Castel Froma

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 9 and 10 November 2016 and was unannounced.

Castel Froma provides nursing and rehabilitative support to a maximum of 57 people suffering from a neurological disability. Most people also have highly complex medical conditions requiring continuous care and support or highly specialised nursing. The home is divided into three units over two floors. On the lower ground floor there is a therapy unit with a hydrotherapy pool, physiotherapy room and an occupational therapy assessment room. A range of on-site therapists provide rehabilitative input. There are large communal areas and extensive grounds which are accessible to the people living in the home.

We last inspected the home in October 2015. After that inspection we asked the provider to take action to make improvements in management of medicines in the home. The provider sent us an action plan to tell us the improvements they were going to make. At this inspection we found improvements had been made.

A registered manager was in post. 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.

Staff were proud of the service they provided and committed to providing high quality, compassionate care. Staff were friendly and thoughtful and took time to understand the needs of people with no or limited verbal communication. Staff treated people with dignity and respect and understood the importance of making them feel valued.

Friends and family were welcomed into the home and able to visit when they wished. Staff showed an awareness of how families and friends needed their support to manage their emotional needs and understand people's conditions.

There were enough skilled and experienced staff on duty to meet people's care and support needs safely and effectively. Staff had the necessary knowledge and information to ensure people were kept safe from abuse or harm. The provider's recruitment process was thorough and ensured, as far as possible, staff were of a suitable character to work with people who lived at Castel Froma.

Staff had clear guidance on how to mitigate identified risks associated with people's health and well-being. Risk assessments were an essential part of keeping people safe, and some risk assessments were for 'positive risk taking' which promoted people's independence. The provider had procedures and policies to ensure the safety of the environment and equipment in the home. People's medicines were managed, stored and administered safely.

People received care from a multi-disciplinary staff team who were qualified and trained to meet their needs

effectively. Staff were encouraged to undertake additional training and qualifications relevant to their roles. Nurses were offered reflective practice sessions where they could discuss any issues with their work.

The rights of people who were unable to make important decisions about their health or well-being were protected. Staff followed the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were assessed on an on-going basis by dieticians and speech and language therapists (SALT) who visited the home every week to ensure people's nutrition plans met their medical and health needs.

People's medical and personal needs were assessed and care and support was planned and delivered in line with their individual care plans. Each person had a named nurse who co-ordinated their care and regularly evaluated care plans to ensure they continued to meet the person's health and medical needs. Staff knew and understood people's needs and how to support them. Staff worked closely with a range of external healthcare professionals to monitor and maintain people's health.

People were supported to achieve personal goals through rehabilitative input from physiotherapists and occupational therapists. Staff celebrated and were proud of people's achievements in attaining their goals.

Whilst some staff felt included, valued and supported within the home, others did not. Care staff told us they felt the demands on their time were not always understood and there was inconsistency when senior managers gave instructions and directions outside their own areas of responsibility. They were not confident their concerns were always listened to.

There was a clear management structure in place to support the management and governance of the home. The provider completed various audits and checks to ensure the service people received was safe, effective and responsive to people's needs. The provider's quality assurance system involved asking people and their relatives about their experience of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were enough staff to provide effective care in a safe way. The provider checked staff's suitability for their role before they started working at the home and that they had the appropriate skills and qualifications. Risks to people's health and welfare were assessed and plans implemented to minimise the identified risks. Staff ensured people who lived in the home were safe and protected from abuse and harm. Medicines were stored, given and managed safely.

Is the service effective?

Good

The service was effective.

Staff had the training they required to meet people's needs safely and effectively. Staff worked within the principles of the Mental Capacity Act 2005 and supported people to take part in the decision making process. Relatives and the appropriate healthcare professionals took part in the best interest decision process when people lacked capacity. People were supported to eat and drink enough to maintain a balanced diet that met their individual needs. The provider worked with a range of health professionals to ensure people received the support they needed to maintain their health.

Is the service caring?

Good

The service was caring.

Staff were compassionate and thoughtful and communicated effectively with people. Staff made time to know and understand people so they could build positive relationships with them. Staff showed kindness and knew how to show empathy when people and their relatives faced challenging situations. People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and people and their relatives were fully involved in the planning of care, treatment and support. Staff knew and understood people's needs and delivered support in accordance with their care plan. Staff were flexible and responded to people's changing needs or wishes. People were supported to achieve personal goals through rehabilitative input from the therapy team and were encouraged to take part in a range of activities.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People were happy with the care they received and staff were proud of delivering a high quality service. There was a clear management structure in place to support the management and governance of the home. Not all staff felt included, valued and supported within the home because communication between managers and some staff was not always effective. The quality assurance system involved asking people and their relatives about their experience of the service. Audits and checks were carried out to ensure people received a good quality service that was effective, safe and responsive to their needs.

