Nottinghamshire County Council

James Hince Court Residential Care Home for Older People

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 3 March 2016. James Hince Court Residential Care Home for Older People is registered to accommodate up to forty five people who require nursing or personal care. The home provides long and short term accommodation as well rehabilitation services for people who require support before returning to their own homes. At the time of the inspection there were thirty four people were using the service.

On the day of our inspection there was not a registered manager in place, however an application had been received for the manager to become registered with the Care Quality Commission. A registered manager is a person who has registered with the CQC 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.

During our previous inspection we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to a lack of robust quality monitoring processes in place to identify and act on risks to people using the service and records relating to the running of the service were not always up to date. During this inspection we saw improvements had been made.

There were a number of quality assurance processes in place that regularly assessed the quality and effectiveness of the support provided. The quality of the records used in the running of the service had improved and in the majority of cases were now up to date.

The manager was new to their post but had the experience and skills from previous roles to manage the service effectively. Staff understood their roles and responsibilities and enjoyed working at the home. Attempts had been made to involve people with the development of the service. People and relatives felt the manager was available when they needed them.

The risk to people's safety was reduced because staff had attended safeguarding adults training, could identify the different types of abuse, and knew the procedure for reporting concerns. However, some staff needed to attend refresher courses for this training. Accidents and incidents were investigated and used to reduce the risk to people's safety. Regular assessments of the risks to people's safety, the environment in which they lived and the equipment used to support them were carried out. However, access to the home was possible through two unlocked doors. Hot ovens used to store people's food prior to meal times and were placed in each of the four units for up to two hours at a time, placed the safety of people at risk. People had personal emergency evacuation plans (PEEPs) in place.

People were supported by an appropriate number of staff. Appropriate checks of staff suitability to work at the service had been conducted prior to them commencing their role. People were supported by staff who understood the risks associated with medicines. People's medicines were managed safely; however, when medicines were being administered, a member of staff, at times, left the trolley unlocked and unattended.

People were supported by staff who completed an induction prior to commencing their role and had the skills and training needed to support them effectively. However, some staff required refresher training to be completed.

The manager ensured they had recorded how the principles of the Mental Capacity Act (2005) had been applied when decisions had been made for people. The appropriate processes had been followed when applications for Deprivation of Liberty Safeguards had been made. Staff knowledge of DoLS was poor.

People spoke highly of the food and were supported to follow a healthy and balanced diet. People's day to day health needs were met by staff and external professionals. Referrals to relevant health services were made where needed.

Staff supported people in a kind and caring way. Staff understood people's needs and listened to and acted upon their views. Staff responded quickly to people who had become distressed and communicated well with people living with dementia.

People told us they were provided with the information they needed that enabled them to contribute to decisions about their care. Although evidence of people's involvement was not always recorded within people's care records. People were provided with information about how they could access independent advocates. People's friends and relatives were able to visit whenever they wanted to.

People were involved with planning the care they wanted to receive from staff. People's care records were written in a person centred way and staff knew people's likes and dislikes and what interested them.

People's care records contained information for staff that enabled them to support people in an effective way and to respond to their needs. However, there were a small number of examples where information about people's current health needs and conditions was not recorded. People were encouraged to do the things that were important to them and they were supported to follow their hobbies and interests. People were provided with the information they needed if they wished to make a complaint.

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 not consistently safe.

People were supported by staff who knew the procedure for reporting concerns. Staff had attended safeguarding adults training, although some of this training was out of date.

Risks to the environment had been assessed, however access to the home could be made through two unlocked doors, and hot ovens placed in the kitchen area of each unit, placed people's safety at risk.

People's medicines were managed safely, however during an administration round; the trolley was left unlocked when unattended.

Accidents and incidents were investigated and used to reduce the risk to people's safety.

People were supported by an appropriate number of staff to keep them safe.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff received the training they needed to do their job effectively, although some staff required refresher training in some areas.

People's records showed how the principles of the MCA had been adhered to when a decision had been made for them. DoLS processes had been appropriately applied; however staff knowledge of these safeguards was poor.

People were supported to follow a healthy and balanced diet. People enjoyed the food provided.

People's day to day health needs were met by staff and external professionals.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and caring way and they had a good understanding of people's needs.

People felt listened to and staff acted on and respected their views.

People were provided with the information they needed that enabled them to contribute to decisions about their care, although this was not always recorded in people's care records.

People's dignity and privacy were maintained by the staff and friends and relatives were able to visit whenever they wanted to.

Is the service responsive?

Good

The service was responsive.

People's care records contained guidance for staff to support people, although a small number of these records did not contain reference to people's current care and support needs.

People's care records were written in a person centred way and staff knew people's like and dislikes and what interested them. Staff communicated with people effectively and responded to their needs in a timely manner.

People were involved with planning the support they wanted to receive from staff and their needs.

