Inglewood Nursing Homes Limited

Inglewood Nursing Home

Inspection report

7-9 Nevill Avenue
Hampden Park
Eastbourne
East Sussex
BN22 9PR

Tel: 01323501086

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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

We inspected Inglewood Nursing Home on 18 and 20 December 2017 and our visit was unannounced. At the previous inspection Inglewood Nursing Home was rated 'good'. Inglewood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Inglewood Nursing Home provides nursing and personal care and accommodates up to 60 people in one adapted building. At the time of the inspection there were 53 people living at the home. People were living with a range of complex health care needs which included people who have stroke and diabetes. Some people had a degree of memory loss associated with their age and physical health conditions. Some people were also receiving care and support for end of life care needs. Most people required help and support from two members of staff in relation to their mobility and personal care needs. Accommodation was provided over two floors with a passenger lift that provided level access to all parts of the home.

There was a registered manager at the home. 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.'

Improvements were needed to ensure the service was consistently meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Quality assurance systems were in place but these had not identified some areas that needed to be improved in relation to people's records, and documentation in relation to people's mental capacity. We made a recommendation about this. Other areas for improvement had been identified and work was taking place to address these.

Staff knew people really well. They had a good understanding of each person's needs and choices. They could tell us about people's personal histories including their spiritual and cultural wishes. Each person was treated as an individual and their choices and rights were respected and upheld. People were supported to make their own choices about what they did throughout the day.

People were supported by staff who were kind and caring. Staff knew people well and had good relationships with them. Staff maintained people's privacy and dignity. They understood the importance of confidentiality. Relatives were able to visit at any time, and were made to feel welcome.

There were enough staff, who had been safely recruited, working to ensure people's needs and preferences could be met. Staff had received the training they needed to support people and deliver care in a way that responded to people's changing needs.

People were looked after safely. Staff had a good understanding of the risks associated with the people they looked after. Staff understood the procedures in place to safeguard people from the risk of abuse and

discrimination.

People were supported to eat and drink a variety of food. They were provided with a choice of freshly cooked meals and drinks each day. People's health was monitored and staff responded when health needs changed. People were supported to attend healthcare appointments and were referred to external healthcare professionals when needed.

There were systems in place to ensure medicines were ordered, stored administered and disposed of safely. There was a complaints policy and people told us they were able to discuss any concerns with the registered manager or staff.

There was an open and friendly culture at the home. The registered manager was well thought of by people, visitors and staff. She worked hard to include people and staff in decisions about the home, and was committed to improving and developing 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

Inglewood Nursing Home was safe.

People were protected from the risks of harm, abuse or discrimination.

Systems were in place to ensure there were enough staff, who had been safely recruited, to meet people's needs.

Risk assessments were in place and helped to keep people safe.

There were systems in place to ensure medicines were ordered, stored administered and disposed of safely.

Is the service effective?

Good

Inglewood Nursing Home was not consistently effective.

Improvements were needed to ensure The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Staff received the training and support they needed to enable them to meet people's needs.

People were supported to eat and drink a choice of food that met their individual needs and preferences.

People's health and well-being needs were met. People were supported to have access to healthcare services when they needed them.

Is the service caring?

Good

Inglewood Nursing Home was caring.

Staff knew people well and treated them with kindness, understanding and patience.

People were supported to make their own decisions and choices throughout the day.

People's privacy and dignity were respected.

Is the service responsive?

Good

Inglewood Nursing Home was responsive.

People received care that was person centred and met their individual needs. Staff had a good understanding of providing person-centred care. They knew and understood people as individuals.

There was a range of activities taking place and people told us they had enough to do throughout the day.

There was a complaints policy in place and people and visitors told us they would raise any concerns with staff.

Is the service well-led?

Requires Improvement

Inglewood Nursing Home was not consistently well-led.

Quality assurance systems were in place, but these had not identified some areas that needed to be improved in relation to people's records. Other areas for improvement had been identified and work was taking place to address these.

There was a positive culture at the service. People and visitors spoke highly of the staff team and their life at the home. The registered manager worked hard to improve and develop the home.

Inglewood Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 and 20 December 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the home, including previous inspection reports. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

During the inspection we reviewed the records of the home. These included staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits and policies and procedures along with information in regards to the upkeep of the premises.