Castel Froma

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.

The inspection took place on 9 and 10 November 2016 and was unannounced. The inspection was undertaken by two inspectors, an inspection manager, a pharmacist inspector, an expert-by-experience and a specialist advisor. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge of nursing people with neurological conditions.

The provider had completed a provider information return (PIR). The PIR 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 reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

We spoke with seven people and nine relatives about what it was like to live at the home. We spoke with three nurses, nine care staff, two therapy staff and one support member of staff about what it was like to work at the home. We spoke with the registered manager, clinical lead nurse and human resources manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed five people's care plans and daily records to see how their care and treatment was planned and delivered. We looked at 10 people's medicine records. We checked whether staff were recruited safely,

and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection in November 2015, we had identified medicines were not always managed safely in the home. This was a breach of the regulations and we asked the provider to make improvements. At this inspection we looked at the management of medicines including the medicine administration records (MARs) for 10 people. The provider had received medicine management support from the NHS and local clinical commissioning group. We were shown their report dated April 2016 which recommended what action should be taken. The service undertook regular medicine audits and any issues with medicines were identified. We were shown examples of learning from these audits and what lessons were learnt to prevent them happening again. We found that medicines were managed safely.

Medicine storage was secure with access only by authorised members of staff. People's medicines were labelled individually and kept secured in locked medicine trolleys. The keys for medicine storage were held by the nurse in charge. Controlled drugs which require separate secure storage arrangements were stored securely in a dedicated controlled drug cupboard. Medicines were stored within the recommended temperature ranges for safe medicine storage. Arrangements were in place to ensure that medicines with a short expiry were dated when they were opened to ensure they remained effective.

People's medicines were available to give to treat their diagnosed health conditions. MAR charts were completed to document if people had been given their prescribed medicines. We observed a nurse administering medicines from the medicine trolley. This was undertaken following safe practice to ensure the correct medicine was administered and recorded on the person's MAR chart.

Arrangements were in place for accurate medicine stock checks. This meant it was possible to check the balance of all medicines to ensure they had been given as prescribed. We found that all the balances we checked were accurate. Although there was a record for the quantity of medicines received from the pharmacy, the actual date of receipt was not recorded. This is important to ensure audit trails are accurate, for example in the event of a query. The clinical lead assured us this would be undertaken in the future.

Supporting information for staff to safely administer medicines was available and easily accessible. There was clear documentation for the site of medicine patch applications on a person's body. This was particularly important for pain relief medicines so nurses were aware where a medicine patch was located. When people were prescribed a medicine to be given 'when required' we found person centred information was available to enable nursing staff to make a decision as to when to safely give the medicine.

Any changes or additions made to people's medicines by a doctor were recorded and kept together with their MAR charts. This information was very helpful for nursing staff to quickly check that the correct medicine and dose was being administered.

People told us they felt safe living at Castel Froma. One person told us, "I would speak to staff if I feel unsafe." No relatives we spoke with had any concerns about the safety of their family members within the home.

Staff explained how they ensured people who lived in the home were safe and protected from abuse and harm. They had received safeguarding training to help them understand their responsibilities and there were procedures and policies for them to follow should they be concerned that abuse had happened. Staff demonstrated a good understanding of the different forms abuse could take and told us they would report any concerns immediately to the registered manager or clinical lead. A typical comment was, "I would tell [name of clinical lead] and report it." Staff were clear they would escalate their concerns if they felt appropriate action had not been taken. One staff member told us, "I would keep track that what I had reported was being dealt with. If nothing was done, I would report it to the safeguarding people if the manager had not done so." A staff noticeboard displayed information about 'what safeguarding is and actions to take'. The clinical lead explained, "This board is a constant reminder to staff about what to look for and what to do." The registered manager understood their responsibilities to safeguard people from actual or potential harm and to report and concerns to the local safeguarding team and CQC.

The registered manager told us they had a consistent staff team, many of whom had worked at the home for a long time, which provided people with a consistency of care that met their individual care and support needs. Due to the complex nature of people's medical and health needs, care staff generally worked in pairs when providing personal care. One staff member told us that when agency staff were used, they were always paired with a permanent member of care staff. This ensured that people always received their care and treatment from at least one member of staff who knew them well and their personal routines and preferences.

People and relatives felt there were enough nursing and care staff to keep people safe and meet their needs. One relative told us, "There are enough staff because [person] always gets the care they need and this has improved in the last year."

Staff felt there were enough staff to provide effective care in a safe way. However, care staff sometimes felt pressured and said they would like to have more time to spend with people outside of meeting their care needs. One member of care staff told us, "The staffing level is safe, but it would be lovely to spend more time with people. An extra pair of hands would be nice." During our visit there was a staff presence in communal areas throughout the day. Staff were busy, but not rushed and apart from two occasions, call bells did not ring for any extended length of time.

