Life Style Care plc

# The Grange Care Centre

## Inspection report

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## Ratings

| Overall rating for this service | Good |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Good |

## Overall summary

The inspection was carried out on 29 and 30 June 2015 and the first day of the inspection was unannounced. During the last comprehensive inspection in November 2014 we found a number of breaches of regulations. At a focussed inspection in February 2015 we found the provider had taken action to address the breach in medicines management. At this comprehensive inspection we found the provider had taken action to address the other breaches we had identified and standards of care for people using the service had improved.

The Grange Care Centre provides accommodation for people requiring nursing or personal care for up to 160 people. The service has eight units, each with single en suite bedrooms, dining and sitting rooms and bath and shower facilities. At the time of inspection two units were closed for refurbishment and people were accommodated in the other six units, with 103 people using the service.

The service is required to have a registered manager in post, and the registered manager has been at the service

# Summary of findings

since August 2014. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found improvements had been made in many areas to improve the safety and experiences of people living at the service. These improvements needed to be sustained.

People were happy with the service and we received positive feedback from people, relatives and visiting healthcare professionals, who felt the service had improved significantly and people's needs were being met.

The service was being maintained and servicing and maintenance records were up to date. Risk assessments were in place for identified areas of risk, to minimise risks to people.

Staff recruitment procedures were in place and were being followed to ensure suitable staff were being employed at the service. The service was being staffed to meet people's needs.

Safe and effective systems for medicines were in place, so that people consistently received their medicines safely and as prescribed.

Staff had received training and demonstrated an understanding of people's rights, their individual needs and choices and how to meet them. Staff supported people in a gentle and professional manner, respecting their wishes and maintaining their privacy and dignity.

Staff understood safeguarding and whistleblowing procedures and were clear of the process to follow to report any concerns. Complaints procedures were in place and people and relatives said they were able to raise any issues so they could be addressed.

We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted. Staff listened to people and sought their consent when providing them with care and support.

Food and drink to meet people's individual needs and preferences was provided and staff understood people's nutritional needs. Staff recognised people's changing needs and people received input from healthcare professionals when they needed it.

People were involved with their care records and these were person-centred and reflected people's needs, interests and wishes. Systems were in place for the auditing of care records to identify any shortfalls so they could be addressed in a timely way.

People and relatives were consulted about the running of the service and they were listened to. The service took part in research projects to improve the knowledge of staff and the experience of people who used it. Systems were in place for monitoring the service and these were effective so action could be taken promptly to address any issues identified.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Requires improvement**

The service was safe, with improvements made since the last inspection. Sustained improvement in some areas needed to be shown.

The provider had arrangements in place to safeguard people against the risk of abuse, which were being followed.

Staff recruitment procedures were in place and were now being followed. The service was being staffed to meet the needs of the people living there.

People told us they were happy living at the service. Risk assessments were in place for identified areas of risk and were kept up to date.

Safe and effective systems for medicines were in place, so that people consistently received their medicines safely and as prescribed.

**Is the service effective?**

**Good**

The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively, and we observed this in the care and support they provided to people.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's individual dietary needs and preferences were identified and were being met, including for people on specialist diets and food supplements.

People's healthcare needs were being monitored and they were referred to the GP and other healthcare professionals for input when required.

**Is the service caring?**

**Good**

The service was caring. We saw staff listened to people, interacted with them well and supported them in a gentle and caring manner.

People were involved with making decisions about their care so these could be met. Staff understood the individual care and support people required and treated them in a respectful and dignified way.

**Is the service responsive?**

**Good**

The service was responsive. Care plans were in place and were being reviewed updated to reflect changes in people's needs. There was input from religious representatives to meet people's faith needs. The activities provision was good and met people's different needs and interests.

People and relatives said they knew how to raise concerns and complaints and these were listened to and responded to.

# Summary of findings

**Is the service well-led?**

Good

The service was well led. The service had a registered manager who was approachable and a staff team who worked together well. A management team was in place and they worked consistently together and provided support and clear leadership for staff.

The opinions of people and their relatives were sought and acted upon to improve the service. The service took part in research projects to improve care practices.

Systems were in place to monitor the quality of the service, so areas for improvement could be identified and addressed.

# The Grange Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 29 and 30 June 2015 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service.

The inspection team consisted of five inspectors, including a pharmacist inspector, a specialist advisor in nutrition 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. They had experience with older people including those with dementia care needs and of care services for older people.