We also looked at five care plans and risk assessments along with other relevant documentation to support our findings. This included 'pathway tracking' people living at the home. This is when we looked at their care documentation in depth and obtained views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with 12 people who lived at the home, three visiting relatives, and 17 staff members, this included the registered manager. Following the inspection we received feedback from seven health and social care professionals who visit the service.

We spent time observing people in areas throughout the home and were able to see the interaction between people and staff. We watched how people were being cared for by staff in communal areas. This included the lunchtime meals.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Inglewood Nursing home. Comments included, "Staff make me feel safe, they are all very nice" and "It is very safe and secure here."

People's risks were safely managed. There were a range of risk assessments in place which were specific to people's needs. These included mobility, risk of falls and skin integrity. The assessments identified risks and the measures in place to reduce or eliminate the risk. There was guidance about how to support people to move safely which included the use of equipment and support from staff. Where people were at risk of developing pressure wounds there was guidance about regular position changes, the use of pressure relieving equipment and continence care. Staff had a good understanding of the risks associated with supporting people. They were updated each day at handover about any people's needs and any changes. During the inspection we observed safe care practices taking place, such as staff supporting people to mobilise around the service.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. A fire risk assessment had been completed and regular fire alarm checks had been recorded. Staff received training and knew what action to take in the event of a fire. People's ability to evacuate the building in the event of a fire had been considered and each person had a personal emergency evacuation plan (PEEP). Equipment was also available around the home to aid evacuation if required.

Health and safety checks had been undertaken to ensure safe management of utilities, these included amongst others water and legionella checks, electrical appliance testing, regular checks and maintenance of moving and handling equipment, and the lift. There was an emergency plan which informed staff what to do in the event of the service not being able to function normally, such as a loss of power or evacuation of the property.

People were protected against the risk of abuse because staff knew what steps to take if they believed someone was at risk of harm or discrimination. One person told us, "Nothing happens that I need to tell anyone, the staff look after me very well." Staff received safeguarding training and this was updated regularly. Staff described what action they would take if they suspected abuse had taken place and there was information displayed in staff areas to remind them what steps to take. Staff told us they would generally raise an issue with the registered or deputy manager if appropriate. They said they were able to contact senior managers from the provider or contact the local authority safeguarding team. Documentation showed that the provider cooperated fully and transparently with relevant stakeholders in respect to any investigations of abuse. After any safeguarding concerns had been raised this was discussed with staff during daily handover, on a one to one basis if required or during staff meetings to ensure everyone was aware of issues and actions taken.

There were enough staff to support people safely. People told us staff responded to them promptly. One person said, "If I ring my bell they come as soon as they can," another commented, "If I ring my bell they come quite quickly all things considered." From the staffing rota we saw there were regular staffing

numbers. There were designated nursing, care, housekeeping, maintenance and administration staff. There was a dependency tool to help determine staffing levels. However, the registered manager told us people's individual needs were taken into account through discussions with staff and if extra staff were needed they were provided. There were two registered nurses on duty at all times. There were twelve care staff on the morning shift and nine care staff in the afternoon. Care staff were allocated to the ground or first floor at the start of each shift. Registered nurses were allocated to each floor for a month at a time. This meant they knew everybody who lived at the home to ensure they received consistent care. At night time there were four care staff. The registered and deputy manager were also registered nurses and provided support when needed. A number of staff had worked at Inglewood nursing home for many years and staffing was stable. Agency staff were rarely used but if required the registered manager told us that they used agency staff who had previously worked at the home to ensure continuity. Throughout the inspection call bells were being used and these were responded to promptly. The registered manager told us that call bell response times were monitored and any concerns were able to be investigated.

People received their medicines when they needed them. One person told us, "I understand what they (medicines) are all for, I say what is that pill and they say blood pressure or something." Another person said, "I get my medicines on time."

There was a safe medicine system in place. The registered nurses were responsible for ordering, administering and recording of medicines. Some people had been prescribed 'as required' (PRN) medicines. People took these medicines only if they needed them, for example if they were experiencing pain. There were protocols for their use to ensure they were given consistently. When people had their PRN medicines this was recorded on the Medicine Administration Record (MAR) to show the medicine had been given. Medicines were stored safely in locked cupboards in peoples own rooms. Spare medicines or items too large to store in cabinets and items that required to be refrigerated were kept in the treatment room. For people who wished to self-administer their medicines assessments had been completed to ensure this was safe and appropriate.