The registered manager told us that each week there was an analysis and review of the number of care hours each person required each day. This information was used to determine how many staff were needed to treat and care for people on each shift. They explained, "If we are admitting a new resident, we will look at the staffing and see if we need to increase the numbers. We do discuss it each time there is a change."

The provider's recruitment process was thorough which meant risks to people's safety were minimised. The human resources manager obtained references from previous employers, checked people's identity and ensured that professional registrations for nurses were up to date with no concerns about their professional conduct. Checks were made to see whether the Disclosure and Barring Service (DBS) had any information about newly recruited staff. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with people who use services. All staff had to wait for the checks and references to come through before they started working in the home. The human resources manager told us they planned to complete additional DBS checks for long serving staff to ensure they continued to be of good character to keep people safe.

Risks to people's health and welfare were assessed and plans implemented to minimise the identified risks. The therapy manager explained that the therapy team were fully involved in supporting nursing and care

staff in managing risks. Therapy staff were involved in assessing people's needs before they moved to the home to determine whether the service could meet people's specific needs safely. When people moved in, there was a further assessment and risk management plans were completed to keep people safe. These plans were communicated to all staff involved in supporting people's care needs and reviewed regularly to ensure they reflected any changes in people's health.

We looked at how the risks to one person who was at risk of skin breakdown were managed. The person had appropriate equipment in place to reduce the risks. Records demonstrated that care was being provided in accordance with the person's risk management plan. Other risk management plans related to other aspects of people's care, such as risks around nutrition, choking and falls. For people who were unable to mobilise independently, their care plans described the number of staff and the type and size of equipment needed to support them safely. Equipment was checked regularly to ensure it remained safe to use and some stock equipment was kept on site. One staff member told us, "If anything goes wrong with the bed, bedrails or mattress, maintenance can replace them almost immediately."

A physiotherapist explained that whilst risk assessments were an essential part of keeping people safe, some risk assessments were more about 'positive risk taking' rather than preventing people from doing things or restricting their independence. For example, they told us about one person who received physiotherapy to strengthen their leg muscles so they could weight bear. We were told this person could be going home and to reduce the level of risk in their home environment, therapy staff wanted them to mobilise using a stand aid, rather than a full hoist. They said that risk assessments had identified the potential risks, but by working with the person and supporting them in line with the risks management plans, the person received safe support to achieve their own personal goals and ambitions.

Staff were aware of the procedures to follow in the event of a medical emergency. Staff told us that once the alarm had been raised, they responded by going to the site of the emergency. The responsible staff member then delegated actions to those in attendance. Emergency medical equipment was available in all three units of the home and was checked daily to ensure it was in good working order.

The provider checked the premises were maintained to minimise risks to people's safety. Records showed external specialists regularly checked that essential supplies, such as water, gas and electricity were tested and maintained. Records showed equipment such as the lift, hoists, electrical items and mattresses were regularly tested and serviced and there were emergency contact numbers for the equipment suppliers.

The provider had policies and procedures for the management of an emergency within the premises. Each person had a personal emergency evacuation plan so staff and emergency services knew how to support people to evacuate the building in, for example the event of a fire.

Good

Is the service effective?

Our findings

Relatives were confident the skill sets of staff who worked in the home met people's needs. One relative told us their family member could become anxious and agitated and staff managed their anxiety really well. They told us, "The involvement of the psychologist and her suggestions has brought a vast improvement in [person's] behaviour. There is a significant reduction in their challenging behaviour to the point that they now enjoy things."

New staff received an induction to the home which included training in line with the Care Certificate. The Care Certificate sets the standard for the fundamental skills and knowledge expected from care staff working in a care environment. The induction lasted 12 weeks and new staff were not confirmed in post until they had been assessed as competent.

Staff told us they had the training they required to meet people's needs safely and effectively. One staff member told us, "Training is good. They are really good at keeping on top of training and we are always given our certificates." Another said, "Our training is brilliant here and the management of our training is really good."

Staff had training in basic health and safety requirements every year, as well as specialist training to support people's individual needs. Where necessary, and appropriate, external trainers came to the home to train staff. Staff whose training was due to be refreshed, had training booked to ensure their skills and knowledge continued to support current practice and effective techniques. If a person was admitted to the home with a specific piece of equipment or medical need, the registered manager ensured staff had the necessary knowledge to support the person. They explained, "We normally have training before the person is admitted. Staff will go to the hospital and see the equipment in use before they are admitted here."

