicker and personal care would be given quicker." In addition we noted that whilst there were relatives visiting no staff were present in the ground floor lounge area for the majority of the afternoon. We observed staff coming to the lounge to give people their afternoon tea and cake, but did not see staff sitting observing in the lounge. We saw one person regularly attempt to get up from their chair and their relative encouraging them to sit back down. People's walking aids had all been stacked in one corner which meant had people attempted to get up and walk they may have been left in an unsafe situation.

The lack of a sufficient number of deployed staff to respond to people in a prompt manner was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appropriate checks were not always undertaken before staff began work. Criminal records checks had not been undertaken with the Disclosure and Barring Service (DBS) for domestic or administration staff working in the home. This meant that staff who may have access to people's confidential or financial information had not undergone a check to ensure they were safe to work with people who used care and support services. We also found that the registered provider had not always obtained a declaration from staff to say they were fit and well enough to carry out their role. We did however see other relevant recruitment documentation, including employment history and professional and character references in staff files to show that staff were suitable to work in the service. On the second day of our inspection the registered manager informed us that DBS applications had been submitted for all ancillary staff. A member of care staff confirmed to us that they had been asked to provide references and had a DBS check carried out before they started work.

We recommend the registered provider ensures that they meet the requirements of Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to employment of staff.

People and their relatives told us they felt safe with staff. One person said, "Oh yes, I'm safe here. More safe than at home I think." A relative commented, "I like the fact she is opposite the nurses station and they can keep an eye on her." A second relative told us, "I've never had any concerns." A third relative said, "I am really happy she is safe. I can sleep at night."

Risks to people's health were identified and managed but the plans to manage them were not always documented clearly. Care records documented the risks that had been assessed in respect of areas such as skin care, dehydration and malnutrition. However, where a risk had been identified there was not always a clear plan in place to manage it. For example, one person was at risk of malnutrition and dehydration. Although staff had taken appropriate action in that they had sought advice from the dietician in relation to this person, they did not keep a record of this person's food and fluid intake. The registered manager did tell us however on the second day of our inspection that they had requested a visit from the GP in relation to this person and they routinely fortified the full fat milk with full fat milk powder. They also told us that this person did not wish intervention and that they respected this. Another person's care plan stated, 'monitor the amount of food eaten at mealtimes' but this was not being recorded by staff. A staff member told us about one person, "He's isn't very well…. we need to take a note of his diet". However this person did not have a food chart in place. A lack of recording of people's weights and food intake may mean that the provider will not have records to satisfy themselves that people were maintaining a healthy weight. Food

and fluid charts enable staff to decide on the most appropriate intervention for a person and provide vital information in the formulation and review of a person's care plan. Fluid records can give information about the pattern of drinking of a person and is important especially for people with poor fluid intake and those who are unable to communicate verbally. Fluid records can be used to plan care effectively around times when people's fluid intake was highest. A staff member told us, "We ensure everybody gets enough fluid by asking staff to encourage people to take fluid. We don't record the amount of fluid people take."

People with risks of falls from their bed had bed rails and bumpers fitted to their beds to prevent the risks of entrapment. However, the risk assessment completed in relation to people using bed rails only covered consent to the use of bed rails and did not consider the risk of entrapment. We noted one person had difficulty in swallowing. Staff had referred the person to the Speech and Language Therapy team and as such were following their guidance in relation to food and drink. However, there was no choking risk assessment in their care plan to indicate the action staff should take in the event of choking.

