M D Homes

Frithwood Nursing Home

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?	Good

Summary of findings

Overall summary

We undertook an unannounced inspection of Frithwood Nursing Home on 9 October 2018. The service was inspected on 3 August 2017, when we rated the service requires improvement. We identified two repeated breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which related to safe care and treatment and good governance and issued the provider two warning notices. We undertook a focused inspection of the service on 10 October 2017 to check if the provider had met the requirements of the warning notices and found they had.

Prior to this inspection, we received anonymous concerns highlighting some areas of poor practice at the home. We considered these as part of our inspection and in assessing how well the service was meeting the five key questions we asked of providers. We found that the service was rated good in all key questions.

Frithwood Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The service provided both nursing and personal care and is registered to care for up to 26 people. At the time of our inspection, 22 people were living at the service. All the people were over the age of 65 years and some people were living with the experience of dementia.

The service is owned and managed by MD Homes, a partnership which also owned other similar services, mostly in North-West London.

There was a registered manager in place who had been running the service since June 2015. 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 and associated Regulations about how the service is run.

Risks to people's wellbeing and safety had been assessed, and where risks had been identified, the provider had taken appropriate action to mitigate these.

There were procedures for safeguarding adults and staff were aware of these. Staff knew how to respond to any medical emergencies or significant changes in a person's wellbeing.

Staff followed the procedure for recording and the safe administration of medicines.

The service employed enough staff to meet people's needs safely and had contingency plans in place in the event of staff absence. Recruitment checks were in place to obtain information about new staff and ensure they were suitable before they started working for the service.

There were systems in place to protect people from the risk of infection and the environment was clean and

free of hazards.

The provider had sought relevant guidance and had taken steps to improve the environment to meet the needs of people living at the service and in particular of those living with the experience of dementia.

The provider was aware of their responsibilities in line with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty safeguards (DoLS). Staff had received training on this. People's capacity to make decisions about their care and treatment had been assessed. Processes had been followed to ensure that, when necessary, people were deprived of their liberty lawfully.

People's health and nutritional needs had been assessed, recorded and were being monitored. People had access to healthcare professionals as they needed, and their visits were recorded in people's care plans.

People were supported by staff who received regular training and who were regularly supervised and appraised to ensure they were skilled and competent to care for people living at the service.

The provider told us they ensured that lessons were learned when things went wrong, such as speaking with staff and providing additional training as needed, to prevent reoccurrence.

We saw that staff supported people in a kind and caring way and interacted with them throughout the day. People were supported with their individual needs in a way that valued their diversity, values and human rights.

Staff provided a range of activities to people using the service. The provider had purchased new activity material and staff consulted people about what they wanted to do.

People's wishes about end of life care were recorded in their advanced care plan and people's needs were met when they reached the end of their lives.

The provider had robust systems to monitor the quality of the service and put action plans in place where concerns were identified.

People's needs were assessed prior to receiving a service and care plans were developed from the assessments. Care plans were comprehensive and contained details of people's background and care needs.

There was a complaints procedure in place which the provider followed. However, no complaints had been received in the last year.

Staff told us that the provider was approachable and supportive and encouraged an open and transparent culture within the service. There were regular staff meetings where relevant issues were raised.

The provider sought guidance and support from other healthcare professionals and attended workshops and provider forums in order to keep abreast of developments within the social care sector and shared important information with staff.

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.

Risks to people's wellbeing and safety had been assessed, and where risks had been identified, the provider had taken appropriate action to mitigate these.

Staff followed the procedure for the recording and safe administration of medicines.

There were procedures for safeguarding adults and staff were aware of these.

There were enough staff on duty to meet people's needs in a timely manner. Checks were carried out during the recruitment process to ensure only suitable staff were being employed.

Is the service effective?

Good

The service was effective.

The provider was aware of their responsibilities in line with the requirements of the Mental Capacity Act 2005 and DoLS and understood its principles.

The provider had taken appropriate steps to improve the environment in a way to support people who were living with the experience of dementia.

Staff received training and training certificates were available to confirm this. People were supported by staff who were supervised and appraised.

People's health and nutritional needs had been assessed, recorded and were being monitored to ensure these were met.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and caring way and interacted with people throughout the day.

People were supported with their individual needs in a way that valued their diversity, values and human rights.