People were cared for in a clean, hygienic environment. They told us the home was always clean and tidy. One person said, "It's very clean here, the washing (laundry) is extremely good." During our inspection, we viewed people's rooms, communal areas, bathrooms and toilets. We saw that the home and its equipment were clean and well maintained. There was an infection control policy and other related policies in place. Protective Personal Equipment (PPE) such as aprons and gloves were available. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

The provider had safe recruitment processes in place. We looked at four staff files. These included all the relevant information to ensure all staff were suitable to work in the care environment. Records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

All staff had access to policies and procedures. These were available on the computer and each staff member had their own log in details. An alert was sent to the management if staff had not logged into the system for some time. This meant that staff had access to up to date and relevant information to support them to carry out their role safely. Policies included guidance about how to respect people's rights and keep them safe from harm and clear systems on protecting people from abuse.

Good

Is the service effective?

Our findings

People told us staff understood their needs and supported them appropriately. Comments included, "Definitely, the staff know how to care," I am always treated well" and "Staff are very good, they do their job, they're very kind and caring." People told us they enjoyed the food. One person said, "The food is very good, plenty to eat, they come round and ask you what you want, there's two choices, it's cooked nicely and they will offer something instead if I don't like it."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager told us where people lacked capacity best interest decisions had been made through discussions with people, their representatives, staff and health and social care professionals. We found that best interest decisions had not always been recorded. Mental capacity assessments were in place and these were reviewed each month. However, these were not decision specific. Some people who lacked capacity had bed rails in place. Bed rail assessments stated consent had been sought from the person or the decision was made in the person's best interest. However, there was no information to show how this consent had been obtained or how the best interest decision had been made. The registered manager told us some people's capacity was variable. However, there was no information on which areas they had or lacked capacity. Consent forms had been signed by people who had capacity to do so. Relatives had signed consent forms for some people who lacked capacity. However, it was not always clear whether these people had the legal authority to do so. This did not impact on people because the registered manager and staff knew people well and had a good understanding of their needs. The registered manager had started to address this immediately.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. DoLS applications had been submitted for people who did not have capacity and were under constant supervision. Copies of the applications were in people's care plans and available to staff. At the time of the inspection seven people had DoLS authorisations in place.

Staff had completed mental capacity training and demonstrated an understanding of mental capacity and DoLS. They told us about the importance of providing people with choices and supporting people to make their own decisions. People told us staff asked their consent before providing any care or support. This is what we observed during the inspection.

People were supported to receive effective care because care was delivered in line with current legislation, standards and evidence based-guidance. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. Training included safeguarding, food hygiene, fire, health and safety, moving and handling

and equality and diversity. These were regularly updated. Staff also received training specific to the needs of people at the home. This included dementia, continence and catheter care. There was a quality and training co-ordinator who was responsible for ensuring staff received the training they needed and identified further training needs. Staff had recently received training in relation to hearing aids. This had given insight into how to care for the equipment appropriately to ensure it was of maximum benefit to people. Registered nurses also received appropriate clinical training to ensure they could meet people's needs safely and effectively. They told us people would not be admitted into the home unless all their needs could be met. They told us about one person who had been admitted for a short stay and required specialised bandaging. The registered nurses did not have these skills therefore arrangements had been made for a visiting healthcare professional to provide this aspect of the person's care until the registered nurses had received the appropriate training and were competent. This meant the person was able to receive the 24 hour support they needed and be confident their health needs were met.

There were systems in place for staff development. This included one to one, group and observational supervision and staff meetings. Annual appraisals were completed. This helped staff identify further training or areas where they required further support. Staff told us they could ask for further training and support at any time. Staff had a good understanding of equality and diversity. They were supported by training and policies. The registered manager and staff were told us how they would support people and were confident people's equality, diversity and human rights would always be protected.

People's nutritional needs were met. The chef and staff had a good understanding of people's individual dietary needs, likes and choices. There was information available within the kitchen and in people's care plans. People told us they were supported to have enough to eat and drink each day. They said they were given choices and could eat their meals where they wished. Their comments included, "The food so far has been good. There's more than enough and plenty of drinks. They asked me if I didn't like anything and said I could request something else. I choose to eat in my room." "Food is very good, plenty to eat and drink, there's nothing I don't like. I go to the dining room, it is a nice experience."