Although people lived in an environment that was clean we found environmental risks had not always been considered. We noted that jars of thickening powder were being stored on the ledges in the main lounge areas both downstairs and upstairs. We observed people walking past it without staff present. Although people did not appear to be at risk of picking it up and inadvertently ingesting it, the thickening powder was not being stored in line with an NHS England safety alert in 2015 that recommended that thickening powders should be stored securely, out of reach of people. We found the doors to the sluice rooms (rooms where staff clean soiled equipment) had no locks on them, a cleaners storage room was unlocked leaving people able to access cleaning fluid and a door to the laundry room was not locked which meant people had access to washing fluids and powder. The sinks in two sluice rooms were dry, however bins had soiled waste in them indicating staff had been in there but had not washed their hands. In a third sluice room there was nowhere to put soiled waste as there was no clinical bag. A staff member told us, "Some staff don't like using the sluice room sinks as the rooms are not very nice." We asked one staff member about the process of hand hygiene in relation to soiled laundry and they told us, "I use the sink to wash my hands." We pointed out to them the sink was dry and they told us, "I haven't used it today." We found bagged soiled and non-soiled clothing together with each other on the floor of the laundry room. There were no designated clean and non-clean areas and whilst talking to a staff member we observed them start to sort through these bags without gloves on. The provider's infection control policy stated, 'hand washing will be carried out using un-perfumed liquid soaps' however we found bathrooms contained perfumed liquid soap. However, we saw housekeeping staff cleaning throughout the day and did not find any malodours within the home. A relative told us, "There is no smell in the room or the home. She is incontinent but it has never been an issue" Another said, "It's always clean when I visit and it never smells."

The lack of ensuring people were receiving safe care and treatment in relation to individual and environmental risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to manage medicines safely. However we found protocols for 'as needed' medicines (PRN) such as painkillers were not in place for each person. These guidelines are particularly important for people living with dementia as they may be unable to communicate that they require pain relief. On the second day of our inspection the registered manager told us they had been in contact with the GP and they now had generic PRN forms to complete for people although they had yet to do this. We also found that staff were not checking the temperature of the main clinical room. This is important to help ensure medicines are stored at the optimum temperature, as outlined by the manufacturer. One staff member told us, "This room is very hot and we normally put the fan on because it is unbearable otherwise." In addition, staff did not always record the opening date on bottled medicines. They told us they went by the

date printed on the pharmacy label, however we found a bottle of homely medicines (medicines that can be purchased over the counter without a prescription) that had neither an opening date or pharmacist's label. Clinical staff were failing to use sharps boxes appropriately (sealed containers which store used needles). We found two sharps boxes in use at one time. We were told, "I don't know why staff are using two boxes at the same time, they should close one when it is full and use a new one." Both sharp boxes did not have the name of the staff who assembled them on or the date of opening. There was no information on sharps injuries in the clinical room which is important to ensure that quick and appropriate action is taken should an incident occur. We spoke with the registered manager about all of these areas during and at the end of our inspection. Following the inspection they sent us their up to date medicines policy to show they were addressing these areas.

We recommend the registered provider ensures that best practices in relation to medicines processes are followed at all times.

Each person had a Medication Administration Record (MAR chart) and we found these had been completed properly and without any gaps. We observed the nurse administering medicines to two people and saw that they checked the person's MAR, dispensed the medicine into a cup and took it to the person checking they had taken the medicines before signing the MAR. One person told us, "I get my pain tablets when I require it and I have all my medicine on time." A relative told us, "They know whenever he is in pain and they keep him comfortable."

Where people were at risk of pressure sores and they spent their time in bed staff did not keep records of when people were repositioned. One person's night care plan stated, 'ensure she is repositioned 3-4 hourly during night time'. We saw that staff had undertaken hourly checks on this person during the night, but they had not noted when or if they had repositioned the person. The registered manager told us this was done routinely three or four times at night and before lunch in the day and again in the afternoon. Although a healthcare professional confirmed they had seen staff reposition people and had no concerns about people's skin breaking down they also told us they knew that staff did not record this. We asked the registered manager how they could assure themselves that people were being repositioned and they told us that no one had developed a pressure sore from lying in the one position for too long and that the nursing staff checked it was happening. On our second day of inspection the registered manager showed us they had introduced repositioning charts for people who were being cared for in bed. We looked at the repositioning charts for some people and found that staff were repositioning people in line with what we had been told.

A health and safety check was routinely carried out. This covered all aspects of the service and the environment. Routine checks of fire safety equipment were completed as well as fire drills. In the event of an emergency people's care would continue with the least disruption and staff would know what action to take in the event of a fire. Staff had undergone fire training and there were routine fire drills held. Where people had accidents and incidents, action was taken in response to these. A relative told us, "She had falls so they moved her bedroom to downstairs and put in protective mats around her bed."