Care plans contained people's background and their likes and dislikes so staff could consider these when providing care to people.

Is the service responsive?

Good

The service was responsive.

There were regular activities provided for people using the service. The provider had purchased new material to help meet the needs of people living with dementia.

People were consulted about their end of life wishes and these were recorded in their advanced care plans.

People's individual needs had been assessed and recorded in their care plans prior to receiving a service, and were regularly reviewed. Care plans contained enough detail for staff to know how to meet peoples' needs and were written in a person-centred way.

There was a complaints policy and procedures in place.

Is the service well-led?

Good

The service was well-led.

The provider had a number of systems to monitor the quality of the service and put action plans in place where concerns were identified.

The service conducted satisfaction surveys for people and visitors. These provided information about the quality of the service provided.

Staff found the provider to be approachable and supportive.

The provider encouraged good communication with staff and people who used the service, which promoted a culture of openness and trust within the service.

Frithwood Nursing Home

Detailed findings

Background to this inspection

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

This comprehensive inspection took place on 9 October 2018 and was unannounced. The inspection team consisted of two inspectors, a member of the Care Quality Commission's medicines team, a nurse specialist advisor 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 visit we looked at all the information we held about the service. This included contact from commissioners, the local authority, members of the public and notifications from the provider. Notifications are for certain changes, events and incidents affecting the service or the people who use it that providers are required to notify us about. We also looked at public information about the service, including their own website, other websites providing information about care services and the food standards agency report.

We contacted the local clinical commissioning group and local authority and asked them for feedback about the service. The local authority sent us details of a recent visit they had undertaken at the service.

During the inspection we spoke with eight people who lived at the service, two visiting relatives and three visiting healthcare professionals. We spoke with staff on duty, who included the registered manager, nurses, care workers, kitchen and domestic staff. We also met with the owners of the business who have their offices in the building.

Throughout the day, we observed how people were being cared for and supported. We looked at records used by the provider for managing the service. These included care plans and records for six people, four staff recruitment records, records of staff training and support, quality audits and checks on the service, meeting minutes, complaints and records of incidents and accidents. We looked at how medicines were managed, which included the storage, recording and administration of these. We also looked at the

environment and equipment being used.

At the end of the inspection, we gave feedback about our findings to the registered manager and the owners.

Good

Is the service safe?

Our findings

People told us they felt safe living at Frithwood Nursing Home. Their comments included, "Yes I feel safe. I can't complain", "The staff are very good and they are always around" and "Yes I am alright." Relatives echoed this and said, "I feel that my [family member] is looked after" and "Yes I feel [family member] is safe."

People were protected from the risk of infection and staff used appropriate personal protective equipment, such as gloves and aprons. All areas of the home were odour-free, clean and tidy and free of any hazards and all cleaning products were safely locked away. A relative told us, "There are never any smells" and another added, "The place is kept clean and tidy."

The provider had a health and safety policy in place, and staff told us they were aware of this. There were processes in place to ensure a safe environment was provided, including gas, water and fire safety checks. A general risk assessment was in place which included medicines administration, infection control and manual handling. Equipment was regularly serviced to ensure it was safe, and we saw evidence of recent checks. This included fire safety equipment such as fire extinguishers and moving and handling equipment such as hoists and wheelchairs. Where people were supported to mobilise with a hoist, we saw they had their own individual slings and these were regularly checked and kept clean. Environmental risk assessments were in place and included electrical appliances, lighting, smoke detectors, call bells, fire doors and window restrictors.

We observed the staff supporting people to move around the home, and from chairs to wheelchairs using equipment. They did this in a safe and appropriate way, providing gentle support and reassurance to people. We saw that staff had regular training in moving and handling. Equipment was serviced and checked to make sure it was safe to use. There were assessments for each person about how they should be supported to move and any special requirements they had, as well as whether they were at risk of falling and how to minimise this risk.

Where there were risks to people's safety and wellbeing, these had been assessed. Risk assessments and plans were available and included the risks of falls, skin breakdown, choking, malnutrition and those associated with mobility and moving and handling. Person-specific risk assessments and management plans were based on individual risks that had been identified at the point of the initial assessment or during a review of people's needs. We saw detailed guidance was available for staff to follow on how to mitigate these risks. For example, a person using the service had been admitted from hospital with a pressure ulcer and this person was being cared for in bed. We saw that the registered manager had involved the tissue viability nurse who was visiting regularly to provide care to the person and advice to staff as to how to support them. Records and checks were up to date and staff demonstrated their knowledge about how to support the person and meet their needs in a safe way. We saw that the care plan was written in a person-specific manner and included recommendations for staff to follow.