Staff told us they were encouraged to complete further training and complete external qualifications appropriate to their role. For example, the therapy lead told us they wanted to gain further knowledge in specialist areas such as 'neurology in aquatic therapy' and 'prolonged disorder of consciousness'. They were attending training workshops and explained how this knowledge would benefit them and the people they supported within the home. The registered manager confirmed, "As an organisation we encourage training. We want people to gain new skills and improve our standards."

Nursing staff told us they received training to ensure they followed best practice and their clinical skills remained up to date. This included training in catheters, syringe drivers, and communication skills. Every two weeks nurses attended 'forums' which were led by the clinical lead. The forums were used as an opportunity to discuss people's complex needs and wider issues such as the implementation of policies and procedures within the home. Nurses were also given two hours a month for 'reflective practice'. Reflective practice is a way of studying your own experiences to improve the way you work and an essential component of re-validation. Nursing staff found the forum and reflective practice sessions very useful. One member of nursing staff told us, "At one meeting we spoke and reflected on PEG feed and this was very good because it enabled us to talk about our practice." Percutaneous endoscopic gastrostomy (PEG) is a

procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of providing nutrition when oral intake is not possible. Many people received their nutrition through a PEG. Records showed these were managed well and in accordance with people's care plans.

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 an assessment shows a person lacks 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had applied for a DoLS for people when they did not have the capacity to understand the risks associated with the restrictions to their liberty. At the time of our inspection, two DoLS applications had been agreed by the local supervisory board and the rest were in progress.

Staff were aware of the MCA principles and used their knowledge to help people take part in the decision making process. This included support to make every day to day decisions such as what food they would like to eat and what clothes they wanted to wear. Care records provided staff with information to ensure people's highest participation in the decision making process. For example, staff used pictures to communicate with one person. Where people did not have capacity to consent to day to day decisions, staff worked in the person's best interests. However, care plans reminded staff that they should always be mindful of people's body language. For example, one person's care plan read: "[Person] is unable to give verbal consent to assessment and treatment therefore this is given in their best interests. However, on occasions [person] will indicate with body language that they do not consent, for example by gently pushing you away. In these instances we respect [person] and stop what we are doing."

Records showed that relatives and other healthcare professionals involved in the person's care took part in the best interest decision process. Some people had lasting powers of attorney to allow other people to make decisions on their behalf. The clinical lead had recently written to all relative's requesting copies of the documents issued by the courts so they could be confident that people's relatives and representatives had the legal right to make decisions on their behalf.

The provider ensured people's nutritional and hydration needs were met. People's care plans had a malnutrition universal screening tool (MUST). A MUST is a tool to identify adults who are at risk of malnutrition or obesity. It allows the staff to manage people's nutrition correctly and identify any risk. Where risks had been identified around people swallowing, they received a soft diet or their food was pureed. Some people had thickeners added to their fluids because they had been identified as being at risk of choking. Information about each person's dietary needs and allergies was kept in the kitchen so staff preparing meals had the information to hand. People were assessed on an on-going basis by dieticians and speech and language therapists (SALT) who visited the home every week to ensure people's nutrition plans met their medical and health needs.

At lunch time we saw a large television screen near the kitchen displayed the days menu in both words and pictorially. People had a choice of menu, subject to any dietary needs. Meals looked appetising and well-presented and it was clear they were enjoyed as many plates were emptied.

Some people had adapted plates and cutlery to assist them to eat independently, but many people needed assistance. Care staff only fetched meals when they were ready to assist the person, so food was not left standing and going cold. People who needed assistance to eat were assisted by staff sitting beside them. Staff did not rush people and allowed them sufficient time to enjoy their meal. Staff encouraged people as much as possible to eat independently. For example, we saw spoons being filled and handed to people who could then manage independently.

People with hydration needs had fluid balance charts in place to record their input and output. Fluid balance charts we looked at did not include a recommended amount of fluid per day, although we did not identify any signs of dehydration.

People living at Castel Froma have complex physical and neurological needs that require constant monitoring and input from a range of healthcare professionals. Records showed that people received good support with their healthcare needs. The GP visited the home three times a week and was available outside those times to provide support to staff. People also received support from a variety of other healthcare professionals including opticians and chiropodists. People were supported to attend healthcare appointments with specialists at hospitals and clinics throughout the area. The provider's own team of a psychologist, physiotherapists and occupational therapists worked with people to maintain and improve their health.

Good

Is the service caring?

Our findings

Some people were able to tell us whether they felt cared for. One person who had lived in the home for several years told us, "I like it." Another person described themselves as happy and told us they felt involved "every day" in planning their care needs. A relative told us, "The care given by the care staff is excellent. They spend a lot of time with [person]. They talk to him, they joke with him and they have come to know him very well and this has made a big difference in the way he is……...The carers really care. Once when [person] was in hospital, two care staff came to visit him after they had finished work."

