Forever Care Ltd

# Fairlight Nursing Home

## Inspection report

121 Worthing Road
Rustington
Littlehampton
West Sussex
BN16 3LX

Tel: 01903772444
Website: www.fairlightnursinghome.co.uk

Date of inspection visit:
07 June 2022
09 June 2022

Date of publication:
28 July 2022

## 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

About the service
Fairlight Nursing Home is situated in Rustington, West Sussex. It is a residential 'care home' which provides accommodation and personal care for up to 62 people. People living at the service have a range of needs including physical disabilities, nursing needs, and needs associated with older age and frailty. Some people were living with dementia. At the time of the inspection there were 57 people living in the home. The home accommodates people over two buildings which are joined together. Both buildings had been adapted to suit people's needs and one part of the home was adapted for people living with dementia.

People's experience of using this service and what we found
Since our last inspection it was evident the managers of the service and the staff had made improvements which had raised the standard of care people received. Processes for managing medicines and quality assurance and monitoring systems had been revised and embedded. This had improved managerial oversight and the overall governance of the home.

People were protected from avoidable harm as risks to people's health and safety were identified and assessed. People and their relatives told us they felt safe and were cared for by staff who knew them well. One person told us, "I enjoy it here, I'm well looked after. If I was worried about anything, I'd tell the nurses." A relative said, "My [person] is in a good place, I feel that they are safe."

People received their medicines as prescribed and improved practices now ensured medicines were managed safely. Accidents, incidents and safeguarding concerns were reported and investigated as required and actions taken to prevent reoccurrence. People were protected from the risk of abuse and staff were aware of their safeguarding duties and how to report concerns.

People received a comprehensive assessment and felt involved in discussions about their care. People were supported by staff who had completed training in line with people's needs and were equipped with the skills and competence to deliver safe and effective care. Staff were recruited safely and received supervision where opportunities to develop and feedback about their practice were discussed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People had access to external healthcare services and were supported to attend appointments and monitor their health, for example, check-ups with the dentist, optician and audiology.

People were observed in a homely environment adapted for their needs and were supported to drink enough and maintain a balanced diet. People spoke positively about the food and could choose from a varied menu developed by a chef who collated and acted on people's feedback.

People were treated with kindness, dignity and respect. Staff interactions with people were warm and

caring. People were happy and the home had a pleasant atmosphere. A relative told us, "Staff are caring and have a good attitude."

People and their relatives were complimentary about the service, the staff and the management team. Comments included, "I find the manager approachable and they care staff listen" and, "The staff are caring, my [person] is clean and tidy and the care has improved."

The culture of the service had improved, and staff told us morale amongst the team was "getting better." The manager embraced continuous learning and improving care. They told us, "I feel I have oversight of the service. People are feeling content and safe. It's nice."

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
Following an inspection undertaken on 30 November 2020 (report published 5 June 2021) we served a Notice of Decision imposing conditions on the provider's registration. The provider was required to submit monthly reports to CQC to demonstrate their oversight of risks and provide assurance that appropriate actions to mitigate risks had been taken. The last rating for this home was Requires Improvement (report published 11 November 2021). There were continued breaches of regulation in relation to the leadership and management of the home and management of medicines. The conditions of registration remained imposed. The provider continued to submit monthly reports to CQC to provide assurance of the management of risk.

At this inspection enough improvements had been made and the provider was no longer in breach of regulation 12 (safe care and treatment) and regulation 17 (good governance).

Why we inspected
We undertook this comprehensive inspection to check the provider had complied with the conditions imposed on their registration. We also needed to ensure that actions submitted in their monthly reports were embedded and confirm they now met legal requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Requires Improvement to Good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fairlight Nursing Home on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## 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.

Details are in our safe findings below.

### Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

### Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

### Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

### Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

# Fairlight Nursing Home

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was undertaken by one inspector 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.

Service and service type
Fairlight Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Fairlight Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. However, the service did have a manager who was in the process or registering with CQC.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR), and the monthly reports submitted in line with conditions on the providers registration. The PIR is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and eight relatives about their experience of the care provided. The Expert by Experience made calls to relatives remotely by phone. We spoke with 17 members of staff including the quality assurance and deputy managers, manager's assistant, registered nurses, care managers, carers, housekeeping staff, maintenance staff, the activities team and the chef. We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the leadership team to validate evidence found. We looked at staff rota's, minutes from meetings and audit and quality assurance records. We spoke with the manager who was not present at the time of the on-site inspection.