Some people had difficulty in swallowing and required pureed or soft diets and some required thickened fluids. Staff had a good understanding of people's needs and their food and drink requirements. The provider had developed an innovative way to remind staff where people had swallowing difficulties. This included a magnet on the person's medicine cabinet in their bedroom with a picture of a fish. There were also place mats with fish pictures which could be used in the main dining room. Staff told us the fish reminded them to, 'Find Information on Swallowing History' (FISH) before supporting people to eat or drink. A detailed nutritional assessment was completed. It detailed people's dietary needs, preferences and choices and this included any cultural or religious requirements. A copy of this was kept in the kitchen which ensured all staff were aware of people's dietary needs. These were regularly reviewed and if any concerns were identified referrals were made to the dietician or speech and language therapist.

Meals were freshly cooked each day and nicely presented; tables were laid with cutlery and condiments. Where people ate in their rooms meals were served individually on trays laid up with cutlery and a napkin. Where people required support staff sat with people and engaged with them throughout the meal. People were supported to enjoy meals at their own pace. People were supported to retain their independence through the use of specialised cutlery.

People were supported to maintain good health and received on-going healthcare support. When there was a change in their health people were referred to see the GP or other appropriate professional. Staff knew people well and were attentive to changes in their physical and mental health needs. They contacted the appropriate professionals in a timely way. Throughout our inspection we observed staff discussing changes

in people's health and a registered nurse contacted a GP to visit a person who was unwell. Records demonstrated there was regular contact with other professionals. This included local GP's, tissue viability nurses and speech and language therapists. People confirmed their health needs were met. One person told us, "You can see a doctor when you want to, I am seeing an optician soon, and a chiropodist does my feet. The staff help me care for my glasses." Visiting healthcare professionals told us, staff contacted them appropriately and follow guidance provided. One healthcare professional said, "Staff are very approachable and responsive to my advice and very keen to develop their good practice."

People's individual needs were met through the design of the premises. The home was an old building which had been adapted and enlarged over the years. There was a large lounge and a smaller coffee room. There was coffee and cold drinks machines with a variety of snacks available for people and their visitors. When people had visitors they were supported to spend time with them in private in their bedrooms or remain in the lounge or smaller and quieter coffee lounge. Staff told us often families would spend time with their relatives in the coffee lounge which gave them both space and privacy. There was a passenger lift which allowed people access to all areas of the home and there were adapted bathrooms and toilets in place to support people. Most people required support with their mobility and were accompanied by staff when moving around the home. There was a well-kept garden which people told us they enjoyed during the warmer weather. One person said, "I enjoy going into the garden in the summer."

Good

Is the service caring?

Our findings

People told us they were treated in a kind, caring and patient way. They said their spiritual and cultural needs were respected. Comments included, "Staff are very good here, they're kind and caring", "I am treated with dignity and respect" and "Staff are very good, especially the ones in the green tops, very caring and respectful."

People were treated with kindness and compassion by staff who knew them really well. Staff had a good knowledge of people as individuals, their needs, likes and choices and what was important to each person. Staff were committed to providing good, compassionate care. From talking with people and staff, it was clear staff knew people well and had a good understanding of how best to support them. They told us about the people they cared for, their personal histories, and interest's cultural and religious needs. They spoke about people's individual care needs and preferences for example what time they liked to get up, what they liked to do during the day and food and drink preferences. Staff told us about the importance of knowing each person as an individual and how this could have a positive impact on each person's time at the home. One staff member told us that although it took time to get to know people they took extra steps to help develop the relationships. The staff member explained that when people moved in they made sure they knew what people liked to drink and how they liked it. They said, "If you can say, 'here's your coffee (or tea) with milk and no sugar,' then it makes people relaxed, they feel listened to and feel that they belong."

There was a happy and relaxed atmosphere at the home, with lots of fun and laughter. Interactions between staff and people were kind and thoughtful. Staff acknowledged people when they entered a room. They greeted people with a smile and spoke to them in a cheerful voice. This helped people to feel relaxed in their company. Staff approach to people was gentle and patient. We observed staff supporting people in their own rooms at mealtimes. Staff engaged with people and spoke to them about what they were eating. They explained what the meal was and engaged with the person throughout, supporting them appropriately. When staff supported people in communal areas we observed they chatted with them and supported people at their own pace.