Staff told us they worked well as a team and shared the same focus, "To care." One nurse explained, "I am happy working here. I want to help. I want to make a difference and it makes me happy and gives me satisfaction." Other staff we spoke with shared the same philosophy. Comments included: "It is lovely to make somebody smile," "I treat these residents like my family" and, "We are all here for one reason, for the residents."

The provider information return completed by the registered manager told that the provider's policies for equality, diversity and human rights included training for staff. We saw staff understood the principles of treating people fairly and equally and according to their individual needs. During our visit, we saw staff were friendly and caring and thoughtful in their exchanges with people. For example, we saw a staff member holding a person's hand and asking how they were. The staff member asked the person if they would like their spectacles on. When the person indicated they would, the staff member ensured they were clean before helping the person put them on.

Most people had no or very limited verbal communication. When talking with people, staff used simple and easy to understand language and listened carefully to their responses. Where people had no verbal communication, staff took time to understand people's body language and respond to their needs. Staff told us they always informed people about the actions they were going to carry out before they provided care. This meant that people knew what was going to happen and were provided with an opportunity to express their preferences. One member of staff told us, "There are communication guidelines provided by SALT (speech and language therapy) and this helps me to involve people in making decisions about their care."

The clinical lead made sure they obtained support for people who did not speak English as their first language. On the second day of our visit a Romanian person was due to be admitted to the home. The clinical manager told us they were aware this person was very anxious and explained, "I have made arrangements for a nurse who speaks Romanian to be on duty and there will be a Romanian nurse on shift at some point every day."

One relative told us their family member's memory had been impaired following a serious head injury, and they became confused and anxious because they did not know where they were. Staff had identified this and acted to reduce the person's anxieties and put them at ease. The occupational therapist had prepared a sheet which explained where the person was, who they were and what help they needed. The relative

explained how this had reassured their family member and stimulated their memory, which was beneficial "because it makes [person] think." They went on to say how therapists used photographs and personal memories for mental stimulation which "helped with laying new memories".

Staff told us that an important aspect of treating people with dignity and respect was to take time over their appearance and make them feel valued. One member of staff explained how they looked at photographs of people before their illness progressed, or before they experienced their trauma, so they understood how people would like to be supported with their personal care. For example, whether it had been important for ladies to wear make-up or have their hair done in a particular way. They explained, "Would they have done that before they came here. Everybody wants to look their best. We respect them by making them look nice." Another staff member explained that some people enjoyed being pampered and said, "This is their home, why shouldn't they look lovely every day." Staff explained that it was also important for relatives to see that care had been taken over their family member's personal care needs. During our visit we saw people were well-presented and staff took time to make positive, affirming remarks to people about their appearance. One member of staff told a person, "You look nice today in pink," and another member of staff remarked to one person as they were brought into the lounge, "Who has done your hair today, it looks very nice."

Staff told us that it was vital to have empathy with people and part of that was to understand the person and their life before they became ill or had their accident. One staff member told us that knowing about people's backgrounds helped them "empathise with the situation." Another explained, "How can you care for someone you don't know. Knowing about a person makes your relationship stronger with them and creates bonds with them." We observed one staff member on one to one observations with a person. The staff member was interacting with the person and trying to engage them in activities they enjoyed. The staff member knew the person's personal history and used that information to have a conversation with them. The staff member maintained eye contact with the person and the person's facial expressions showed they enjoyed the interaction.

Many people who lived at Castel Froma had acquired brain injuries and in some cases were young adults. Staff showed an awareness of how families, relatives and friends needed their support and compassion to manage their emotional needs and understand their relative's condition. One staff member told us how family units could be 'shattered' in a moment and that it was important to understand that. They explained, "We know all the relatives and they know us. We have a good relationship with people. You have to go out of your way to make sure their family are okay. Sometimes they are still grieving."

A relative spoke with us about the emotional impact their family member's health condition had within their immediate family. They said, "It has changed everything, nothing is the same." They said staff at Castel Froma were understanding, supportive and available for them to speak with whenever they wanted. They said because staff cared, it helped to ease their worries because they knew their family member was getting the right support.

Relatives and friends confirmed they could visit the home whenever they wished to. On both days we observed visitors being welcomed by staff and people living in the home.

Staff celebrated and were proud of people's achievements, however small. Two staff told us about a person who had been PEG fed. This person was now able to eat and enjoy the tastes of some foods. They told us, "[Person] has started to put weight on and it is great to see. It is lovely when they improve." Another person had made great progress and was able to walk unsupported. A member of staff pointed the person out as they walked around the garden and was clearly proud of how the person had been supported to regain

some independence. Another staff member told us, "When they improve you hope they can go home and have a care package at home. It is great to see them go home and know you have done your part in that."