Good

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last comprehensive inspection undertaken on 9 and 10 December 2019 this key question was rated Requires Improvement. During a targeted inspection undertaken on 30 November 2020 the rating of Requires Improvement was not changed as we only looked at parts of the key question we had specific concerns about. On 7 and 13 September 2021 a focussed inspection was undertaken and the rating for this key question remained the same. This key question had remained Requires Improvement for the last three consecutive inspections. We imposed conditions on the providers registration.

At this inspection the rating has changed to Good. This meant people were safe and protected from avoidable harm.

Using medicines safely

At the last inspection the provider had not always ensured people received medicines when they required them. The provider had not always ensured there was proper and safe management of medicines. This was a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● At the last inspection medicines were not always well managed to ensure people received their medicines as prescribed. Systems were not always effective in identifying when people's medicines had been delivered to the service. This led to one person not receiving one of their prescribed medicines for several days. Following the last inspection immediate action had been taken to ensure improvements were made. Systems had been revised to ensure staff were always aware when medicines had been delivered and where they would be stored, so they could be easily located when needed. This system was sustained and embedded and had improved safe management of medicines.
● At the last inspection people did not always receive analgesia for pain as prescribed. At this inspection the manager had implemented audits to monitor the administration of medicines with actions taken when shortfalls were identified. Nurses were observed using an alarm system to notify them when people's pain medicines were due and when to check back to monitor whether the medicine had been effective. Records showed and our observations confirmed people were safely supported to receive their medicines when displaying signs of pain or discomfort.
● Medicines were stored and disposed of safely. Staff responsible for administering medicines kept accurate medicines records, had received training in medicines and were assessed as competent in the task.
● People prescribed 'as required' (PRN) medicines had protocols in place which guided staff on what condition or symptoms the medicines were prescribed for and the circumstances for which they could be administered. Protocols included the risk of potential side effects and strategies to help try and alleviate

symptoms first before PRN medicine was offered.
● People's medicines were regularly reviewed, and people and their relatives told us they felt involved in discussions about their medicines. Comments included, "They always discuss any changes to [person's] medication", and, "They [staff] discuss medication with me, they recently withdrew some of their medication."

Systems and processes to safeguard people from the risk of abuse
● Systems and processes were effective in safeguarding people from the risk of abuse. People and their relatives told us they felt safe and knew who they could speak to if they had any concerns. One relative told us, "I would speak to the person in charge if I was unhappy with [person's] safety or care."
● Staff had undertaken safeguarding training and understood how to recognise signs of potential abuse. Staff understood their responsibilities and were confident the manager would report any concerns. One staff member said, "I would inform the manager, and if they're not here I would tell the next person in charge."
● Incidents of alleged abuse were appropriately identified and reported to the local authority and CQC. The manager understood their responsibilities in relation to safeguarding and conducted investigations as required. Incidents were analysed, and actions taken to reduce the risk of reoccurrence. For example, one staff member's medicines training and competencies had been re-visited following a medicine error.