People told us that staff treated them well and as such we found staff understood their roles and responsibilities in safeguarding people. Staff were able to list categories of abuse and confirmed they had received training. One staff member told us, "If they were acting differently or their personality was different I would worry. If I noted they were timid or scared I would question this. I would always be looking for marks. If there was anything I would go to matron. I would not be too shy to say anything." Another staff member said, "I know the residents. If something had happened I would pick up on the change in personality." Staff were clear about the need to report any safeguarding concerns. They told us they would report abuse to

outside agencies if necessary and knew where to find the contact details for these.

Requires Improvement

Is the service effective?

Our findings

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked to see if staff were following the legal requirements in relation to consent. We saw two people had mental capacity assessments in relation to their personal care and another person who had been at the home for a short while had a mental capacity assessment completed. However, people who we were told were living with dementia were found not to have had a mental capacity assessment carried out for them. People's records contained a DoLS screening tool but this did not reflect the 2014 Supreme Court judgement and as such did not record whether a person was under continuous monitoring and supervision of they would be free to leave the home if they wished. One person did not have the capacity to make the decision to live at Wray Common Nursing Home however there was no mental capacity assessment or best interests discussion and decision with regard to this. Other people who lacked capacity to consent to them, had bed rails and yet we did not see records of mental capacity assessments or best interests decisions in relation to these.

The failure to follow the legal requirements in relation to consent was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to explain to us their understanding of the MCA. One staff member said, "If they can make choices for themselves and if they understand the choices and the consequences. However, if they don't you have to assess their capacity. It's putting their best interests first." Another told us, "It's when you are restricting someone like putting up bed rails to stop them getting out."

Although staff received annual appraisals they had not had the opportunity to have regular one to one supervisions which would give them the chance to speak to their line manager in a confidential setting. The registered manager told us they were aware that supervisions had not been taking place and had started afresh for this year. As such staff were not being provided with supervision in line with the home's policy and that was that staff should have supervision every second month. To date the registered manager had carried out supervisions with the nursing staff. A staff member told us they could not remember when they last had their one to one.

We recommend the registered provider ensures staff receive supervision in line with the provider's policy.

People were cared for by staff who received appropriate training. One relative told us, "She has to be hoisted out of bed. The staff seem perfectly fine using it (the hoist)." A staff member said, "Training is good. We do online and face to face. With face to face we actually go in the hoist. It helps us to understand how the residents feel." A healthcare professional told us they felt that the nursing staff seemed competent and they had all the right observations and information to inform their judgements when they visited people.

Assessments in relation to people's health care needs were carried out upon admission to check that staff were able to meet people's needs. People's skin integrity and risk of developing pressure ulcers were assessed using the appropriate scoring tool. Where people came in with a pressure ulcer the service had ensured they had appropriate measures in place to provide good care. There was adequate equipment in place for people who required pressure relieving equipment, hoists for transferring or mobility aids to allow them to move around the home independently.

Staff followed guidance and policies from professional bodies. For example, we noted that the service held advice sheets on Warfarin and anti-coagulant medicines. The service worked closely with the local hospice and as such followed their guidance in relation to looking after people who were receiving end of life care. People who had Parkinson's had been referred to the Parkinson's specialist and their recommendations formed part of the person's care plan.

People gave positive feedback about the food they received. One person told us, "We have what we want to eat. I shall have scrambled eggs for breakfast, that's what I like every day." Another person said, "It is absolutely fantastic food."

Where people had specific dietary requirements on the whole this was known by staff and the chef. However, we found the chef was not always aware of the most up to date information about people and people did not always get a choice. For example, one person was a diabetic and yet the chef did not know this. The chef told us that 15 people were on a pureed or soft diet and they kept this information, "In my mind". They said that people on pureed or soft diets did not get a choice of meal and if someone was vegetarian the only choice they would offer them was an omelette. The chef did not meet with new residents to discuss their menu preferences and as such did not ask for feedback on the foods they cooked. We spoke with the registered manager about this at the end of our inspection who told us that food was discussed at the residents and relatives meetings. They said they would address our concerns around the lack of choice to people.