The local authority's safeguarding and quality assurance team had issued an award to the provider for achieving 100 days pressure ulcer free. This was a pilot scheme, which was run with the aim of preventing

pressure sores developing in care homes and the community.

At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies. All prescribed medicines were available at the service and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people who used the service. Medicines were stored securely in locked medicines cupboards or trolleys within the treatment area, and immobilised when not in use. Current fridge temperatures were taken each day (including minimum and maximum temperatures). During the inspection (and observing past records), the fridge temperature was found to be in the appropriate range of 2-8°C. Room temperatures were also recorded on a daily basis.

People received their medicines as prescribed, including controlled drugs. We looked at 12 MAR charts and found no gaps in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed. We found that there were separate charts for people who had patch medicines prescribed to them (such as pain relief patches), insulin administration records and also topical medicines. These were mostly filled out appropriately by staff. For entries that were handwritten on the MAR chart, we saw evidence of two signatures to authorise this (in line with national guidance.) Running balances were kept for all medicines which had a variable dose (for example one or two paracetamol) and there was a record of the exact amount given. We found that antibiotics were given at the correct doses for the appropriate length of time as specified by the prescriber. Also, for people taking inhalers we saw records to indicate the number of puffs they had received from each inhaler and this was in line with the prescriber's instructions.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw 10 PRN forms for pain-relief/anxiety medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine did not have its intended benefit.

We looked at three MARs for people who were administered their medicines covertly. We found that they had a best interests meeting and the appropriate authorisation to have their medicines administered covertly. This assured us that people were administered medicines covertly in accordance with legislation and recommended guidance.

Medicines were administered by nurses that had been trained. We saw the nurse giving medicines to a person using the service and saw they did this with a caring attitude towards them. The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a monthly basis. A recent improvement made by the provider included creating a separate form to ensure all people who were on antibiotics were monitored to ensure appropriate length of treatment, route of administration and signing upon administration was done so that these medicines were received safely by these people. This had been highlighted from previous medicines errors and showed the provider had learned from medicines related incidents to improve practice.

Incidents and accidents were recorded and analysed by the manager to identify any issues or trends. We

saw evidence that incidents and accidents were responded to appropriately. For example, where a person had a fall, they had been checked by the GP and measures were in place to reduce the risk of reoccurrence. Lessons were learned when things went wrong. The manager told us they believed that good communication was important and they ensured that any concerns were discussed in staff meetings and individual supervision meetings. They stated, "I have open discussions with staff. Very important for me to listen. Staff have different views and from that I get new ideas. I am a person who wants everything to be done as soon as possible and get it right. I want people to be safe."

The provider had systems in place to protect people from the risk of abuse. Staff received training in safeguarding adults and training records confirmed this. Staff were able to tell us what they would do if they suspected someone was being abused. One staff member told us, "If I saw anything, I would contact the supervisor or the manager. We have a policy and need to follow that. First thing is to report it" and another said, "You need to keep your eyes open." When asked what they would do if their concerns were not taken seriously, one staff member said, "We can report to the office people upstairs, next on the chain, and then the CQC. That can be done on line." The service had a safeguarding policy and procedures in place and staff had access to these. Staff told us they were familiar with and had access to the whistleblowing policy.

Staff were clear about how to respond in an emergency. Senior staff were available to help and support the care staff and people using the service as required, and involved healthcare professionals as needed. The staff told us the manager was always around and they could call them anytime if they were worried about anything. The manager undertook spot checks of the service, including night checks, to ensure that people's needs were met at all times. We saw evidence of this in the records we checked.

The provider had taken steps to protect people in the event of a fire, and we saw that there was an up to date fire risk assessment in place. There were regular fire drills and weekly fire alarm tests, and staff were aware of the fire procedure. There had been a fire inspection in August 2018 and we saw that all recommended actions had been completed. People's records contained individual fire risk assessments and personal emergency evacuation plans (PEEPS). These included a summary of people's impairments and abilities, and the appropriate action to be taken in the event of fire.