Assessing risk, safety monitoring and management
● Risks to people's health and safety were identified, assessed and mitigated. People had risk management and care plans which were regularly reviewed and provided guidance for staff on how to support people and meet their needs. For example, people living with long term wounds had care plans to guide staff on how the wound should be managed, including the frequency of dressing changes, what dressings were required and signs to look out for which would indicate the condition of the wound. One person was receiving regular wound care, they told us, "They [staff] change the dressings every other day, it's well looked after." People were referred to specialist health professionals as required, with recommendations implemented and followed by staff. Any changes to people's skin, bruising or minor injuries observed were investigated, recorded and monitored accordingly.
● People who had, or who were at risk of developing urinary tract infections were quickly identified and actions taken to treat the infection and reduce any symptoms. For example, increasing their fluid intake. Records to show how much people had been drinking were completed by staff and regularly reviewed. Shortfalls in people's intake were escalated and actions taken where required. We observed people were offered drinks throughout the day and had drinks available to them. In addition, the manager was recruiting an extra staff member who would be responsible for promoting people's fluid intake each shift.
● People who experienced falls, or those at increased risk of falls were referred to external healthcare professionals for advice on how to keep them safe and their care regularly reviewed. People who had fallen were monitored in line with the providers post falls protocol and subject to enhanced monitoring if a head injury was sustained. This ensured any changes in the person's clinical presentation could be identified quickly and acted upon. Staff were aware of people who were at increased risk due to anticoagulant medicines and demonstrated their knowledge of how to promote people's safety.
● Staff understood their responsibilities regarding premises and equipment. Maintenance issues or concerns were reported in a timely way and quickly resolved. External contractors were sought when repairs could not be made in house. For example, two of the three lifts in the home were broken at the time of the inspection. Staff had worked to ensure the lift management company was promptly informed and made contingency plans to ensure people were safe and impact was minimal.

Staffing and recruitment
● People and their relatives told us there were enough staff and staff came quickly when they pressed their

call bell. One relative told us, "If we press the bell they come rushing to attend to [person]." Another said, "My friend is safe because there are lots of staff around to care for them."

● The manager used a dependency tool to determine how staff would be deployed and ensure staffing levels were aligned to meet people's needs. The team adopted a flexible approach to staffing and responded to changes as required. One staff member told us, "There was always seven of us, then it went up to eight, then down to six and now it's up to eight again. It's nice to finish and support your colleagues so we can be free to support people, for example, with extra fluids."

● Although the service had vacancies, the manager had active plans to recruit more staff. One staff member said, "Managers are trying to recruit staff. Staffing has no impact to residents; they are our number one priority." When required, the service used agency and bank staff to cover any short notice absence such as sickness or annual leave. One staff member said, "Now we use bank staff, this has helped with consistency. The service feels better, and we have good carers."

● Staff were recruited safely, and appropriate Disclosure and Barring Service (DBS) checks and other relevant recruitment checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

The care homes approach for visitors was in line with current government guidance. People and their relatives were positive about their experience of visiting and being able to see their loved ones. Comments included, ""I can visit anytime as long as I let them know that I am coming, I have to produce a negative Covid test", and, "During Covid in February, only essential carers were allowed in to the home, we wore face masks, gloves and they did checks."

Learning lessons when things go wrong

● The service learnt lessons when things went wrong. The management team encouraged openness and transparency about safety and risks. Accidents or incidents were discussed with staff and the people involved, and actions taken to reduce the risk of reoccurrence. Our observations and records confirmed this. For example, when risk information about a person's use of bedrails was not communicated effectively, signage was introduced in people's rooms as an additional prompt for staff, and the handover process updated. This ensured people's safety and demonstrated the managers commitment to learning and continued improvement.

Good

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last comprehensive inspection, we rated this key question good. At this inspection the rating has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs were comprehensively assessed prior to, and during their admission to the home. Care was delivered in line with standards guidance and the law. For example, people's weights were assessed using the Malnutrition Universal Screening Tool (MUST). MUST is a nationally recognised tool used to identify people who are malnourished, at risk of malnutrition or obese. MUST was used by staff to inform people's care plans and identify those who required outward referral for professional guidance and support.

- People who were assessed as at risk of choking had care plans which used the International Dysphagia Diet Standardisation Initiative (IDDSI) to guide staff and ensure people were provided meals suitable for their needs. The IDDSI is a global standard which uses terminology and definitions to describe texture modified foods and thickened liquids for individuals who may be at risk of choking. The chef kept records of people's requirements, understood people's dietary needs and knew who required a modified diet. There were clear processes to ensure people received their correctly modified meals. People were observed receiving their meals and being supported by staff in a safe and considerate manner.
- People were supported to maintain good oral hygiene. Staff had undertaken oral health and mouthcare training and completed an oral health assessment tool to ensure people's needs were identified. People had care and support plans which guided staff on how to maintain their oral hygiene. For example, information about how to care for people's dentures and aspects of oral care that people could maintain themselves to promote their independence.