People received the healthcare they required and had access to healthcare professionals when they required them. We saw two doctors visiting during our inspection on the first day. Staff had called them in to see three people who they were concerned about. There was also evidence in people's records that staff involved other healthcare professionals such as the dietician and speech and language therapy team. A relative told us, "The nurses are fantastic. She has never had to go back into hospital since she has been here." Another told us, "They have been very good with that (health care) and they involve the hospice." One healthcare professional told us, "They are very good and very clinically aware. They are quick to recognise things." Another said, "I actually think the care that [name] received is excellent." Health professionals told us they got good information from staff and risks were well managed.

Good

Is the service caring?

Our findings

People told us staff treated them kindly. One person said, "Very good nursing home. Staff are very kind and senior staff are excellent." Another told us, "They couldn't do more for me than they do. They are very kind to me." A third person commented, "The staff are kind. I was up at three this morning and they gave me a cup of tea. I'm an early riser but they know that I'd have a lie down later in the day." A fourth told us, "I think they are brilliant people."

This was reiterated by the relatives we spoke with. One relative told us, "Lots of good staff and nothing but kindness." Another relative said, "It's fantastic!" Another relative said, "The staff are very jolly and caring. They always offer us a drink when we're here." A fourth relative told us, "They are very good, they are loud which really encourages him and gets him engaged."

People were treated with kindness. During the medicines round we observed staff knocking on people's doors and crouching down to people's level to speak to them. Staff spoke clearly and gently to people and where they had to wake one person to ask them if they would like their medicines they did this in a gentle way. A relative told us, "She was always washed and dressed. We chose this place because of the nursing care." Another relative said, "She always looks nice and they (staff) do her nails. She is always clean and I have never had an issue." This person liked to have their hair done each week and we saw that they were with the hairdresser on the first day of our inspection. Their relative told us how important it was to this person to have their hair looking nice. We watched when two staff members transferred one person with a hoist. One staff member held the persons hand and they were lowering them gently into the chair giving gentle explanations and reassurance. One person told us, "The staff are very good. They are very nice here." Another person said, "It is absolutely lovely here. There is nothing that could make it better."

On the whole people were shown respect. We observed staff knock on people's doors or asking if they could enter when people's doors were open. As staff entered they greeted people by saying, 'hello' and telling people what they were there to do. One staff member went into a person's room and said, "Good morning [name] are you alright? Do you need help?" We watched as the staff member assisted the person with their drink. A relative told us, "Staff are really nice." We did however observe some occasions when we felt staff could have shown more respect towards people. We spoke with the registered manager about this at the end of our inspection as these incidents related to a couple of staff members only. They told us they would address this immediately.

Staff were attentive to people and showed concern. We watched as a staff member assisted someone to sit in a chair. We heard the staff member say to the person, "Just stand and get your balance first before you move to the chair." During the afternoon staff went into one person's room with a cake and sang Happy Birthday to them. One person told us, "Staff are kind and gentle." Another person said, "The staff couldn't be better."

Staff spoke fondly about people and we observed caring interactions from staff. There was a friendly exchange between a member of housekeeping staff and one person in their room. As they left the person

told us, "She (staff) is very good she is – such a nice lady."

People were cared for by staff who knew them. One staff member was able to describe people in good detail – what they did for a living, medical conditions, family, etc. They knew people's allergies, what support they required and how they required their food to be prepared. We noted the majority of people's care plans contained good and detailed background information about people. This included what they used to do as a job, their past times and information about their families.

People were enabled to have privacy if they wished and to make their own choices. One person we spoke with chose to remain in their room most of the time. They told us this was their choice and staff respected this. Another person liked to eat their meals in bed and again they said staff respected their wishes. We saw people return to their rooms during the afternoon for a rest or spend time with visitors and relatives in the privacy of their rooms.

We saw throughout both days of our inspection that people received regular visitors. One person told us, "I have a friend visit me every day and my daughter comes too." Visitors were friendly with staff and it was clear they were regular guests in the home.

Good

Is the service responsive?

Our findings

People on end of life care received appropriate input from external professionals. The registered manager told us they already worked well with a local hospice, but planned to work more closely in the future. This was because they had several people who were receiving palliative care. We found people had advanced care plans with details of the person's preferences with regard to their spirituality, preferred place of care and who they wanted to be contacted at the end of their lives.