We saw that there were enough staff on duty on the day of our inspection to attend to people's needs. One staff member told us, "Yes we manage. Five carers in the morning, 22 residents. We're ok" and another said, "If there are more residents, there are six staff." The registered manager told us that some staff had left recently and they had struggled to recruit suitable qualified nurses. However, they had been using a reliable agency and the regular nurses they had provided were in the process of becoming permanent. There were suitable arrangements in place to cover in the event of staff sickness. We viewed the staff rota for four weeks and saw that all shifts were covered appropriately.

Recruitment practices ensured staff were suitable to support people. These included checks to ensure staff had the relevant previous experience and qualifications. Checks were carried out before staff started working for the service. These included obtaining references from previous employers, reviewing a person's eligibility to work in the UK, checking a person's identity and ensuring a Disclosure and Barring Service (DBS) check was completed.

Good

Is the service effective?

Our findings

The Mental Capacity Act (MCA) 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 and hospitals 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.

During the inspection, we saw examples where people were consulted and consent to their care and treatment was obtained verbally. Staff told us people were consulted in other aspects of their care and we saw evidence that they or their representatives (where they had the legal right) had signed consent forms. We asked staff what they would do if a person refused to be assisted with personal care. One staff told us, "We'd encourage them to accept it, if not, leave for 10-15 minutes, change with a colleague. We manage. They have the choice to refuse."

The provider had identified people who might have been deprived of their liberty and had taken appropriate action to make sure these were in people's best interests and were authorised by the local authority as the Supervisory Body. Staff employed at the service told us they had received training in the MCA and records confirmed this.

Since our last inspection, the provider had made further improvements to the environment to make it more 'dementia friendly'. There was clear signage and toilet doors were painted brightly so people could identify these quickly. There was a large mural in the lounge featuring an open window with a view of a park, and themed photographs displayed in various areas of the home, to provide a visual interest to people walking around, such as the royal family or famous film stars of the past. In the lounge, there was a large mural of a tree, where photographs of people who used the service hung from its branches. There was also a board with photographs of the staff, so that people could identify who was supporting them. The garden was spacious and clean, but uninviting. It consisted of a lawn and a few bushes but lacked colour and areas of interest. We saw that nobody used the garden on the day of our inspection although the weather was warm and sunny. We discussed this with the manager and owners who told us they would seek guidance and make improvements to develop this in order to meet the needs of people.

People's care and support needs had been assessed before they started using the service. Assessments we viewed were comprehensive and people and/or their representatives had been involved in discussions about the care, support and any risks that were involved in managing the person's needs. People had been

referred by the local authority and the provider had obtained all relevant information from them including people's background and their medical history. Needs assessments included those associated with daily living such as eating and drinking, getting up and retiring to bed, personal hygiene, communication and people's likes and dislikes.

Each assessment included a document entitled 'Here are the most important things to me that will help make every day a good day'. We viewed a sample of these and saw they reflected the person's personal wishes around their routine, such as "I like to have my breakfast in bed. I like toast and marmalade and tea without sugar" and "I like to have my personal care in bed and have a shower when the hairdresser comes." This information helped staff deliver a personalised service to each person who used the service.

People were supported by staff who had the appropriate skills and experience to care for them. Staff told us they had received an induction when they started to work for the service. This included training and working alongside other staff members. Staff told us they were able to access the training they needed to care for people using the service and this included online and classroom based training. One staff member told us, "Now we have online training, it is much better. I can do it at home. We've had dementia, food safety, hazards in the workplace, mental capacity, safeguarding and moving and handling."

We viewed the training matrix where the provider recorded all training delivered to staff. This indicated that staff had received regular training and refreshers in subjects the provider identified as mandatory, such as moving and handling, health and safety, safeguarding, first aid, food hygiene and infection control. They also received training specific to the needs of people who used the service such as dementia, wound care, communicating effectively, equality and diversity and end of life care. There was evidence of certificates in the staff members' records to certify this.