Staff support: induction, training, skills and experience

- People and their relatives thought staff were equipped with the skills and knowledge to undertake their role. When asked their views on whether staff were suitably trained, one relative said, "The staff are well trained and know what they are doing, and they do discuss [person's] care with me." Another told us, "The staff are brilliant, they seem to have the training to look after my [person]."
- Staff, including agency and bank staff had undertaken suitable training and had the skills and competence to meet people's needs. Staff received an induction and were assessed as competent before they could support people. One staff member told us, "During my induction I was brought in and shown around, I shadowed somebody. It was quite in depth."
- Staff were required to complete the Care Certificate as part of their induction and ongoing development. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of carers working in health and social care. Records confirmed staff had either completed or were in the process of completing the care certificate as part of the requirement for their role.

● Staff received regular supervision and felt supported by the management team. Staff were provided with opportunities to broaden their experience and learn new skills. Some staff had been enrolled on educational courses in care. One staff member said, "I am doing NVQ level three, and NVQ level four is in the pipeline."

Supporting people to eat and drink enough to maintain a balanced diet

● People were supported to eat and drink enough and maintain a balance diet. People could choose from a varied menu and choose where they preferred to sit at mealtimes. Some people were observed eating their meal in their room, others sat at the dining table in communal spaces. People were complementary about the food and choices available. One person told us, "The menu is good, you usually have a choice of two dishes, but you can have what you want if you ask. Today was fish, I'm not keen so [chef] made me a salad instead."

● People were encouraged to give feedback about the food which was used to help the chef construct the seasonal menu. When asked how feedback was obtained the chef said, "The carers tell us, and there was a recent survey. There's nothing better than when the carers come and tell us the residents have cleared their plates and they really enjoyed that."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff worked with other agencies to provide consistent, effective and timely care. On the day of the inspection one person had a hospital appointment which they needed to attend, but the lift was out of use and maintenance service unavailable until the afternoon. The person was unable to use the stairs. Staff had arranged for the fire service and paramedics to attend the home and support the person safely down the stairs to ensure they were able to attend their appointment.

● People had access to healthcare services and support. We observed, and records confirmed people had access to a variety of services. When asked about access to healthcare one person told us, "Well you can never see a GP, who can these days, but a medical practitioner visits every Monday. If I needed to see someone I'd ask [nurse]." A relative told us, "[Person] sees the chiropodist, optician and other professionals." Another said, "I thought that [person] had a urine infection and they [staff] got straight on it and called the GP."

Adapting service, design, decoration to meet people's needs

● People were observed in a homely environment suitable for their needs. People appeared relaxed and comfortable and had their own private rooms which they were encouraged to personalise. We observed people's rooms were decorated with personal items and photos of their loved ones.

● The home was spacious and light with adequate space for people to mobilise safely with their mobility aids. People were observed mobilising independently. For people unable to use the stairs, the home had three lifts available for use if required.

● The environment had been adapted for people living with dementia or people that may have difficulty navigating their surroundings. Bedroom, toilet and bathroom doors had been covered with colourful wraps to help people identify them and doors had people's names on to help orientate them to their rooms.

● Technology was used to enhance people's care. Call bells were in use for people to call for staff assistance if needed. For those unable to use call bells due to their level of understanding, sensor mats were used in people's rooms so when they moved, staff were alerted and could go to offer their assistance.

Ensuring consent to care and treatment in line with law and guidance

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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● The service was working within the principles of the MCA and legal guidance. There were dedicated staff members responsible for the oversight of MCA and DoLS. Capacity assessments were undertaken and reviewed as required; and applications or renewals for people's DoLS were submitted to the local authority in a timely way. Where conditions to DoLS had been imposed, these were complied with. For example, some people were prescribed particular medicines which required regular review. Staff had ensured these medicines were reviewed by the paramedic practitioner or person's GP. Feedback given during the inspection led to improved processes which would ensure these reviews were tracked and recorded.
● People had access to a DoLS advocate if they were assessed to lack capacity and had no one else to represent their interests. There were two people at the service who had been visited by an advocate to seek their views and support their choices.
● Staff had completed MCA training and understood the principles when caring for people. One staff member said, "If someone has a DoLS in place it means they haven't got capacity." Staff asked people for consent prior to undertaking any tasks or supporting them with care. We observed staff were accepting of people's choices about where they wanted to sit or walk and what they wanted to do.
● People and their relatives told us staff asked for their consent before providing care and they were able to make everyday choices for themselves. A relative told us, "Staff do listen, they respect [person] and ask permission to do their care."