Staff adapted their approach to meet peoples' individualised needs and preferences. Staff were observant of people and were aware of their needs when they were anxious or distressed. Staff attended to people promptly, they spoke with them discreetly and with compassion to establish their concern and these were addressed promptly. One person was going outside and staff reminded the person to take a coat as it was cold.

Peoples' equality and diversity was respected. They were supported by staff to maintain their personal relationships. This was based on people's choices and staff understanding of who was important to the person, their life history and where appropriate their spiritual and cultural background and sexual orientation. People were supported to meet their spiritual needs and there were regular visits to the home from a local visiting church team. One person told us, "A Minister visits the home but I choose not to go." Another person said, "My minister can come to give me Holy Communion." Visitors told us they were able to visit their relative whenever they wished and were made welcome at the home. Staff knew visitors well and

engaged with them throughout their visits. One visitor told us, "I am made welcome and offered a drink, they're (staff) very welcoming. There's often meetings and I am not asked to leave."

People were treated with dignity and respect. One person told us, "Staff are very respectful and support my dignity." Another said, "I am treated with dignity and respect, they ask my permission and knock on the door (before entering bedroom)." People were supported to maintain their own personal hygiene and maintain their independence. One person told us, "I wash every day with assistance." People appeared well presented and were dressed in clothes of their choice and it was clear people dressed in their own chosen style. There were dignity champions appointed at the home. They had developed a 'dignity tree' where people had been asked what dignity meant to them. Comments included, "Treat people how you would like to be treated", "To keep the feeling of being human" and "Maintaining self-respect." Staff told us how they supported people who were less able to make decisions about what to wear. This included showing the person a selection of outfits to help them make choices. People told us they were supported to make their own choices each day about where they spent their time and what they wanted to do. One person said, "I get up and go to bed when I want." Throughout the inspection we observed people being offered choices and their decisions were respected.

People's bedrooms were personalised with their possessions such as personal photographs and mementos. This helped to make people's bedrooms appear individual and homely. People told us they were asked about whether they would prefer male or female care staff to support them. One person said, "I'm very much treated with dignity and respect, I am not bothered whether it is a male or female carer." Another person told us, "I don't want a male carer and the staff respect that."

People's care plans are recorded on a computerised system. These were accessed by staff on hand held devices and computers. Each staff member had their own log in details which ensured only staff with appropriate authority were able to access people's details. Where there was printed information about people this was stored securely to ensure that their privacy and confidentiality was maintained.

Good

Is the service responsive?

Our findings

Through our observations, discussions with people, visitors and staff it was clear people were involved in deciding their care and support needs. People told us they were listened to and staff responded to their needs and concerns. One person said, "I can do what I want, the staff really do understand me." Another told us, "I can get up and go to bed when I like." People told us they had enough to do during the day. One person said, "I can do what I want, I am not bored."

Before moving into the home one of the registered nurses completed an assessment to ensure the person's needs could me met at the home. Information from the pre-assessment was then used to develop care plans and risk assessments when people moved into the home. Care plans contained information about each person, their family history, individual personality, preferences and interests. This information had been developed by the person, their family and staff. The care plans were relevant to each person and included information about their mobility, nutrition, continence and personal care. In addition to people's care needs there was information about their lifestyle, social, religious and cultural needs and beliefs. Information was recorded regarding people's healthcare needs and the support required to meet those needs. Care plans contained guidance for staff on how best to support each individual. People were given the opportunity to observe their faith and any religious or cultural requirements were recorded in their care plan. Reviews took place regularly with people, and where appropriate their representatives, were involved with these. Staff knew people well and were able to tell us about each person, their care and support needs, choices and interests. During the inspection we saw people received the support they needed in relation to their needs and choices. This included regular position changes for people who were at risk of pressure damage and support to maintain appropriate continence.

When people's needs changed staff responded promptly. Staff had identified one person who hadn't eaten their lunchtime meal. Staff explained the person, who was living with dementia, appeared to have difficulty chewing their food, although they did not have a problem swallowing. Following a discussion they offered the person a soft diet which they were able to eat. Staff were regularly updated about changes to people's needs during handover at each shift change and throughout the day. This helped ensure staff had all the information necessary to support people.