People were cared for by staff who were well supported. During the inspection we spoke with members of staff and looked at staff files to assess how they were supported within their roles. Staff told us they received regular supervision meetings with the provider. One staff member said, "We have supervision monthly. We talk about how to give a good service to the residents. It shows me the way to get better in the profession." The manager told us that these meetings provided an opportunity to address any issues and to feedback on good practice and areas requiring improvement. Staff also received a yearly appraisal. This enabled staff and the provider to reflect on their performance and to identify any training needs or career aspirations.

People and relatives reported that the food on offer was good. One person said, "Yes I think the food is good" and a relative stated, "There is a decent range of food. On occasions when I have been here at meal times, they always offer food, so I have actually tasted it."

We observed people being supported at lunchtime and saw there was a calm and unrushed atmosphere. People were allowed plenty of time to eat and drink. Staff addressed people in a respectful way and offered choice. For example, "What would you like to drink?" and "Is that ok for you?" Meals were brought on trays and plates were covered. People who could eat independently were encouraged and supported to do so, whilst those who needed support received this in a respectful manner.

People's nutritional needs were recorded in their care plan. We viewed the menus for the week and saw that these changed daily on a four-weekly cycle. There were pictorial menus which were made into placemats so people could clearly see what was on offer. The food served was hot, cooked from fresh ingredients and looked appealing. We noticed that people enjoyed their meal and finished it, before being offered dessert. There was a three-part drink container where people could choose from cranberry, orange or mint drink throughout the day. In addition, they were offered a range of hot drinks at regular intervals and were offered

snacks between meals.

There was information about people's dietary needs, including any allergies in their care plans. The chef was knowledgeable about people's nutritional needs. For example, they told us that one person was supported to put on weight and was provided with a fortified diet. They added some examples of individual people's preferences, for example, one person liked to eat porridge in the evening and this was prepared for them. They added, "They have their choices." People's likes and dislikes were recorded and respected. For example, one person liked certain meals that reminded them of their country of origin and these were offered. There were nutritional assessments in place which were reviewed regularly. These stated the person's body mass index (BMI), their weight and any condition that may indicate a risk of malnutrition. Relevant professionals were consulted, for example speech and language therapists (SALT) and the dietician if staff needed advice about a person.

People were given the support they needed to stay healthy. One relative told us, "I feel that my [family member]'s medical needs are met at this care home." The provider was responsive to people's health needs. Staff told us that external health care professionals provided guidance for them on how to support people with various conditions and visited people regularly. Records of external professionals' visits were recorded and included the reason for the visit and actions taken. A healthcare professional told us that people were happy and their needs were met.

Good

Is the service caring?

Our findings

People told us that staff were kind and caring. Their comments included, "I am fine and I am quite happy with the staff. They are kind and caring", "The nurses are nice", "Some of them are very kind" and "One of the girls did my hair yesterday." Relatives agreed and said, "My [family member] always looks clean…. The nurses are really good", "I think the staff are respectful and generally very good." A healthcare professional echoed this and said, "Everyone is very friendly and it's always clean. No concerns. People seem happy. They have a few challenging clients with complex needs and they look after them very well. People are always clean which is good" and another said, "I would not fault the home or staff in the 20 years I have visited. To date the staff have been more than helpful. The day is always arranged efficiently and staff are always there to assist patients to be tested either in the lounge or in their bedrooms."

We saw several examples where staff were attentive to people's needs and anticipated what they wanted. For example, where a person needed their nose wiped, this was immediately noticed and addressed in a discreet way. Another person had their glasses straightened on their face. One person was enjoying drawing, and we saw that a member of staff came to check if the pencils needed sharpening. During lunch, people were gently reminded to eat by a light touch of the hand. One person was provided with a cushion to make them more comfortable whilst eating their food. When people were assisted to mobilise, this was done effectively and discreetly. We saw staff providing reassurance and explaining to people what they were doing.

Staff spoke with people throughout the day and showed genuine warmth when interacting with them. Their comments included, "[Person's name], give us a smile, go on, I know you have a good smile" and "Yes dear, of course I can help you." They lowered themselves to ensure eye contact with people and softly touched their hands. There was an air of calmness and relaxation throughout the day but the atmosphere still felt lively and happy. People who were being cared for in bed were still engaged with daily activities and not isolated.

The staff and provider spoke respectfully about the people they cared for. Staff talked of valuing people and respecting their human rights and their diverse needs. Staff we spoke with knew people well and were able to tell us their likes and dislikes. People looked clean and well kempt and had clean fingernails. A healthcare professional told us people's feet were kept clean, indicating they were receiving a high level of personal care.