Good

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question Good. At this inspection the rating has for this key question has remained Good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity;
● People were treated with kindness and respect, and their equality, diversity and human rights upheld. Our observations throughout the inspection confirmed this. Staff had undertaken equality and diversity training and understood what this meant for people. One staff member said, "I try to give people the best care I can, protect their dignity, use a person-centred approach; do the best I can for that person."
● People and their relatives spoke positively of staff and said they were kind and caring. One relative told us, "Staff are lovely, caring, and they listen to me and [person], I can't believe how lovely they are. They treat [person] with respect and respect their privacy." A person said, "The staff are very kind here."
● People's cultural, spiritual and religious beliefs were considered, recorded and any associated care needs met. Mass was held at the home once a month and people were offered the opportunity to attend communion should they wish.

Supporting people to express their views and be involved in making decisions about their care; Respecting and promoting people's privacy, dignity and independence
● People and their relatives were supported to express their views and were involved in decisions about their care. Care plans were regularly reviewed and updated when people's needs changed. One relative said, "I have seen [person's] care plan and I am involved in any changes."
● People were familiar with staff and staff knew people well. We observed interactions between people and staff which were warm and caring. People told us staff came to speak with them and our observations confirmed this. People were comfortable asking for support and would ask staff directly, or use their call bell. One person told us, "I have a call bell, but I don't use it. The carers and nurses always look in. [Staff member] will pop in to see me."
● People were supported by staff who ensured that people's privacy and dignity was maintained. Staff had undertaken training in how to ensure people were treated with dignity and respect. Staff were discreet when assisting people with personal care and promoted their privacy. One staff member told us, "I make sure the door is shut and the curtains closed and cover them with a towel or blanket."
● People were encouraged to maintain their independence. People's care plans guided staff on aspects of care people could do for themselves as well as how staff should support them. For example, people were encouraged to walk independently using their mobility aids, we observed people walking by themselves or with support of staff if needed. One person wanted to remain independent with their eye medicines, they told us staff supported them, "I like to do these myself but it's really awkward getting it out the bottle, it's frustrating. They [staff] help me with this."
● People's privacy and confidentiality were respected. Information about people was stored securely and

meetings where people's care needs were discussed, were held in offices to ensure their privacy was maintained.

Good

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating for this key question has remained good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People received personalised care that was responsive to their needs. People had person centred care plans which contained a wide range of information, their likes and dislikes, preferences and personal histories. Care plans were detailed and guided staff as to how people preferred to be supported. Changes in people's care were communicated effectively so staff felt confident of how to meet their needs. A staff member explained, "We have a handover every morning and we're informed of whether anything has changed." One staff member had created an 'at a glance' poster to be placed in people's rooms. This would further provide staff with information about people and enable increased responsiveness to their needs.

● Staff knew people well and demonstrated their understanding of how people preferred to be supported. One staff member shared their knowledge of a person living with dementia and how they support with personal care. They said, "First we go in and say good morning to see if they are ready. [Person] loves pink wafers and music and we know what helps to calm them down, if this doesn't work, we come back and try again later."

● People and their relatives felt involved in their care. A relative told us, "I get phone calls to go through questions regarding [person's] care, I do know that their care is reviewed." When asked about their care plans one person pointed toward their cupboard and said, "I have a care plan in there." They went on to explain how this helped care staff know how to support them apply their topical creams and confirmed these were regularly applied.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● The service was meeting the AIS. People's communication needs were assessed prior to admission and staff completed an AIS questionnaire with everyone living at the home. This included details of the person's preferred method of communication and how they preferred to receive information. People had care plans which informed staff of people's needs and how to communicate with people effectively. Personalised details such as people's non-verbal signs of communication to communicate pain or distress were recorded, for example facial grimacing or touching parts of their body. This meant people who were unable to communicate verbally could express their needs to staff and staff could respond accordingly.