During the inspection we viewed a variety of records including 40 care records, some in detail and some looking at specific areas, the medicine supplies and medicines administration record charts for 51 people, five staff files, servicing and maintenance records for equipment and the premises, audit reports and policies and procedures. We observed the mealtime experience for people and interaction between people using the service and staff on all units.

We spoke with 21 people using the service, 15 relatives and two other visitors, the registered manager, the clinical services manager, the deputy manager, the improvement director, the quality support lead, 12 registered nurses, 12 care staff, three activities coordinators, two domestic staff, the chef and one maintenance person. We also spoke with five health and social care professionals, those being two GPs, a dietitian and nutrition practitioner, a speech and language therapist and a social work researcher involved with research related to the Mental Capacity Act 2005. We also contacted the local authority contracts manager for their input.

Requires improvement

# Is the service safe?

## Our findings

At our last full inspection in November 2014, we found not all staff demonstrated a good understanding of safeguarding procedures. Risk assessments were not in place for all identified areas of risk, so action plans were not in place to minimise these. Staff recruitment checks were not fully completed and therefore did not protect people from staff unsuitable to work with vulnerable people. There were not always enough staff on duty to meet people's needs and staffing levels were not effectively managed. During this inspection, we found the provider had taken action to address these shortfalls. Shortfalls found with medicines management had already been inspected in February 2015 and we found they had been addressed. We revisited medicines management during this inspection to see if the improvements had been maintained.

People confirmed they felt safe at the service, and relatives also said they felt their family members were safe. The safeguarding procedure and a 'Stop Abuse' booklet produced by the local authority were displayed in the reception area of the service and both contained the telephone number of the local authority, so this information was easily available. Staff described the different types of abuse people in the service might be vulnerable to. They were able to articulate the provider's policy on dealing with suspicions of abuse, which included reporting concerns to their line manager and then the registered manager and keeping appropriate records. All the staff were clear about the whistle blowing policy and knew which external agency to contact, should they consider that matters they raised were not being dealt with appropriately by the service, including CQC and the local authority. One member of staff told us, "We are due to go for additional training as there are changes to safeguarding." They also felt staff had a better understanding of safeguarding and the procedures to be followed. Safeguarding reports were recorded and showed safeguarding procedures had been followed. Notifications received from the service showed the registered manager knew to report concerns to ensure people who used the service were kept safe.

Risk assessments were in place for identified risks and staff were able to describe people's individual risks. For example, one member of staff told us about a person who could be aggressive and was able to describe what triggers this behaviour and how to avoid this risk. Another told us about a behavioural chart that was used to monitor one person who was at risk of absconding. We saw from people's records that risk assessments had been undertaken and instructions for staff about risks identified were clear. For example, we saw one person's records highlighted the risk of seizures, setting out clear instructions for staff to deal with these if they occurred. In another person's records we saw that a person was identified as being at high risk of choking and of falls, again with instructions about how these risks were to be mitigated including a referral to the falls team. Where someone had a fall, we saw in the care records this had been recorded and reported. Nutritional risk assessments had been carried out and identified any risks and the action to be taken, for example, providing thickened fluids or pureed diets, and we saw these instructions were being followed by staff. This demonstrated that risks to individuals were now being assessed and the actions to be taken to minimise the risk to an individual were identified were being followed by staff.

Risk assessments were in place for equipment and safe working practices and we saw these had been updated within the last 6 months so the information was being kept up to date. The fire risk assessment had been carried out in August 2014 and we saw the action plan had been updated to identify that all the recommendations in the assessment had been addressed. We viewed a maintenance file and saw staff recorded any items or areas for repair they found. The maintenance person told us these files were checked twice a day and other staff confirmed this. We saw where repairs had been identified, work had been carried out promptly to address them and the service was being well maintained. We noted some doors with signage stating the doors should be kept locked were open, for example, sluice rooms and storage cupboards. Some contained items that could be a risk to people, for example, cleaning products, and others did not, for example, bedding. Action was taken to close them, however the second day we found doors again open. We saw some of the coded locks were not allowing the sluice room doors to close properly. These were checked by the maintenance person so any closure problems could be addressed. In addition the clinical

Requires improvement

# Is the service safe?

services manager placed large 'keep closed' notices on the doors. We discussed that where cupboards were only used for safe items, the signage could be reviewed so staff had easy access to them.

Following the last comprehensive inspection all the staff recruitment files had been audited. In the records we viewed we saw application forms and health questionnaires had been completed and any gaps in employment histories had been explained. Pre-employment checks had been carried out. These included Disclosure and Barring Scheme checks, a photograph and proof of identity documents, the right to work in the UK and obtaining two references, including those from previous employers. The staff records showed employment checks were now being carried out appropriately to ensure only suitable staff were being employed at the service.