Staff told us they ensured they listened to people's wishes and respected their choices. People's care plan included any religious or cultural needs. For example, some people required Halal meat and we saw that this was recorded and respected. One person told us they were visited by the priest once a week to read the bible. Staff also told us they ensured they respected people's privacy and dignity when they supported people with personal care. Their comments included, "We close the door. We try to do everything the way they want", "We cover them… We close the curtains", "We close doors, we close curtains, we give them choice of what they want to wear" and "I ask if they don't mind a man carer. I can ask to swap with a colleague." We saw evidence that staff respected people's privacy and dignity throughout our inspection.

There were a number of posters displayed in communal areas about dignity in care. The purpose of these were to provide information and remind staff and others about the importance of caring and respecting people who used the service. For example, one poster was entitled 'Do not forget the person' and clearly demonstrated how to meet people's individual needs in a respectful way. There was also information about how to become a dignity champion, and the 10 principles of the dignity challenge, including 'Have zero tolerance to any form of abuse' and 'respect people's rights to privacy'. A 'Dignity tree' was also displayed. This contained 14 principles of dignity, including privacy, safety, trust, empathy and choice.

Good

Is the service responsive?

Our findings

People and relatives thought the care was good and staff were responsive to the needs of the people who used the service. A relative told us, "I have always found all the staff to be exemplary, I never had to question anything to do with her care" and "They are organised and deal with special requests I make. I would recommend this service. It has a good
reputation."http://crmlive/epublicsector_oui_enu/images/oui_icons/cqc-expand-icon.png

Staff we spoke with told us they were informed about a person's care needs so they knew how to support them. Their comments included, "The information is given to us by the manager or the nurse, how they speak, if they are bed-bound. And we get information when their relatives come" and "We get the information from the manager before they [new person] comes. They go and assess the person first."

Care plans were developed from the initial assessments and contained information about the care needs of each person and how to meet these. Each care plan included an information sheet. This contained basic details about the person such as their date of birth, preferred name, allergy status and contact details of their next of kin and GP. Care plans were comprehensive and detailed and included the person's needs and wishes in all areas of support. They were split into sections which included lifestyle preferences, medicines and pain management, eating and drinking, communication, sleeping and night time care, end of life preferences and activities.

Guidelines to staff were thorough and clear and included the person's individual needs and how to meet these. For example, one person's communication care plan included, "I am able to use my call bell", "I enjoy chatting with staff and other residents" and "Make sure I am wearing my glasses when awake. Ensure they are clean."

Staff used a dependency tool to measure the level of care and support a person needed. Areas assessed included breathing, washing and dressing, skin and pressure areas, mobility, continence and mental state. Dependency was rated low, medium or high. A person's level of support was decided according to the dependency level. This helped ensure that people's individual needs were met. A healthcare professional informed us that a person using the service had been admitted to the home underweight and with pressure sores. They told us that since their admission, the person had put on weight and their pressure sores had healed. This indicated that the person was receiving appropriate care which met their needs.

The service had a complaints procedure in place and this was available to people and visitors. The provider told us they had not received any complaints since our last inspection. They added that they aimed to listen to people and when there was an issue or a query, this was addressed immediately. We saw that previous complaints had been addressed appropriately.

The provider kept a record of compliments they received from people and relatives. We viewed a sample of these. Comments included, "We just wanted to say a huge thank you for all the care you gave to my [family member] and your continuing support to us as a family", "A very special thank you for all the care and

support you gave our [family member]. [They] passed away peacefully and with dignity" and "Thank you so very much for the excellent care you took of our [family member]. You gave us the gift of peace of mind that [they] were safe and in a friendly home."

The provider had an 'end of life policy'. People's end of life wishes were recorded in their care plans and each person had an advanced care plan in place. This included where they would like to be cared for at the end of their life. It identified each person's medical conditions and needs and detailed how these needs would be met. The end of life care plans were written clearly and in a person-centred way.

There was a pictorial board displaying the activities planned for the day. Each person had their own weekly pictorial activity folder so they knew what was happening each day. Activities on offer included exercises, arts and crafts, talk cards, music time, supersize crosswords, pamper time, talk ball, movie time and memory album. There were also regular events taking place at the home such as parties and celebrations. We saw a written comment from a relative stating, "What a wonderful time we had at the Frithwood summer party… Such a happy day, and the buffet was quite amazing."