People were encouraged to do the things that were important to them and were provided with the information they needed if they wished to make a complaint.

Is the service well-led?

Good

The service was well-led.

Improvements had been made to the quality monitoring processes at the home.

The manager was new to their post but had the experience and skills to manage the home effectively.

People, relatives and staff felt the manager was well approachable and available when needed. The manager understood their responsibilities and had applied to be registered with the CQC.

Staff understood their roles and how they could contribute to providing people with safe and effective care.	

James Hince Court Residential Care Home for Older People

Detailed findings

Background to this inspection

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

This inspection took place on 3 March 2016 and was unannounced.

The inspection was conducted by two inspectors and an expert by experience (ExE). An ExE is a person has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. In addition to this, to help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted external healthcare professionals to gain their views of the service provided.

We spoke with nine people who used the service, six relatives, five members of the care staff, the cook, two team leaders, maintenance person and the manager.

We looked at all or parts of the care records and other relevant records of six people who used the service, as well as a range of records relating to the running of the service.

Some of the people who used the service had difficulty communicating with us as they were living with dementia or other mental health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

People and the relatives we spoke with told us they or their family members were safe living at the home. One person said, "I feel safe, I don't wait long [for staff to come] there's a red cord and I pull that and they [staff] come running." Another person said, "I feel safe here." Another person said, "They [staff] make sure I'm safe, they don't leave me. I don't have to wait long for help, but I'm quite independent." A relative said, "We think [our family member] is safe and well cared for, we wouldn't be able to go away and leave them otherwise."

We spoke with staff and asked them how they ensured the risk of people being abused was reduced. The staff could describe the different types of abuse people could encounter. They knew the procedure for reporting concerns both internally and to external bodies such as the CQC, the local multi-agency safeguarding hub (MASH) or the police. A safeguarding policy was in place; however records showed that although staff had received safeguarding of adults training, fourteen out of the forty nine members of staff required refresher training to ensure their knowledge met current best practice guidelines. After the inspection the manager advised that refresher training had been booked for these members of staff.

Information was provided for people which explained how they could report any concerns they had about their or others safety. This included who to report any concerns to, both internally and to external agencies.

Assessments of the risks to people's safety were conducted. The risk assessments in place included, falls, nutrition, choking and developing pressure ulcers. Assessments of people's ability to carry out safely, parts of their own personal care independently of staff had also been assessed. This included people' ability to shave, shower or bathe themselves. The frequency with which the assessments were reviewed varied, dependent on the reason people were being supported at the home. Where people had changing needs, such as people on short term, rehabilitation placements, their risk assessments were reviewed more regularly than people who resided at the home permanently.

Regular assessments of the environment people lived in where conducted to ensure that people were safe. Regular servicing of equipment such as hoists and walking aids were also carried out. Regular servicing of gas installations and fire safety and prevention equipment were carried out and we saw these had been conducted within the past twelve months. External contractors were used to carry out work that required a trained professional.

However, we did identify two risks to the environment that could place people's safety at risk. Access to the home could be gained via two unlocked doors. In addition to this, we also raised a concern with the manager that hot food storage ovens were left unattended in the kitchen/lounge areas of each unit within the home. These ovens were left switched on and in place for up to two hours, in preparation for the lunch and evening meals to be served. The doors to ovens were easy to open and were very hot inside. This could pose a particular risk to people living with dementia who may not be aware of the potential risk the hot ovens could have to their safety. We raised this with the manager. They told us as they were new to the home and were unaware that this process was in place. They took immediate action to remove the ovens

which reduced the risk to people's safety.

People had a personal emergency evacuation plan (PEEP) in place that enabled staff to ensure, in an emergency, they were able to evacuate people in a safe and timely manner. The manager told us they ensured these plans were regularly reviewed to ensure they met each person's current needs. A business continuity plan was in place which contained contingency plans should there be an emergency such as a loss of electricity, gas, or if there was a major leak in the home. The plans were in place to minimise the impact to people's safety.

We looked at records which contained the documentation that was completed when a person had an accident or had been involved in an incident that could have an impact on their safety. Records showed these were investigated by the manager or other appropriate person. Regular analysis was also conducted in order to identify any trends which could assist the manager with putting measures in place to reduce reoccurrence.

People told us they were free to make their own choices and staff supported them without placing unnecessary restrictions on them. One person said, "I do what I want, I get up when I want and just say I'm going to bed now." We also saw an example in a person's care records where the risk of them doing something had been explained to them, but as they had been assessed as having the capacity to make their own decisions, the staff did not prevent the person from doing what they wanted to do.