● Information had been adapted to aid people's communication. Picture cards with simple words or items

were observed in people's rooms and communal spaces for people and staff to use if preferred. People living with dementia who may have difficulty recalling what they had chosen for their meal could choose from photos of the meals to help them understand the options available and the food on offer.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported to develop and maintain friendships, follow their interests and take part in activities relevant to them. The service had a dedicated activities team who were responsible for facilitating the home's activity programme; and were working to recruit another staff member to extend the programme to weekends. People were confident the team were committed to expanding the activities on offer. A person told us, "[Staff member] is working hard to get activities going. They're really good."

● People had care plans which contained personal information people had given about themselves, for example their hobbies and interests, or previous employment. Staff used this information as a talking point for one to one discussions and personalised activities. When people were unable to recall this information themselves, friends and relatives were consulted. A relative said, "The entertainment staff are always trying to invent activities to keep residents active, they include everyone even if they cannot participate."

● People could participate in regular activities each week, for example seated exercises or virtual horse racing, and there were local entertainers who had started to visit the service again now Covid-19 visiting restrictions had lifted. When asked about activities one person laughed and lifted their legs, "You can do this [seated exercises], and horse racing, that's fun!" People's birthdays were celebrated, as were significant events and religious holidays such as Christmas and the Queen's Jubilee. The chef told us, "Everyone here has a birthday cake. I made a union jack cake for the Jubilee."

● People and their relatives spoke highly of the activities team and family liaison staff member. One person said, "[Staff member] is really nice, we go out in the wheelchair." A relative told us, "The activities team inform me of changes." We observed several people in the lounge listening to a staff member play the concertina. People seemed to be enjoying the music, one person was singing along, another was waving a long feather to the tune. For people cared for in bed or those who preferred a different activity, one to one session's were held, and reassurance visits offered to people at risk of social isolation or those who experienced anxiety.

Improving care quality in response to complaints or concerns

● The provider had a policy which welcomed complaints and looked upon them as an opportunity to learn, adapt, improve and provide better services. The manager was open and transparent when dealing with concerns that had been raised and complaints were used to make improvements when needed.

● People and their relatives told us they knew how to make a complaint if they needed to. People we spoke with either had nothing to complain about or when they had raised a complaint said it had been dealt with satisfactorily. One person said, "The people are nice, the food is good, I have no complaints." A relative told us, "I did have concerns of them not getting [person] out of bed but it was addressed."

End of life care and support

● People were supported to be comfortable and without pain at the end of their lives. People had end of life care plans which recorded their wishes and contained guidance for staff as to how they wanted to be supported. One person was of Christian faith, staff contacted their local church and arranged a visit as they had requested.

● People's files contained up to date information regarding their resuscitation status and guidance for staff should their physical health decline. This included information about whether they had chosen to be treated in hospital or remain at home at for care and support.

● People were supported at the end of their lives by compassionate staff who demonstrated their

understanding of how to care for people. One staff member said, "We regularly go into their room to make sure they are comfortable, offer regular mouthcare, we make sure that families are okay and tell them we're here if they need anything. When people pass, we open a window."

Good

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last comprehensive inspection undertaken on 9 and 10 December 2019 this key question was rated Requires Improvement. During a targeted inspection undertaken on 30 November 2020 the rating of Requires Improvement was not changed as we only looked at parts of the key question we had specific concerns about. On 7 and 13 September 2021 a focussed inspection was undertaken and the rating for this key question remained the same. This key question had remained Requires Improvement for the last three consecutive inspections. We imposed conditions on the providers registration.