At the time of inspection we observed staff were available on all units to provide people with care and support and call bells were responded to promptly. One person said, "Staff are very nice, if I need anything I can ring the call bell." We saw not everyone in their bedrooms had access to a call bell. A member of staff explained that some people were not able to use the call bell and that a designated member of staff was on 'room duty' and required to call in on people in their rooms every 15 to 20 minutes to check them. We saw a member of staff responsible for this and they wore a badge displaying their role as room checker and we saw them checking people's rooms. In one of the care files we saw a record explaining the person was not able to use a call bell. Overall people were positive and felt they saw staff regularly. We did receive comment on one unit that the gaps between seeing a member of staff were quite long, and we fed this back to the registered manager who said she would follow it up.

We asked people if they felt there were enough staff and replies included, "Sometimes they could do with a few more, sometimes less." "Yes, I have never had any issues." and "I think they are a bit short of staff." People and relatives said there were usually sufficient numbers of staff on duty, however occasionally some felt they were still short of staff. There were procedures in place for reporting and monitoring staff sickness and absenteeism and these were being robustly followed, so staff understood the processes to follow if they were unwell or an emergency arose that prevented them attending work. The registered manager said there had been a significant reduction in staff sickness levels over the past 6 months, and we saw evidence of this in monitoring records and the staff rotas we viewed. Staff recruitment was ongoing and action was being taken to identify and provide cover for any shifts not allocated to a member of staff. The clinical services manager monitored the staffing levels and when we asked her about staff cover for shortages she said, "staff talk to each other to help each other out."

There were safe and effective processes in place for the management of medicines. All medicines were stored securely, and at the correct temperatures to remain suitable for use. There were clear processes in place, and being followed, for the storage, recording and administration of controlled drugs. Supplies of all prescribed medicines viewed were available, and medicines records were clearly and fully completed. We checked a sample of medicines against medicines records, and there were no discrepancies. We saw repeat prescriptions were ordered well in advance, and supplies of medicines were already available for the next monthly cycle, due to start in seven days' time. We saw that staff had checked these supplies, and had faxed the GP and the pharmacy with a list of discrepancies, so that these could be sorted out before the next cycle began. Therefore we saw that the ordering system for medicines was effective, and that the problems with supplies of medicines running out and inaccurate record-keeping that we noted at our inspection in November 2014 were now resolved. All of this evidence provided assurance that people were receiving their medicines as prescribed.

We observed the lunchtime medicines round on four of the units, and saw staff took their time to administer medicines safely and at the correct times. People told us they received their medicines. There was evidence of regular medicines reviews and the GPs confirmed these took place. Two people were being supported to self-administer some of their medicines, and this had been recorded and risk-assessed to check that they were able to do this safely. Some people were prescribed sedating medicines for agitation. Care plans were in place so staff had guidance on when to use these medicines, and we saw that these sedating medicines were not being overused. Where night sedation had been reviewed and discontinued, night staff monitored people's sleep patterns for four weeks so any issues could be raised with the GP. Where people were having their medicines administered covertly, the

Requires improvement

# Is the service safe?

appropriate mental capacity act assessments had been carried out, documenting the reason for doing this, and that this was in their best interests. Pain assessments had been carried out for people on 'as required' pain relieving medicines, so people's level of pain and response to the medicines was being monitored. We asked a registered nurse how staff would know when someone with a cognitive impairment required pain relieving medicine. He told us, "Give the person time, ask where the pain is, notice changes in behaviours and always ask effective, short questions." This demonstrated an understanding of how to monitor people's pain.

The deputy manager carried out regular weekly medicines audits, and a more detailed audit was carried out once a month. As daily medicines audits were not being carried out, we identified some minor issues which had not yet been picked up by the weekly audits, such as unclear processes for crushing tablets for covert administration and administration via PEG tubes, recording when food supplements were prescribed and given, one unit had not been monitoring the temperature of medicines storage areas every day, and there was a delay in resolving a discrepancy with the frequency of use of some prescribed eye drops. We brought these matters to the attention of the registered nurses and registered manager and action was taken to address them during the inspection. We noted that some medicines care plans did not identify the risks associated with certain medicines, such as the risk of falls when people were prescribed sedating medicines, and any special monitoring needed, such as when people were prescribed anti-psychotic medicines or medicines for Alzheimer's disease. The provider told us that they had developed a new more comprehensive medicines audit form, to be implemented in July 2015, which would incorporate these additional areas to further improve how medicines were used and managed.