People told us they had enough to do each day. There was a busy activity programme in place. This included trips out, visiting entertainers and activities provided by activity staff. There were copies of the programme available to people so they knew what activities were taking place. This was updated each month to include seasonal activities such as Christmas parties and a Carol service. People told us they were supported to take part in what they chose and enjoyed. People's comments included, "I spend a fair time in my room as I like it better, I only go to the lounge if something is happening that I like", "I am not interested in activities or group sessions, I am happy in my own company" and "I listen to music in my room which I enjoy." We observed people taking part in a group activity and they were enjoying themselves. People were encouraging each other to participate with good support and interaction from the activity staff member. People were seen to enjoy themselves and have fun together. Photos were displayed which showed people taking part in a variety of activities and enjoying themselves.

Not everybody was able to join in with group activities and others chose not to. The activity programme included room visits and one to one sessions for people. There was some information in people's care plans about what they liked to do. One person who was living with dementia enjoyed listening to music, watching the television and reading the newspaper. We saw this was available to the person throughout the inspection.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Although staff had not received AIS training the provider ensured peoples' communication needs had been assessed and met. Care plans contained information about how to support people, for example ensuring they were wearing their glasses or hearing aids. There was an emphasis on ensuring people's hearing aids and glasses were clean and provided maximum benefit to people. One person who was living with dementia had a white board in their room on which staff wrote messages to the person. Staff explained that the person was able to understand the written word better than the spoken word.

People and their relatives were regularly asked for their feedback about the service through quality assurance questionnaires, feedback surveys and regular meetings. "They have residents meetings which I go to, they will answer any questions. "The feedback was positive and any issues raised were responded to. Senior staff had regular walk rounds of the home and were available to discuss any issues with people and respond to them promptly. There was a complaints policy in place. People and their relatives were given a copy when they moved into the home. There was also a copy in each person's bedroom. People and visitors told us they did not have any complaints but would talk to the registered manager or staff about them if they did. The registered manager told us that any concerns raised by people were addressed immediately which prevented them becoming formal complaints. Any issue that identified was discussed with the staff, if appropriate, to prevent a reoccurrence. The registered manager was committed to obtaining feedback to continuously improve and develop the service. She encouraged people and visitors to feedback to her directly or through the www.carehome.co.uk website.

Some people required end of life care and staff supported them to maintain a comfortable, dignified and pain free death. Staff were aware of any changes to people's health and comfort. Appropriate support and treatment was sought in a timely way when needed. People's pain medication was regularly reviewed to ensure each person was comfortable. Advanced care plans were in place which considered what the person's wishes were and where they would like to be cared for. These were completed as far as possible with people and their families. However, staff were mindful of people's wishes to not discuss this. Staff were aware of people's spiritual and cultural needs at the time of their death and these were respected with sensitivity and care. Staff received guidance from the local hospice team to ensure people received the most appropriate and current care and support. A visiting professional told us they recognised the high quality care and service that was provided to people who required end of life care.

The registered manager and her team had identified, that support for people's relatives did not end when the person died. Following a person's death, family members were required to return to the home to collect their relative's possessions. She recognised this could be a difficult time for people. Therefore staff respectfully packed people's belongings into a specially purchased bag. The registered manager told us, "Often you see people's belongings put in a black plastic bag. That feels disrespectful, therefore we have these individual bags which we pack up and relatives can just collect." This demonstrated commitment to ensure ongoing support to people's families through the bereavement process. Staff had recently received feedback from a person's relative which stated. "The care and attention (name) received, extended to us all. It was a great comfort."

Requires Improvement

Is the service well-led?

Our findings

People and visitors spoke highly of the service. One person told us, "The atmosphere is good here. Staff are very friendly and approachable." Another said, "If you have got to go into a home this is as good as any, no one wants to go into a home but if you have got to you have to." Most people knew who the registered manager was, they told us she spoke to them regularly. A visitor said, "I know her, she always speaks to me and I would go to her if I needed to but never had to. The atmosphere is relaxed; it's very good and friendly, very clean and well looked after place." Staff spoke highly of the registered manager and felt well-supported by her.

Although we received positive feedback we identified some areas that needed to be improved.