The provider did not employ an activities coordinator. Staff were expected to organise activities on a daily basis. On the day of our inspection, there were several activities taking place, including singing along to music and colouring. People who were being supported in bed were visited by staff who chatted with them. The manager told us they were constantly looking for new ideas to develop the activity program according to people's needs and wishes. They had purchased a tablet, which staff used to communicate with people who had communication needs, by showing pictures for example. The manager told us they were going to purchase a projector so that pictures could be projected onto the wall. They were looking into a virtual reality programme where a person's favourite location or area would be projected on the ceiling and around the person so they would feel like they were there. This would enable the person to reminisce about their past thus facilitating conversation with staff. In addition, the manager told us they often brought their own dog at the weekend which people enjoyed.

Good

Is the service well-led?

Our findings

People and relatives thought the home was well-led. One relative told us, "I find the manager to be very effective" and "She is always on the ball and has her eye on the staff to check that they are working well and within guidelines."

The provider had systems to review the quality of the care provided. These included checks to cover a range of areas such as gas and electrical safety, lift and equipment maintenance, admissions and discharges of people, incidence of pressure sores, incidents and accidents, review meetings of people's needs, and complaints and compliments. There were also clinical audits such as catheter care, use of clinical devices and wound care. Records were kept of safeguarding concerns, accidents and incidents. We viewed a range of audits which indicated they were carried out regularly and action was taken to address any shortfalls identified. For example, there were some loose floorboards under the carpet in the corridors, and this was addressed without delay.

There were yearly quality assurance questionnaires sent out to relatives. These questionnaires included questions relating to how they felt about the care and support their family members received and whether their needs were being met. It also included questions about the quality of the food, the environment and their social needs. These were analysed and an action plan put in place where issues were identified. We viewed the results of a recent survey and saw they showed an overall satisfaction with the service provided. Comments included, "Everything is good and care of the residents is the priority", "Fantastic staff, lounge never smells" and "Care given to the residents by dedicated staff, prompt medical attention if needed, friendly welcoming atmosphere." Where areas for improvements were identified, the registered manager put in place an action plan.

People and staff were not asked to complete satisfaction questionnaires as part of the quality assurance surveys. We discussed this with the manager who told us they would devise a pictorial version for people who used the service and would put this in place this year. However, they added that they ensured they communicated with people and relatives frequently so they could share any concerns they might have.

Relatives' meetings were regular. However, we saw that attendance had reduced over the year. The manager told us that was because people were happy with the care and did not feel the need to come. Issues discussed included activities, the needs of the people and any concerns relatives might have.

There were regular staff meetings where a variety of items were discussed with staff. Including training, needs of the people, communication, teamwork and activities. There were also senior meetings where items discussed included rota, training, responsibilities, audits and application of DoLS in the home. In addition, there were daily handover meetings where important information was shared and discussions around what was happening on the day took place.

The manager was a qualified nurse with many years of experience as a manager. They kept themselves up to date by attending all training available to them. They kept themselves abreast of development within the

social care sector by attending provider forums organised by the local authority and workshops and seminars organised by Skills for Care. important information was cascaded to the staff team to ensure they were informed and used new knowledge to continue to improve their practices.

The manager told us they also liaised with other managers from other services to share information and ideas. They added that they had visited another care home and had spent a day there. This had provided them with some new ideas about improving areas of the service such as developing the environment to suit people living with dementia, and working with families and volunteers more. Since then, they had also taken students in for work experience and were liaising with a local school to ask the children to come and spend time at the home and perform for people.

Staff were positive about their job. They told us they felt supported by the manager and were confident that they could raise concerns or queries at any time. Their comments included, "The managers are very supportive, as are other colleagues", "They do help a lot, especially the manager" and "I think everyone is treated equally. No one feels left out. We're all the same. Residents, nurses, carers." Staff told us they had regular meetings and we saw evidence of these. The items discussed included health and safety, training and issues concerning people who used the service.

The service worked closely with healthcare and social care professionals who provided support, training and advice so staff could support people safely at the service. Records showed that professionals visited people at the home and had established good working relationships with staff.