People were receiving responsive care although we found that some records in relation to people's care were not as up to date as they could be. We have addressed this under our Well-Led domain. People's care plans contained areas of information about them which covered all aspects of their care, such as nutrition, pressure sore risk, falls risk, medical information and personal care needs. We read that people were weighed regularly and where someone had experienced weight loss staff had alerted the GP. Where we read statements such as, 'prompt and encourage to help to be brought into the lounge' we saw this happened. Where people had particular medical conditions, such as epilepsy or Parkinson's we found guidance in place for staff. Some people had catheters in place and there was guidance for staff on how to ensure these were cared for appropriately so as not to leave the person at risk. A relative told us when their family member returned unwell from a day out staff were very attentive towards them and on another occasion when they mentioned their family member had a sore, staff treated this straight away. A relative told us they felt their family member received responsive care by staff. They told us, "They are doing the best that they can."

One person suffered from epilepsy and there was a seizure care plan in place which gave guidance to staff. This included, ensuring the person was in a safe environment when having a seizure and keeping a record of the type and length of the seizure. This same person had a vision impairment and guidance included, 'make sure any items he needs are near him, explain where things are and ensure call bell is within reach'. We saw staff had ensured this.

Relatives told us they would feel comfortable raising any concerns, although they had not felt the need to. One person told us, "I found my food was cold so my daughter said something to matron. It was sorted and it's a lot better now." One relative said, "If I mention any little thing, they're there and it's done." Another relative told us, "I have not had to make a complaint. There has been the odd little thing, but it's been sorted with matron." The service had a complaints procedure which outlined what people could expect from the provider in response to any complaints or concerns they had. We noted that the complaints policy stated that CQC would respond to people's individual complaints if they were unhappy with the response received from the provider. We spoke with the registered provider about this and asked them to amend the policy to show that people should approach the Health Ombudsman in this instance, rather than CQC. The registered manager informed us they would make this change.

People had access to a range of activities. One person told us, "We have [name] for activities. She has so many ideas. We've been doing all the Christmas things." They later showed us some of the Christmas decorations they had made. A relative said, "They do music and things with him. The activities lady is very

good." During the afternoon of our second day of inspection an external musician carried out a session and people appeared to be enjoying it. During the morning the activities co-ordinator held a quiz and ensured that each person in turn had the opportunity to participate. A staff member told us, "Yes, [name] does lounge activities then goes around to people's rooms. Volunteers also come to do one to one's in their rooms." The registered manager told us they had good links with a local school and the children visited regularly. Other external activities people came into the home, such as pet therapy and there were pictures displayed in the main lobby area of the home showing particular events that had taken place. Where people spent the majority of their time the activities co-coordinator carried out one to one visits. This was confirmed by all the staff members we spoke with. The activities programme covered a range of interests, which included quizzes, baking, external events and special occasions, such a Christmas or Halloween. A relative told us, "I wasn't looking forward to the Christmas party if I'm honest but it was really good fun."

Requires Improvement

Is the service well-led?

Our findings

Internal auditing and monitoring lacked robustness to help ensure that people received good, high quality care. The audit schedule detailed what audits should be completed each month. This was last completed in June 2017 and some audits had not been carried out since then. Staff held a wound audit however this was last done in March 2017. It showed a score of '2' throughout, but there was no indication on the audit as to what that meant. The registered manager did not carry out any analysis of call bell response times. They told us this was because the system they used could not produce this type of information. We spoke with the registered manager about the need to monitor call times in order to assure themselves people were being responded to by staff in a prompt manner. At our second day of the inspection the registered manager told us they commenced daily half-hour monitoring of the call bell response times. At present however we heard this was done by whichever staff member was available and was yet to be embedded into routine practice.