People did not raise concerns with us about the number of staff provided at the home to support them. Throughout the inspection we noted staff available when people needed them. If a staff member was unable to attend to a person they explained why, and then called for another member of staff. When nursing call bells were pressed staff responded quickly. The staff we spoke with told us they thought there were enough staff in place to keep people safe. One staff member said, "Staffing is a lot better now. Sometimes we are one down on a shift but we can still work it." The manager told us that if staff were unable to cover a shift then agency staff were used. The same agency was used and the same staff were requested to ensure continuity of care for people.

The manager told us they carried out a regular review of people's needs to ensure there were enough staff in place. They told us there was not currently a formal assessment in place but one was currently in the process of being produced. They told us this would offer them further assistance in assessing the appropriate staff numbers needed at the home.

The risk of people receiving support from staff who were unsuitable for their role was reduced because the provider had ensured that appropriate checks on staff member's suitability for the role had been carried out. Records showed that before staff were employed, criminal record checks were conducted. Once the results of the checks had been received and staff were cleared to work, they could then commence their role. Other checks were conducted such as ensuring people had a sufficient number of references and proof of identity. These checks assisted the provider to making safer recruitment decisions.

People told us they received their medicines when they needed them. Not all people were able to explain what medicines they took and why, but one person told us, "I like to know what's happening [with their medicines] so I ask [the staff]."

We observed a member of staff administer medicines to assess whether they did so safely. We saw they checked people's records before administering the medicines to ensure they were being given to the right person, and where needed, stayed with people to ensure they took their medicines. However, we did note

that the member of staff did, on occasions, leave the medicines trolley open and unattended. Although they were never further than a few feet away, we were able to access the trolley without the staff being aware. This meant people who used the service may also have been able to access the trolley and medicines which could cause them harm.

People's medicines administration records (MAR) provided staff with information that helped them administer medicines safely. Photographs were place at the front of each person's record to reduce the risk of medicines being given to the wrong person. There was also information which included details of people's allergies and the maximum dosage a person should have within a 24 hour period. Processes were in place to ensure that when people were administered 'as needed' medicines they were done so consistently and safely. These types of medicines are administered not as part of a regular daily dose or at specific times.

We reviewed the storage of medicines and found they were stored in locked trollies, cupboards and refrigerators within a locked room. However, we noted that the trollies were not secured to the wall when not in use. This could increase the risk of people gaining access to medicines that could cause them harm. A member of staff told us they were waiting for brackets to be installed in this room to enable the trollies to be secured safely to the wall.

Regular checks of the temperature of the room and fridge where the medicines were stored were carried out. These were completed to ensure the effectiveness of people's medicines was not affected by temperatures that were too hot or too cold. Some, but not all of the liquid medicines and external creams were labelled with the date of opening. The recording of the date these types of medicines were opened is important, because once opened, many have a certain number of days in which they must be used otherwise their effectiveness could be reduced.

Requires Improvement

Is the service effective?

Our findings

People told us they felt the staff understood their needs and supported them in an effective way. One person said, "They really look after me. I like the staff they're excellent, I couldn't get better staff." Another person said, "I've improved tremendously. They [staff] know what they're doing." Another person told us they thought the staff were well trained. The person also said, "They [staff] support me, they understand my needs."

The staff we spoke with told us they had completed an induction that gave them the skills they needed when they first started their role. This enabled them to provide care and support for people in an effective way. The manager told us staff who were new to the service would complete the newly formed 'Care Certificate' training to ensure they had the most up to date skills required for their role. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It gives people who use services and their friends and relatives the confidence that the staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Training was available for all staff to ensure they had the skills required to carry out their role effectively. Records showed training had been completed in areas such as, moving and handling, safeguarding of adults and infection control. However, the records also showed that many of the staff required refresher training in a number of areas. For example, seventeen of the forty nine staff had not completed moving and handling training for at least three years, for three members of staff this had been six years. We also found fourteen of the staff had not completed safeguarding of adults training for up to two years. The manager acknowledged that more needed to be done to ensure that all staff training was up to date. They told us as they were new to the home and this was one of their main priorities to address. After the inspection they informed us that the refresher training courses had been booked to rectify this to ensure all staff training was up to date and staff carried out their role in line with current best practice guidelines.

We received mixed feedback from staff when we discussed their training with them. One member of staff told us they felt they had received the appropriate training for their role, whereas another staff member told us they did not.

Staff told us they felt supported by the manager and the team leaders and received regular supervision of their work. Records viewed showed staff received supervision regularly. This enabled them to discuss any concerns they had about their role and to identify how to develop their skills. The manager told us they also carried out an annual appraisal of staff performance for the year.

We observed staff giving people choices throughout the inspection, this included; where they would like their meals to be served to them, whether they would like to take part in activity or whether they would like to join people in communal areas or prefer time alone in their room. Staff always respected people's wishes.

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

Mental capacity assessments had been completed when people were unable to make decisions about specific aspects of their care. Decisions that had been made in people's best interest clearly described who had been involved in the decision making process; this included the person themselves, an appropriate relative and external professionals such as social workers. In each person's care records the appropriate documentation had been completed, although we did find one example where a decision had been made where an assessment had not been completed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). Records showed that applications to the authorising body had been made for people that required them.