Due to their complex needs, most people had medical equipment in place to support their condition and keep them safe. However, people had been encouraged to decorate and furnish their bedrooms as they chose, to make them as homely as possible. For example, one person had decorated a wall in their bedroom with the colours of their favourite football team. Personalisation of people's own space helped to soften some of the more clinical aspects of the environment.

Castel Froma had a strong commitment to supporting people and their relatives before and after death. The service was accredited under the Gold Standards Framework (GSF). The GSF is a national framework of tools and tasks that aims to deliver a 'gold standard of care' for all people nearing the end of their lives. People and their relatives were encouraged to share their views in advanced care plans, which set out how people wanted to be supported during the end stages of their life. The advanced care plans were used to direct end of life care, and in many cases avoided hospital admissions and allowed people to remain at the home.

Staff understood the importance of providing compassionate care to people and their families in the final stages of their life. One staff member told us how a person with a young child was admitted to the home for end of life care. They explained how important it was to give that person and their child a happy memory of their remaining time together and said, "For [person] it was important to see a smile on their little girl's face." At the time of our visit, the provider was creating a room for relatives to stay with family members if they were very ill or approaching end of life.

Staff told us that information about when a person had died was shared discreetly with all staff. One staff member explained, "We always know when someone has died because they put a little yellow flower by the clocking in machine so you know there has been a death so you can be prepared." People who had died were remembered at an annual memorial service at the home to which their friends and relatives were invited.

Good

Is the service responsive?

Our findings

A relative told us they were pleased with the care their family member had received since moving to the home. They described the care as 'very good' and as a result, their family member would shortly be moving back to the family home. They explained, "[Person] has a nice rapport with staff, they know [person] and help him, they chat with him and help him with puzzles." They said whenever their family member needed help, staff were very responsive.

Each person living at Castel Froma was allocated a named nurse who was responsible for their care. The named nurse gathered information about the person before they were admitted to the home. This involved liaising with families and healthcare professionals involved in the person's care at their previous placement. The named nurse co-ordinated the person's care, ensured care plans were followed by all staff and regularly evaluated them to ensure they continued to meet people's health and medical needs.

The PIR told us: "Service users' personal preferences, cultural background, likes and dislikes and general history are explored and recorded so that a personalised service is delivered to them." Records showed each person had a 'Make My Day' folder which contained information about their personal history, likes, dislikes, preferences, hobbies and aspirations. This gave staff information that supported them in providing person centred care. One relative told us, "When [person] came here the staff invited me to give information about him, this is a true reflection of him."

There were plans in place to inform staff how to manage specific conditions to support people's health. For example, some people had catheters. There were plans to inform how these should be managed and records showed they were being managed in accordance with those plans.

People and their relatives were involved in planning and reviewing care plans. Records showed relatives were included at regular meetings with the healthcare professionals involved in their family member's care.

Relatives told us staff were responsive when a need was identified. One relative told us their family member had found it difficult to come to terms with their situation and the relative thought they might benefit from extra psychological support. They discussed this with staff and in response the person now went to group meetings within the home to share and explore their feelings. The relative could see how the support their family member received at these meetings had benefited them by providing an opportunity to discuss and understand how they, and others, felt.

Another relative told us, "I visit here three times a week. I have access to the care plans and they are reviewed when I want it. Three weeks ago [person] was agitated and I suspected that it might be their teeth. I asked the staff to make an appointment with the dentist. This was done immediately and the dentist found an abscess. Treatment was initiated immediately. [Person] is now on one to one observation for their safety and they try to have the same staff with them. It is working, [person] is much happier."

We found staff worked innovatively to respond to people's needs. A member of the therapy team told us how relatives wanted to take their family members out for the day or for visits home, especially for special occasions like Christmas. They explained that this naturally presented risks, especially around mobility and transferring people from the home to another location. A physiotherapist said they had assessed local taxi companies could not always transfer people safely, because of the complexity of the equipment people required. They had therefore worked with families so risks could be managed more safely, for example, by offering families the use of the provider's specially adapted vehicle. A relative said they had been offered this facility and before they were allowed to use the vehicle, "I had to have a test. It was very hard, you can't just get in and drive away. I was shown how to secure the wheelchair properly with the clamps." This demonstrated that staff had recognised it was an essential part of people's rehabilitation and wellbeing to be with family outside the home, and responded to facilitate that.

We saw staff knew and understood people's needs and how to support them. Staff told us they knew about people's needs because they read their care plans and had a handover of information between each shift. We attended a handover between the morning and afternoon shift. The handover concentrated on the physical care of people and was quite brief. However, there was also a written handover which was more comprehensive. One member of care staff told us, "Most of us look at the written handover before starting work because they are more accurate." The registered manager told us they had recently implemented a new handover system specifically for nurses. The nurse leaving the shift visited each person's room with the nurse taking over the shift to handover any specific points relating to that person's nursing care. The registered manager explained that this meant nurses were more accountable for ensuring all necessary nursing tasks had been completed on their shift.