Accidents and incidents were recorded, however there was no analysis of trends to identify whether further action was required for people. We found that some incidents were not logged in the accident and incident book which meant staff may be unaware of the level of incidents some people were experiencing. For example, we identified one person who had several skin tears on one side of their body. Although we found some of these incidents had been recorded, others had not. The registered manager and nurse were unaware of the regularity of skin tears for this person. Although we were told they were small skin tears this was not clear from the record as the incident reports did not record the size and there were no completed body maps for this person. This meant that the registered manager would be unable to identify whether staff required further moving and handling training, or this person needed the input of external healthcare professionals. One person had had five falls in a period of one month and although upon speaking with the registered manager action had been taken to help prevent further falls, we did not find any records within this person's care plans to demonstrate this. We found another person had a sore and although they told us and staff confirmed appropriate treatment had been provided, records in relation to this sore had not been recorded on the person's care plan. We spoke with a member of staff about this who told us, "It should have been recorded." Following the first day of our inspection the registered manager told us they had met with the nursing staff and a record of skin tears was now being kept. This was a positive step, however we reminded the registered manager that it was important that accident and incident records were analysed routinely to look for trends.

We noted the last care plan audit was March 2017. We spoke with the registered manager about this who told us that they were looking to allocate a lead nurse to this and would be discussing this with the nursing staff at their next meeting. Medicines audits were not carried out and the clinical staff were unaware of doing any such audit. The registered manager told us there had not been a pharmacy medicines audit, "For ages" and they could not find the last audit report. In addition to auditing medicines procedures and MAR charts, people who are on transdermal pain patches should have had an application record completed (TPAR). This would evidence removal as well as administration of patches. The site of administration of patches should be rotated and recorded on the TPAR. We were told by the senior nurse and registered manager, "We do not use TPARs and we don't use pain charts to monitor pain." This meant that when one person's analgesia was increased in November 2017, it could not clearly be justified by the records held by the service. In addition a

clinical staff member said, "[Name] patches come off frequently. When that happens we replace it and place it on the opposite side." However, without the use of a TPAR record it was difficult to see how the nurse could ensure that people were receiving analgesia in a safe and effective manner. Following discussion with the nurse and registered manager the registered manager devised a TPAR for pain patches which they said they would develop further and put into use. In addition, they told us that they already had a policy of attaching yellow stickers to people's wardrobe doors if they were on pain patches which they felt would make staff more aware of checking the patches were still in place.

Records in relation to people were not always maintained accurately. For example, people had daily pressure mattress check lists but we noted that for some people staff had not indicated each day that they had checked the person's pressure mattress was working properly and put on the right setting. One person's pressure mattress setting had not been recorded, although their care plan stated, 'staff to ensure it is on correct setting'. We read that this setting ranged from 60kg to 80kg seemingly at random and there was no written information as to why the setting changed. One person's daily mattress checks were only recorded on three occasions for December and another five times in January?

Other documentation was lacking further detail for staff which may have helped them provide person-centred care. One person had a poor appetite. Although they had been seen by the dietician they had been discharged because they had refused supplements. The registered manager and deputy manager told us they had stopped checking this person's weight because they could not help this person any further if they refused to eat. We noted their care plan stated, 'find out favourite foods, offer alternatives, offer snacks and fortified foods'. We spoke with staff about this as there was no further information about the type of foods this person liked. Staff were able to tell us immediately that they liked jacket potatoes and ice cream and would eat these every day if they could. This meant that staff may not have looked at alternative ways in which to support this person to maintain a healthy weight. We spoke with the registered manager about this on the second day of our inspection who told us, "Staff are probably always offering them that." However, the registered manager had no way of demonstrating this was happening. If a food and fluid chart had been kept staff would have been able to have monitored what foods this person was being offered. One person had lost three kilograms in a month but again no food or fluid chart had been introduced. In addition this person had hypertension but there was no care plan in relation to this and their diabetic care plan gave information around the signs of hyperglycaemic attack (caused by high blood sugar levels) but nothing in relation to hypoglycaemic attack (caused by low blood sugar levels). The same person had recently been seen by the doctor but their care plan had not been updated. We spoke with a nurse about this who stated this should have been done and that they would raise it at handover, however when we checked the handover book it had not been recorded. A further person had a catheter. Their care plan stated, 'monitor urine output and record it' but this was not being done. Staff told us they would verbally tell each other is something was not right, but they did not record this anywhere. This same person had multiple sclerosis but there was no care plan in place for this. Although information was gathered about people's preferences, likes and dislikes this was not used to construct their daily routines. For example, the time people received their personal care did not always take into account the time they preferred to have a wash. A staff member told us, "(People have their wash) depending on who is up first and this varies from day to day."