At this inspection the rating has changed to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At the last inspection the provider had not always assessed, monitored or improved the quality and safety of services provided. They had not always ensured staff were able to maintain accurate, complete and contemporaneous records of the care and treatment provided. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● At the last inspection systems were not always operated effectively to ensure people received medicines as prescribed. Records were not consistently maintained, and the providers visions and values were not always implemented. At this inspection improvements had been made. The clinical lead had been appointed as the lead for medicines and, with the nurse's involvement, had revised their processes and implemented audits to monitor medicines stock and administration. This had created a robust system which had improved the oversight of medicines and ensured medicines were managed effectively.
● The manager had continued to provide CQC with a monthly analysis of their quality assurance and auditing systems in line with the conditions imposed on the providers registration. These systems had been evaluated to ensure they were effective in identifying concerns which could lead to shortfalls in people's care. Information collated from these systems was analysed and discussed in clinical meetings. This enabled the managers to identify themes and trends from which actions to improve could be taken.
● The provider had ordered additional electronic hand-held devices for staff to record the support they provided to people in real time. We observed staff using the hand-held devices after supporting people. This ensured records regarding the persons care were accurate, timely and up to date, for example, when people were supported with fluids, personal care or repositioning. The management team utilised the electronic

record system to run reports which highlighted if records were not up to date. An alert system was used to flag when records had not been completed in a timely way, this enabled the leaders of the service to investigate why this had occurred and provided effective oversight of records and people's care.

● Staff spoke positively about the manager and acknowledged the improvements made within the service, they told us morale amongst the team had improved. Staff said the manager was approachable and they felt supported by the leadership team. One staff member explained, "[Manager] understands the staff's position, knows the staff and they're always here, always open, always talking to us. There is open communication. They have a different style of managing to the manager before. They are a good, hard worker."

● Staff continued to express mixed views about support offered by the provider. One staff member said, "[Provider] says their door is always open but no one really sees them very often and no one is comfortable doing that." Despite some staff's views, the manager and provider met regularly to discuss the service, any issues or concerns and identified actions to take forward. The manager told us, "I have a good relationship with [provider], I feel supported by them. This is a good company to work for."

● The managers and staff understood their roles and responsibilities and were motivated to provide safe and effective care. Staff were passionate about their role and the care they provided. Our observations confirmed this. One staff member said, "It is what you make it here, we have a laugh. I just love the residents, the residents and the staff I work with."

● People and their relatives gave complimentary feedback about their experience of care, the manager and leadership of the home. A relative said, "The home seems to be well led now, the new manager seems approachable." Another told us they were, "Very impressed with the service, no need to change anything, we are happy."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The manager understood their responsibilities under the Duty of Candour and was open and transparent when people's care did not go according to plan. These values were shared with the team. The manager told us, "I need to be open and transparent, I included this in my last round of supervisions. If anyone does anything wrong, they need to be honest." The manager had notified CQC of incidents that had occurred, and any lessons learnt or actions taken.

● At the time of the inspection the service did not have a registered manager. When the previous manager left, the current manager stepped up into the role, and shortly after they were appointed into the position permanently. This ensured there was ongoing managerial oversight of the home and the care people received. The manager had already begun the process of registration with CQC; after the inspection their registration was approved.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others

● People, their relatives and staff were involved in discussions about the home in a meaningful way. Feedback was collected in a variety of forums and acted upon to make improvements. For example, staff surveys had indicated communication between departments was poor. To address this, the manager implemented 'heads of department' meetings each week to learn about the issues and improve communication between the teams. They told us, "I feel it's my job to bring the teams together."

● Relatives told us they were asked for their views and received information which kept them updated on what was going on in the home and their loved one's care. Comments included, "We are updated, and things are well displayed in the home", "They contact us by email, by phone or text" and, "I have filled in questionnaires." One to one session's with people were regularly held to ensure people could share their thoughts and discuss matters of importance to them.

● Staff were kept up to date with changes in the service and people's care. Staff meetings were regularly held and gave opportunity for staff to express any concerns and share their views. Records confirmed issues raised were acted upon and shared with other teams as required to drive improvements within the service.
● The manager had a clear vision for the service which demonstrated ambition for staff and people to achieve the best outcomes possible. They told us, "I want our staff to feel happy working here, for the residents to feel happy and safe. I want this home to thrive. We have worked so hard and I am so proud of everybody."
● The management team and nurses worked professionally with external agencies such as the GP practice, pharmacy and specialist health professionals. Staff were aware of the importance of working with other agencies and sought their input and advice. People had access to a range of health and social care professionals and were referred appropriately in response to their changing needs. This enabled people's health needs to be continually assessed to ensure they received the appropriate treatment and support.