In light of the issues identified, we need to see sustained improvements in this area.

Good

# Is the service effective?

## Our findings

At our last full inspection in November 2014, we found staff had not received adequate training and support to understand and meet people's needs effectively, including the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People's individual dietary needs and wishes were not always being met. During this inspection, we found the provider had taken action to address the concerns we raised.

We met with the learning and development facilitator for the provider, who explained she was based at the service and all new staff received induction and ongoing training, to provide them with the skills and knowledge they needed to care for people effectively. We saw records of training and staff employed in the last 9 months confirmed they had undertaken comprehensive induction training. The main training programme combined theory and practical training so staff were assessed when putting what they had learnt into practice, and the learning and development facilitator described this as "making the working place a learning place." We asked staff about their training and they told us the training at the home was very good. Staff listed the courses they had attended including safeguarding, health and safety, infection control, manual handling, mental capacity and deprivation of liberty safeguards, medicines management and dementia care. Staff told us about a training initiative that had been introduced and several members of staff had already attended the course, which sought to improve the way staff delivered person-centred care. On the first day of inspection two training sessions in nutritional support were carried out by a dietitian and we saw at mealtimes staff understood people's individual nutritional needs and how to meet them.

We saw there were comprehensive training programmes planned each month to keep staff knowledge and skills up to date. The clinical services manager and the training coordinator met each Monday to view the training planned for the week and ensure staff were identified to attend and appropriate cover was provided on the units to meet people's needs. We viewed training records and saw staff undertook formal training sessions and also 'mini-modules', where training took place on a unit during the working day to look at an area of work, for example, a behaviour specific to an individual, to provide staff with 'hands on' learning in how to care for and support that person to meet their needs.

Staff received supervision every two months, and this was cascaded down from the registered manager to all staff. Staff confirmed they received supervision and were able to discuss their training and development needs and any other issues that might arise. Annual appraisals were also taking place and these were recorded on the supervision record to evidence they had been carried out for 2015. From our observations and conversations with people, relatives and healthcare professionals, we saw staff had received the training and support they needed to understand people's needs and care for them in a person-centred and effective way.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). This is where the provider must ensure that people's freedom is not unduly restricted. Where restrictions have been put in place for a person's safety or if it has been deemed in their best interests, then there must be evidence that the person, their representatives and professionals involved in their lives have all agreed on the least restrictive way to support the person. Policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and DoLS were in place and staff confirmed they had received training. Staff were clear about acting in a person's best interest and allowing them to make decisions for themselves, and we observed staff listening to people and respecting their wishes. The service was involved with a research project related to MCA and DoLS and this had also helped staff to increase their understanding. The registered manager understood the criteria and process for making a DoLS applications and had made these appropriately, with twelve pending assessments to be carried out by the local authority DoLS officer. Where applications had been approved, statutory notifications had been submitted to CQC.

Staff told us how they offered people choices about their care and how they obtained consent before giving care. They were able to describe the kinds of questions they could ask a person and how people they cared for indicated their choices. Throughout our visit we observed staff asking people before they did something. For example, we saw people being asked if they wanted help in

moving from the sitting room to the dining room, if they wanted help with their food and whether they wanted to get up or sit up in bed. Some people told us they had relatives who could represent them if they so wished and some had chosen to give this permission, for example, for a relative to be involved with their care records. Care records included information and assessments around people's capacity to make decisions for themselves. The records had been reviewed and were audited to ensure the information was meaningful and kept up to date. Where people did not wish to be actively resuscitated (DNAR) forms had been completed and signed by the GP, who confirmed correct procedures were being followed to consult with people and their relatives in respect of DNAR form completion. The forms were at the front of care records, so healthcare professionals had easy access to them, for example, ambulance personnel who would need to see the document and ensure it was taken to hospital with a person.

We asked people what they thought about the food provision in the service. Comments included, "Very good, I chose lunch for today, yesterday." "I would ask for a sandwich at 10pm and they bring it." "Meal time is enjoyable" "The food is excellent, always hot. They will cook things if [relative] does not like something." "Food is like an hotel, you get a choice of everything." And "Food is ok, staff get me soft food." We saw that people were offered a choice of food. Porridge, cereals and a cooked breakfast was available each morning. One person told us "I had eggs this morning. The breakfast here is good." Another person who was not eating explained, "I don't have breakfast. I just like a cup of tea in the morning. I will eat something later."