The lack of robust quality assurance monitoring and record keeping was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had a hands-on approach within the service and it was clear observing their conversations with relatives and professionals that they were visible and involved. In turn the registered manager told us they felt supported by the registered provider. They said, "They are interested in the residents and very supportive. If I make suggestions they will listen and act." They told us the providers had

built a patio to one side of the garden for residents as they had suggested more outside space would be beneficial to people. Furthermore, relatives had commented there were times they had to wait for the front door to be answered. As such the registered provider installed a key entry system of which the key code was known only by senior staff, nursing staff and relatives.

The registered manager had visions to continue to improve the service provided. They told us they had a dignity team in place and said, "I want to promote that more." They also told us about working with community groups to bring more people into the home, such as a local toddler group visiting regularly. In addition, they had recently introduced 'employee of the month'. At present this was open for staff to nominate each other but would be raised at the next residents and relatives meeting with a view to opening it out for everyone to submit nominations. The registered manager said the culture within the team was, "Quite good" and that the registered provider was good at arranging team building events for staff. We found on both days of our inspection the registered manager was open to our suggestions and discussions around the areas that we had identified. They responded promptly where they could take action quickly and we felt assured that they would start to address the other areas as soon as possible.

We asked staff about the values and vision of the service. One senior staff member told us, "Top quality care, a family feel that's not institutionalised. Looking after wellbeing and care needs." We asked how these values were shared throughout the staff team and were told, "Through training. We work with new carers and show them the priorities. We make sure they read all of the care plans. It's important to have information on their past and present. We share the work, if you are not stressed it reflects on the residents." A staff member told us, "We are here to care for the residents 100%. Have compassion for them. Make them feel like they are in their own home." Another said, "We give them all they need. It's team work and I work with good people. I'm happy."

The registered manager kept up to date with best practice and worked with external professionals to share knowledge and expertise. They were on the local hospital's board looking at how hospital admissions and discharges could improve to help ensure people were discharged back to the nursing home as soon as possible. They were also part of the nurse advisors forum and on the registered manager's Skills for Care scheme. A health professional told us, "[Registered manager] is very good at advanced planning."

Staff were involved in the running of the service and felt supported. Staff told us they had staff meetings every six months. They said their handover was also like a mini staff meeting each day as they could talk about anything they wanted during that time. From general staff discussions the lunchtime routine had changed and those who took longer to eat were served their meals first. We noted in the May 2017 meeting the nursing staff discussed medicines, care plans, documentation, staff skill mix and revalidation. There was also a discussion about staff not always knowing what quantities to use when mixing thickening fluids. As a result the deputy manager had held a practical session with staff, which was rolled out and now formed part of new staff induction. A staff member told us, "Matron is very lovely to approach. She always listens and takes into account what we've said and responds. I've never not had support for things here." Another said, "[Name] is very nice. Lovely to approach. Makes time to spend with me. I feel supported, I've always got the nurses with me or I can go straight to the office." A third staff member told us, "The manager is very kind and approachable. Her heart is in the right place. She is very well liked by the staff. She really cares for her staff and the residents."

Relatives and stakeholders felt the home was well managed. One relative told us, "Very efficiently run." Another relative said, "I've seen improvements since [registered manager] has been here. The signage has improved, we now have residents and relatives meetings and activities are going on." A third relative said, "The matron is fantastic, she has always got her door open." A healthcare professional told us, "[Registered

manager] is very competent." The registered manager told us on our second day of the inspection that they had arranged for a residents meeting to be held on 25 January and a relatives and residents meeting on 27 January 2018. Following our inspection we received positive feedback about the home from a relative.

The registered manager was aware of their statutory duties in relation to their registration. As such they sent in notifications to CQC of important events that took place within the service. This included accidents and incidents and safeguarding concerns. The registered manager discussed with us how they liaised with the local safeguarding team if they had any concerns and following a recent safeguarding incident and provided the local authority with all the information they required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had failed to follow the legal requirements in relation to consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure people's individual and environmental risks were being managed.

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 The registered provider had failed to ensure there were robust quality assurance processes in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide sufficient numbers of staff to respond to people in a prompt manner.