There was a range of audits and quality monitoring in place. However, these systems had not identified all the areas for improvement we found. Further development of mental capacity assessments is required to ensure they are decision specific and the recording of best interest decisions is in place. The provider had introduced an electronic care planning system and all care plans and risk assessments had been transferred to this new system. The information was accessible to staff via computers and a hand held device on which staff accessed care plans and recorded the care and support people received. However, care plans had not been consistently completed with the detailed information staff may need. For example, the care plan for one person who had difficulty making choices included guidance about how staff could support the person to make choices. For a second person there was no detailed guidance. Another care plan did not include a rationale for why the person was dressed in a particular way. Some people had pressure relieving mattresses in place, there was information about these in people's care plans but this was not consistently recorded. For example, some were recorded in 'sleeping' care plans, another in 'skin integrity' care plan and another in 'safe environment' care plan. This did not impact on people because staff knew how to support people appropriately and understood their care needs. Daily notes did not fully reflect all the care and support people received. We observed one person was distressed; staff attended to the person promptly and recorded the actions they had taken. However, these records were task based and did not reflect the person's original distress. The registered manager explained staff were still learning to use the system. There was the facility for them to record more detailed information but further learning was needed to fully embed the new system into practice. The registered manager recognised in the PIR and throughout the inspection that further improvements were required to ensure all information was recorded. We recommend the registered provider monitors that all documentation is continually reviewed and updated to ensure accuracy.

Before the inspection the registered manager had identified that the registered nurses had not consistently documented when people were given PRN medicines. Although information was recorded on the MAR to show the medicine had been given. Staff had not documented why the medicine had been needed and whether or not this had been effective. This did not impact on people because staff knew people well. The registered manager had sent a memo to the registered nurses to remind them to record this appropriately.

The registered manager responded immediately to issues identified during our inspection and

demonstrated they were committed to ongoing development and improvement. The registered manager and deputy manager worked at the home most days. They knew people really well and had a good understanding of the needs of both people and staff. They were visible and approachable to staff. We observed open and friendly interactions throughout the inspection. The registered manager, or most senior staff member on duty completed a 24 hour report on the home. This gave daily information about people at the home which included changes to people's needs, new admissions, accidents and staffing. This provided good oversight of the home on a daily basis.

There was a clear management structure in place and staff were aware of this. There was a positive culture at the home. Staff told us they were happy working at the home, they spoke highly of the registered manager and management team. They told us they felt well supported by both the management team and their colleagues. One staff member said, "I love every part of my job, there's no division between the teams, there's no airs and graces, we're literally a family." Another staff member said, "I have been well supported, both personally and professionally." A further staff member said, "You can go to any staff here (for support)." Staff were also complimentary about the training they received and how this was embedded into every day practice. One staff member said, "You could work here for 50 years and still learn something."

Staff understood their roles and responsibilities. They were allocated their work each shift and understood their responsibilities in relation to both care needs and reporting concerns. Staff were observed to discuss concerns with them freely and honestly. Staff had a clear understanding of whistle-blowing policies and how to raise any concerns. They told us they were always able to speak to the registered manager or deputy manager and in their absence said they would discuss concerns with one of the registered nurses. There were regular staff meetings where staff were encouraged to feedback any ideas or areas for development.

Staff were valued and staff culture and diversity was respected and celebrated. There had been a recent visit to the home from an Indian dance group which included staff member's children. Staff had also prepared and shared local Indian food with people as part of the celebration. The provider had recently introduced 'Cards for Culture.' These cards were available for people, visitors and staff to complete if they wished to recognise staff contributions to the home. These were under the headings of thanks, dignity, commitment and care. Cards received were then passed on to staff members as appreciation and recognition of their service.

The registered manager was committed to improving and developing the service. There had been the introduction of 'Champions' in a number of areas. This included dignity, dementia, nutrition and continence. These roles were still being developed through ongoing support and training for staff. The registered manager told us how improvements had already been made by the continence champion who had developed effective systems to ensure people's continence products were fully assessed and used correctly. The registered manager also liaised regularly with the Local Authority, Continuing Healthcare Team Service and visiting healthcare professionals in order to share information and learning around local issues and best practice in care delivery. The registered manager engaged with the local community and local teenagers visited the service to spend time with people and support them with activities.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events appropriately. The registered manager was aware of their responsibilities under the Duty of Candour. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong. The Duty of Candour is a regulation that all providers must adhere to.