Four activities co-ordinators were employed at the home to encourage and support people to engage in meaningful activity. Staff and relatives told us that people were encouraged to partake in a range of activities, both individually and as a group. During the day we saw some people taking part in a quiz and then a game of bowls. One person read the newspaper with support, whilst another enjoyed a game of cards with a staff member. Volunteers visited the home to support people in participating in activities. Various events were put on in the home to entertain people. For example, there was a full Christmas entertainment plan with singers, a pantomime, carol service and Christmas party. Information about these was prominently displayed to encourage people and their visitors to attend.

Many people living in the home had an acquired or progressive neurological disability, so there was a strong emphasis on rehabilitation and skills maintenance. People were supported to achieve personal goals through rehabilitative input from physiotherapists and occupational therapists. Therapy staff worked closely with activities staff to support people to achieve their individual goals and objectives. This included more clinical activities to establish, for example, whether restrictions on hand movement were physical or neurological. During our visit some people took part in an exercise session with physiotherapists and some joined the occupational therapist to make some cakes.

Staff recognised the importance of supporting people with their cultural and religious beliefs in a way they wanted. For example, staff supported one person to eat in accordance with their cultural beliefs. During our inspection, another person had some visitors from a local church. We asked the visitors if they were able to have a private room to pray if required and we were assured that their needs were always met.

The provider's complaints policy and procedure were displayed on a noticeboard in a communal area. Complaints received were dealt with in accordance with the policy and procedure. One complaint had related to a relative's concerns regarding their family member settling in when they first moved to the home. The PIR told us: "After this complaint was satisfactorily resolved a new system was introduced whereby a

service user and family members are invited to a settling-in meeting attended by members of the multi-disciplinary team during the first six to eight weeks after admission." This demonstrated that the provider had taken action to improve the quality of the service as a result of the complaint.

A relative said they were pleased with the service and had not made any formal complaints. They said when they had raised informal concerns, they were listened to and action was taken to make improvements. However, we spoke with another relative who wished to raise a complaint but did not understand the process. We signposted them to the provider's complaints policy and procedure. The provider had recently appointed a Liaison Officer to act as a point of contact if anybody had any concerns.

Requires Improvement

Is the service well-led?

Our findings

During our visit we received positive feedback from relatives about the quality of care people received within the home. The provider had a person centred vision and mission statement to provide the highest standard of nursing care for people with neurological conditions. Staff were proud of the service and committed to providing high quality care. Comments from staff included: "I am proud we can manage all these challenging cases. We do have some critical cases here and we are so proud that we can deal with it." "It is very rewarding and I feel so proud." "It is a caring and compassionate workforce, they have very good staff in all departments. People are very well looked after."

The senior management team reported directly to the chief executive who was also the registered manager. The senior management team had responsibility for the day to day running of the service under the direction of a Board of Trustees. The Board comprised people with clinical skills and people with expertise in other areas to support the governance of the home. Members of the Board had specific responsibilities under a committee structure that covered areas such as finance, care standards and clinical governance. The senior management team and committees met regularly and reports from the meetings were fed back to the Board who provided strategic governance and direction. Day to day clinical management of the home was undertaken by the clinical lead.

We looked at a selection of minutes from the clinical management, senior management and care standards meetings. The minutes were detailed and where actions were identified, it was clear who was to take ownership of the action with a target date for completion. Actions were reported on and followed up at subsequent meetings.

We found that nursing and therapy staff felt included, valued and supported within the home. One member of therapy staff said communication in the home had improved over the last 12 months. They said, "Shift management is better, communication is better which has improved staff morale." They said they felt more supported in their role, which made them feel valued. Other therapy staff and nurses confirmed this. They said the therapy team worked well with nursing staff and they noticed newly recruited staff were, "Keen to support people with personal goals." They said, "We all sit around together to discuss."

However, one staff group felt under-valued. Care staff told us they felt the demands on their time were not always understood. A typical comment was, "There is no understanding of how hard the job is." Care staff felt some tasks ancillary to their primary caring role, such as tidying rooms, left them rushed and with little time to spend time with people beyond providing care. Although care staff were supposed to work in pairs, staggered shift patterns meant there were occasions when they had to work alone. This meant they could not always immediately deliver the level of care people required until another member of staff was available .They also felt some senior managers were giving instructions and directions outside their own areas of responsibility which led to inconsistency in the content and delivery of messages. Care staff told us the delivery of some messages was very negative, which impacted on morale. One staff member told us, "I love my residents, but management need to appreciate what we do more." Others told us they were reluctant to raise issues with nursing staff with one member of care staff explaining, "There is not much (communication

between care staff and nursing staff), just the handover." We discussed some of the issues raised by care staff with the registered manager, such as care staff expressing concern that they were not allowed into the communal lounge until 1.00pm. Although the registered manager assured us that was not the case, the consistent responses we received from care staff over both days of our visit, indicated this was their understanding. This demonstrated that communication between managers and care staff was not always effective in the home. The provider has undertaken to look into this, as they have told us that they are keen for all staff and volunteers to feel valued.