Care plans for people's nutritional requirements were in place and identified people's needs including any special dietary requirements, for example, if a person needed a pureed diet or their fluids thickened. Nutritional assessments had been carried out and where people had been identified with a specific nutritional problem, for example, weight loss or swallowing problems, they had been assessed by the dietitian and/or a speech and language therapist. If they identified people had specific nutritional needs they would complete a diet plan and we saw copies of these in people's care records. We spoke with the chef who was knowledgeable and understood the diet each person required and we saw people received the diets they required. Copies of the diet plans were not all available in the kitchen and action was taken during the inspection to address this. Food record and fluid balance charts were being used appropriately and these were discontinued when people were identified as eating well and not at nutritional risk. Some people who were unable to take food and drink orally were fed via a percutaneous endoscopic gastrostomy tube (PEG). This was documented to show people were receiving their nutrition correctly.

Diets for religious and cultural needs were also identified and we saw these were being met. For example, halal and vegetarian meals were prepared appropriately and served to meet people's needs. We asked the chef about providing food outside the usual mealtimes and he said snacks were available on each unit. Staff on the units confirmed this and said there were always sandwiches available. If someone wanted an alternative at mealtimes the kitchen staff were able to provide this, for example, an omelette, so people's needs could be met. Staff were available to provide the support and assistance people needed during mealtimes and took time to help people in a calm and unhurried way. We observed a member of staff see someone was not eating so they gently encouraged the person who then ate some of their meal. For people in bed or who did not wish to come to the dining room, meals were taken to their rooms. We observed staff ensuring people were sitting up and able to reach their meals. Protective clothing was provided for those who wished and staff provided support and assistance to people who needed it. For others, staff went back periodically to check people were eating their meals. We noted one person asleep with their meal in front of them. We discussed this with staff and they explained the person liked to eat when they were ready. We then observed them at another mealtime and saw staff check with the person who made it clear they wanted to eat in their own time, confirming what staff had told us.

We discussed the evening meal with the registered manager, as at the last inspection some people were receiving their evening meal at 4.30pm. She explained that following the last inspection the evening meal timing had been reviewed and had been agreed with people so they had the meal at a time to suit them. We did not receive or note any concerns about the timings of meals at this inspection. Fruit was available in the dining rooms throughout the day and we observed people were served with chopped fruit with their mid-morning drinks. Choices of drinks were available during meals and drinks were encouraged regularly throughout the day. We observed a member of staff making up a thickened drink for one

Good

# Is the service effective?

person and they did this to the correct consistency, so the person could drink it safely. We saw that staff supported people to eat, maximising their independence where possible by encouraging and supporting people to hold their own utensils. Special plates and bowls were available which enabled people who required this support to eat as independently as possible.

People confirmed they saw the GP and could access other healthcare input they needed. One person said, "Every Friday and Monday a GP comes and sees you in your room." We saw in the care records that people received input from healthcare professionals including GPs, dietitian, speech and language therapist, optical and chiropody services. The dietitian said they assessed all the referrals they received and we saw this was recorded in people's care plans. The speech and language therapist assessed people with communication needs and we saw an example where specialist communication had been provided, enabling the person to communicate effectively. We saw staff responded to people's changing needs and sought medical input promptly where required, for example, if someone's condition deteriorated and they needed to be transported to hospital for input. The service had input from one GP practice and the GPs carried out two visits to the home each week. We spoke with the GPs who confirmed staff referred people to them appropriately and followed any instructions they gave. We spoke with a member of the London Ambulance Service who confirmed staff were helpful and had the knowledge to provide effective assistance.

Good

# Is the service caring?

## Our findings

At our last full inspection in November 2014, we found staff often worked in a task led way, care was not person-centred and staff did not always show people respect. During this inspection, we found the provider had taken action to address the concerns we raised.

People confirmed the staff were kind and caring and treated them with respect. Comments we received included, "I do have a good attitude with carers, and they with me." "You can go to bed when you want." "I'd recommend this place, staff are caring." "I'm definitely happy." and "Staff here are very kind and efficient, I am very happy. The food is good. No complaints".

Relatives comments included, "The staff are very nice – they offer me a drink, staff check on [relative] to make sure she's safe." "Staff work very hard, they are wonderful." "All the family are very happy with the care home, other family members have been involved in care planning, giving information to the home." and "Staff are very nice, they come immediately [when called]."