There was a divide between the responses we received when we asked staff about supervision. Supervision is a one to one meeting between staff and their managers which gives staff opportunities to talk about their practice and personal development and raise any concerns or issues. Therapy and nursing staff said they found supervision useful. However, some care staff were inconsistent in saying how often they had supervision and how supportive they found it. Some care staff felt they did not always get an opportunity to discuss issues or concerns with their manager, and when they did, they were not confident they would be dealt with satisfactorily.

The human resources manager said the provider's expectation was to hold six supervisions per year, with one annual appraisal. They told us on occasions this was not always achieved and that following a staff survey in 2016, they identified this was an area that required improvement. They said they had introduced a supervision record that helped them to monitor which staff had not received regular supervision meetings so they could make sure they were completed in line with the provider's and staff expectations.

Developments and changes in the home were communicated to staff through staff briefings (meetings) and a written staff bulletin. Staff briefings were used to share information and reinforce learning around issues such as safeguarding. Relatives also received a monthly bulletin which provided an overview of any alterations to the service provision and staff changes and upcoming events in the home.

The provider's quality assurance system involved asking people and their relatives about their experience of the service. This was through surveys and meetings. Unfortunately, the number of people and relatives who responded to the survey in 2016 was low. Further, the survey results included another service owned by the provider and there was no clear analysis of which responses related to Castel Froma. Overall, the responses were positive and where areas for improvement had been identified, actions had been put in place.

A touch screen feedback tablet had been installed at the end of September 2016 to encourage people, relatives and staff to give immediate feedback about the service. At the time of our inspection visit, there had been 29 comments. The registered manager told us the responses would be analysed on a quarterly basis to identify any emerging trends so action could be taken to improve. Some people we spoke with were not aware of how to share more serious concerns through the provider's complaints procedure.

Members of the management team completed various audits to ensure the service was responsive to people's needs. For example, the therapy manager completed clinical audits to ensure the therapy service met people's needs and was responsive to changing demands. Surveys were sent to people and relatives seeking feedback about the therapy team and whether the service they provided was effective and what people wanted. Following feedback, the service was improved to deliver a more tailored service. For example, the provider increased hydrotherapy support for people by trialling 'private' hydrotherapy sessions which were in addition to the usual hydrotherapy service. Therapy staff told us these sessions had proved popular and a further review would inform them which services to provide in the future and how this could be resourced without adversely affecting the current service.

The therapy lead manager had undertaken a physiotherapy audit at the end of 2015. This audit analysed the amount of physiotherapy sessions provided to individuals and groups. The audit had been completed because people's health conditions had changed, so the provider wanted to be confident the service continued to meet people's changing needs. The results showed people's needs had changed because, "people were being discharged from hospital earlier and needed slow stream rehabilitation." The therapy manager explained, "The service needed to evolve with people's needs, although what we provide is safe (treatment), we need to change." They told us they used this information to look at which therapies they provided and to supplement them with other therapy support, such as respiratory and movement therapies. The therapy manager told us these audits helped them to better understand what they provided and what they needed to do to continue to provide a quality service, such as recruiting for additional therapy staff.

A review of psychology services had identified a need to employ a part time psychologist to provide sufficient psychology support at the home. The role was being recruited to at the time of our visit.

There was a system of audits and checks in areas such as medicines management and care documentation to check that quality of care and best practice were maintained. The checks were effective at identifying issues and ensuring action was taken to address them. For example, we found the management of medicines in the home had improved since our last visit in November 2015. Members of the Board of Trustees also carried out monthly visits to check whether standards were sustained. Records of the visits evidenced that the service was meeting the fundamental standards of care in the regulations for care home providers.

There were links with the local community. The League of Friends of Castel Froma raised funds through a variety of events to support the provision of therapy services within the home. Students from the local schools sometimes visited the home to provide support with activities.

The management team was able to tell us which notifications they were required to send to us so we were able to monitor any changes or issues with the home. However, we identified two serious injuries that had occurred in the home that we had not been notified of. These injuries had occurred before the registered manager and clinical lead had taken up their roles within the home. They assured us serious injury notifications would be submitted as required by the regulations. The ratings from our previous inspection visit were prominently displayed in the home.