In the care records we saw a page called 'All about me' which included information about the person and their preferences. We asked people if they could choose to have their room doors open and they said they could. One person said, "Yes, it would not be acceptable if staff decide." We asked people if they were able to make choices about their daily lives. Comments included, "I'm free to go to bed and get up whenever I want to." "I go to bed whenever I feel tired." We asked one person if they had been asked if they would like to receive care from a male or female carer. They told us, "They have asked, my answer is always the same, I don't mind as long as they know what they are doing." On both days of inspection we saw people could choose when to get up, with some getting up early and others later in the morning. We saw staff knocked on doors before entering people's rooms. Doors were closed when personal care was being provided. At other times some people's doors were left open, ajar or closed according to people's preferences.

Staff listened to people and responded to them in a gentle and caring way. We observed a person being assisted with eating her breakfast in bed. The staff member was chatting to them and there was a calm, unrushed manner to her interaction. She respectfully was saying, "is that nice?" and "are you enjoying this?" We saw the same standard of care given to another person who also had their breakfast in bed. Those eating breakfast quite late in the morning said this was because they preferred not get up early on that particular day.

At lunchtime we saw staff offer people a choice of drinks. Some of the people told us they had been offered meal choices in advance of the lunch and we observed a member of staff asked a person their preference at lunch, including offering a vegetarian option. On some units we saw staff presented each person with a tray containing two different meals, gently explaining what they were and then asking the person for their choice. People were offered the choice of orange, water or blackcurrant juice, and were encouraged to drink. We observed one person who chose a yogurt but after the first spoonful said they did not like it because it was cold. The member of staff assisting him said, "That's ok, would you like hot rhubarb crumble and custard instead?" Another person complained they were cold and member of staff immediately closed the window and asked if that was better.

The atmosphere was calm with happy banter and chatting. Staff provided support and assistance at mealtimes and did so in a gentle and unhurried manner, taking time to converse with people during the meal. On two different units we observed people who were agitated or confused. Staff responded immediately in a calm and reassuring way. We saw another person who was sad and needed comfort. A member of staff put her arm around their shoulders and softly said, "It's ok, don't cry, she will be here soon." During lunch a person asked to go back to their room and a member of staff supported them to do so in a timely manner. We saw people enjoying spending time in the garden with staff and family members present and there was a good atmosphere.

We observed people who were in their own rooms had the items they needed such as drinks, tissues and their glasses within reach. Bedrooms were personalised and people were encouraged to bring in belongings to make their rooms homely. People were dressed to reflect individuality and we received positive comments from a relative about the care staff took, "Some night staff are really good at picking colour co-ordinated clothes for [relative]." We asked one person if staff respected their cultural or religious needs and they said, "Yes they do respect." We observed a member of staff speaking with an Asian lady and called her

Good

# Is the service caring?

'Auntie' which was a sign of respect and the lady responded positively. The registered manager said staff had received training in different religions and cultures, to provide them with the knowledge to meet people's individual needs in this area. For example, knowing the religious practices to be observed after death for people of Islamic faith.

Good

# Is the service responsive?

## Our findings

At our last full inspection in November 2014, we found people had not been asked their opinions nor been involved in care reviews and care records were quite general and not always up to date. The activities provision was limited and the activities coordinators were often deployed on other duties. People had not been given information about how to make a complaint. During this inspection, we found the provider had taken action to address the concerns we raised and work was ongoing to with the care records to identify shortfalls so they could be promptly addressed.

We asked people if they had seen their care plans and comments included, "Yes, and I agree what is in it." And "Yes, my daughter checks it." We saw a placement review document that evidenced a review had been attended by the person and their relatives, so they had input and could express their opinions. In the records we viewed we saw work had been done to personalise the information to each individual. They were clearly indexed and comprehensive. Each person had a care plan which contained sufficient detail about their needs and preferences to enable staff to care for them in a person-centred way and staff followed these. Where appropriate advanced care plans were in place and identified people's needs and wishes. For example, for a person of Islamic faith the care plan stated they did not want to be cremated, so their wishes were known and could be respected. On one unit some monitoring records for the day before the inspection were incomplete, for example, hourly night checks, and this was looked into by the deputy manager and the registered manager. It was found that in some cases the monitoring was no longer required, but the forms had been left in the records and needed to be removed. The deputy manager followed up on our findings with staff to ensure, where required, checks had been carried out and to revisit their record keeping responsibilities.

We asked people about activities and they told us these were arranged. Comments included, "They do trips out to restaurants, games like bingo", "They take you to the Theatre, war museum the week before, they are doing very well." Another person said about activities, "yes, well organised" and pointed to the weekly activity list on their bed. We saw these lists in people's rooms and also displayed throughout the service, with a wide variety of activities being offered. We saw staff visit people in their rooms and tell them about the activities that were taking place, so they could choose to join in if they so wished. We saw that efforts had been made to differentiate areas of the service and the spaces within each unit. For example, on one unit there were paintings relating to London, whilst on another unit different types of clothing were displayed on walls. Staff explained this helped people recognise where they were and provided talking points for people. We spoke with the activities coordinators during the inspection. They knew people's individual interests and who liked to join in various activities. They also encouraged the staff on the units to be proactive with reminding people about activities, for example, knowing who liked to be involved in activities in the garden, so they could be asked.

We also saw a social coffee morning held in the café on the first floor on the second morning of our inspection. This was a popular choice for people who enjoyed being in a different environment and activities coordinators had to limit the numbers attending and asked for care staff to accompany people to enable them to attend in a way that could be effectively managed. We saw that staff bought pets into the home which the people living at the home really enjoyed. There was a well-equipped sensory room available for use and staff explained this worked well to help reduce agitation and help people relax. People were able to use different sitting areas available within each unit. A number of people liked to wander around and were able to do so freely. On one unit we saw it was more difficult for staff to encourage people to engage in conversation, or to do a puzzle with them. Many people there preferred to sleep in their chairs and it was difficult to always engage with them, although we saw some staff attempt to do so.

The weekly activities programme included a morning and an afternoon activity augmented by one to one activities. The activities coordinators explained they were able to encourage care staff to engage people in other activities such as board games in the communal areas and said they did one to one sessions with individuals in their rooms. One of them described one of these sessions with a person who spent most of their time in bed. They explained how they had rearranged their family photos for them so they were more easily visible from the person's bed, and had engaged with the person, talking about their relatives and the pictures, which had been a meaningful activity for the individual. The service had input from religious representatives from Christian and Islamic faiths. Church

Good

# Is the service responsive?

services took place three times a month, with Catholic, Church of England and Interdenominational services for people to attend if they so wished. The registered manager told us festivals including Christmas, Easter, Eid, and Diwali were marked with celebrations in the service. For example, for the Diwali festival last year representatives from the temples and community attended the service and did a candlelit procession and fireworks in the garden.

We asked people and relatives if they knew how to make a complaint should they wish to and they said they were aware of the provider's formal complaints procedure and would be confident that any complaint would be taken seriously. Responses we got to asking people if they knew how to make a complaint included, "Yes, and if she [manager] didn't listen I would contact CQC." and "Yes, definitely, first there is [staff] in charge of this ward, then above them is the manager, they are very approachable"

When we asked a person if they had ever had to make a complaint they said "Not a thing." Another said they had been able to raise concerns, some of which had been addressed and they knew the process to follow. One relative said, "I can go to the manager anytime – there is an open door and she is more than prepared to listen." Another said, "I feel I can approach the manager and can raise concerns." We saw copies of the complaints procedure were available by the signing in book in the reception area, so they were accessible to visitors. The complaints procedure was also displayed in the service. We viewed complaints records and saw complaints had been recorded, investigated and responded to, with an apology made and a report of the actions taken to address the complaint. A log of complaints was maintained and this was kept under review to identify any trends so they could be addressed.

Good

# Is the service well-led?

## Our findings

At our last full inspection in July 2014, we found systems were in place to monitor the service but these were not effective. Best practice guidance was not being followed when planning peoples care, leaving them at risk of not having their needs met. There had been a high turnover of staff and this had a negative impact on the service. There was little evidence that people and their relatives were consulted about the running of the service. During this inspection, we found the provider had taken action to address the concerns we raised.

We asked people their views on the management of the service. Comments included, "People in charge are more approachable than when I first came here." "The manager is approachable." and "I see the manager once or twice a day and she chats." We asked relatives their views about the registered manager and the service generally. Comments included, "Good, she moved her office to the reception….the manager is very accessible." "The home has gone through ups and downs….new manager seems to have turned things round….activities are now more joined up. They [staff] do listen to me." "I can't think of anything that is not happening and I would like to improve. It is not cursory, I can't think of anything." and "I would recommend the Home to someone else……I would like some staff to interact more, one member of staff just puts the plate on the table and walks away. I feel the home has been pulled up enormously in recent weeks."

The registered manager, clinical service manager and deputy manager were the management team for the service, with management input also provided by the improvement director and quality support lead. All the staff we spoke with said they found the management team were supportive and standards of practice had improved over the last six months. Staff meetings took place and minutes were available for staff to read and points were followed up and addressed. There was a daily 'flash meeting' with the registered manager and senior staff on duty to share and discuss information about any current issues. This meant senior staff were kept informed about what was going on throughout the service. We attended a management meeting and topics covered included staff training and supervision, improvements in areas including care planning, staff sickness rates and staff confidence and empowerment in their work. It was clear the management team worked well together and were consistent in the support and information they provided to staff, so staff were clear about the expectations of the management team and could be effectively supported by them.

One registered nurse from overseas had worked at the service for nine months. She said had received a lot of training and her induction had been long and thorough. She had been given the opportunity to shadow people and re-take training courses that she had found difficult to understand. She had found it easy to learn the language and was now enjoying the job. She found the management team were very good and supportive. She said: "people are looked after very well here, I would not hesitate to have my mum living here." We found staff were welcoming, friendly and polite towards people living at the home, relatives and the members of the inspection team. They were happy to speak with us about their work, which they told us they enjoyed. There were good interactions between staff and they worked well as a team.

People and relatives were aware of the quarterly meetings and one told us, "There are quarterly residents meetings and a Newsletter." Minutes of the meetings were available and action was taken to address any points raised during these meetings. We saw a notice on display with two sections entitled 'What You Said' and 'What We Did'. This listed the points brought up at the last meeting and the action the service had taken to address them. This showed people and their relatives were being listened to. The registered manager said the newsletter had not been completed for a few months, but was due to be started up again to keep people and relatives informed of events at the service. Food satisfaction questionnaires had been commenced earlier in the month and the chef was receptive and welcomed feedback from people to compliment or suggest improvements to the catering service provided. We saw a suggestion box in the dining rooms so people could complete the forms and hand them in anonymously if they so wished. The provider's annual satisfaction surveys for people, relatives and stakeholders were due to go out in August 2015.

A management review of the service had taken place in April 2015 and the business development plan had been updated to reflect the improvements that had been made in the service in recent months and future plans, for example the redecoration and refurbishment of two units for people with physical disabilities, due for completion in

Good

# Is the service well-led?

September 2015. This showed the previous problems with the service had been recognised and action planned and taken to address them. The service was involved with two University research projects. One, relating to MCA and DoLS, aimed to incorporate informal assessments of capacity by staff as part of their day to day care and support of people, as well as at formal assessments. The other was a nutrition and hydration project to look at ways to encourage people who were reluctant to eat and drink. The aim was to improve staff knowledge and skills in these areas when providing care and support. We spoke with a professional involved with one project, who was positive about the manner and approach of the staff they had seen supporting people.

Monthly audits were carried out and these were thorough and covered areas relating to people, risks, care, staffing matters and several other aspects of the service. Action plans were drawn up to address any issues identified and they were signed off when the actions had been completed. We also viewed the providers audits, which consisted of two different documents which together covered all areas of the service, each carried out bi-monthly, so areas of the service were audited and monitored by the provider each month. The recent audits reflected the improvements that had been made in areas such as care records, staff files and staff training statistics. These also contained action plans and we saw where these had been completed. These auditing tools for monitoring had been reviewed and updated to reflect the new regulations and to provide a more comprehensive audit of the service. This included the medicines auditing and the improvement director said they were being put into place from July 2015. A protocol was in place for the ongoing monitoring of care records to try and sustain the improvements and ensure any issues were addressed weekly by the management team.

There was a programme of auditing taking place for all the care records. The audits were thorough, identifying a range of areas, for example, requiring more information about people's background and interests, or evidencing the involvement of the person or, where a relative had permission from or power of attorney for the health and welfare for an individual, the relative's involvement in the development of the care plans and care reviews. Dates were set for the improvements required and we saw evidence of when the action points had been revisited and signed off when completed. The level of detail contained in the audits showed a focus on increasing the personalisation of each care plan and ensuring people's independence and autonomy were maximised where possible, as well as ensuring that care plan reviews were meaningful and informative. Some of the care records were still to be updated following recent audits, and a monitoring system for care record audits was in place so they could be followed up in a timely way.

The quality support lead worked with the nursing and care staff in respect of care planning, risk assessing and auditing. She had been in post for 6 months and had developed a traffic light system for monitoring the progress with each person's care records. When a care plan was up to date and complete, it was rated as green. When there were some incomplete sections, it was rated as amber. If some sections were not completed or had not been updated, then it was rated as red and marked as 'care plan unsafe'. We saw short timescales were set, with care records in the red category being identified for updating the same day as the audit. The quality support lead would then recheck the documents to ensure the necessary updates had been completed. We saw from the records of these audits where improvements were being steadily made as staff had received training and record keeping was improving. It was agreed this was work in progress and the care records would continue to be audited to maintain good standards of record keeping.