Records also showed that all staff had received MCA and DoLS training although ten staff required refresher training. Some of the staff we spoke with had a poor knowledge of DoLS and could not explain how they implemented these safeguards into their role.

Some people had 'do not attempt cardiopulmonary resuscitation' (DNACPR) documentation in place. These had been completed by the person's GP or other appropriate professional person. Some of the documentation had not been appropriately completed or reviewed, which meant in an emergency people's wishes could not be adhered to. We raised this with the manager who told us they would review all of these forms and would contact the appropriate professional person to correct errors made when they completed the forms.

When people presented behaviours that may challenge, a behavioural care plan was in place. This gave a full description of the behaviours the person may exhibit and actions to reduce or manage the behaviour. In addition, each person's care plan for the activities of daily living, considered how their behaviour could be best managed to support them effectively as well reducing the risk to others.

People and their relatives spoke positively about the food provided at the home. One person said, "The food's good." Another person said, "The food's alright, it's great they [staff] cater for your needs." Another person said, "The food's good, can't grumble. It's nice, they're good cooks." A relative said, "The food's good, [my family member] enjoys the food, we can come in and have a meal with them."

The cook, as well as other staff, had undertaken a nationally recognised qualification in catering and food hygiene training. They had detailed dietary information for each person who used the service. This included information about allergies and food intolerances, food likes and dislikes, preparation of food [e.g. soft or pureed diet] and any assistance they required with eating and drinking. However, we did find examples where people, who were staying at the home for short periods of time, had not had their food and drink preferences recorded.

Nutritional risk assessments and care plans were in place to ensure people received the appropriate food and drink to maintain a healthy lifestyle. People were weighed regularly and food and drink monitoring charts were in place for people who were at risk of significant weight loss or gain. Where external

professional advice was required to support people with their weight or other risks associated with food and drink, records showed these were done in a timely manner.

The kitchen was stocked with a wide variety of fresh fruit, vegetables, meat and snacks. People had access to fresh water and juices throughout the day. Regular checks of the temperature of the fridges and freezers were carried out. This ensured food was stored safely.

We observed the lunch time meal in three of the four units. Where needed, staff were available to support people with eating their meals, or, they provided people with specially adapted equipment to assist them with eating independently. Menus were not available for people to make an informed choice on the day. Staff told us people chose their meals the day before. This could be problematic for people living with short term memory loss.

People told us they had regular access to external health and social professionals when they needed them. People told us they were able to see their GP and a person told us a chiropodist and optician regularly visited the home. A relative said, "They [staff] get the doctor out very quickly." The relative also felt their family member's health had improved since being at the home.

Where appropriate, staff supported people to attend appointments with external healthcare professionals. If people were unable or unwilling to leave the home, then staff ensured that visits were made to the home to ensure people received the treatment they needed. People's care records contained information of all visits that people had made and detailed examples of how staff had supported people with maintaining good health.

Good

Is the service caring?

Our findings

People and relatives felt the staff were kind and caring. One person said, "They're [staff] very kind, they'll do anything to help you." Another person said, "The staff are fantastic, I'm not used to being looked after. They help you, and have a great sense of humour, they're great." A relative said, "The staff are very kind and caring."

We observed staff treating people kindly and compassionately. Staff showed concern for people's wellbeing in a caring and meaningful way and responded to their needs. We observed good and positive engagement between staff and people throughout the inspection. Staff appeared busy at times, but we did observe staff taking time to sit and talk with people, showing a genuine interest in what they had to say. For example, we saw one person mention their favourite music; a member of staff picked up on this and facilitated a conversation about people's favourite singers. Another person came over and they were also encouraged to participate in the conversation.

People's care records contained some information about their life history and what was important to them. Information was also recorded for people who were staying at the home on a short term basis. The staff we spoke with had a good understanding of people's personal preferences and used that information to provide them with the support they wanted. One person who was new to the home told us, "Staff soon got to know my likes and dislikes. I have no complaints whatsoever."

We observed staff respond quickly if people became upset or distressed. We saw a member of staff take the time to reassure a person who had become disorientated. The staff member sat with them, reassured them that they were safe and supported them in a kind and caring way. This approach resulted in a quick and positive change in the person's mental well-being.

People's care records showed their religious and cultural needs had been discussed with them and support was in place from staff if they wished to incorporate these into their life. Where people had specific religious requirements the manager told us they ensured all staff were aware of what support people needed to practice their chosen faith.

Some of the people we spoke told us they had been involved with the planning of their care. People told us they had held discussions with staff about how they would be looked after and what support they might need. One person said, "My care was explained." We saw limited documented examples in people's records of their involvement in the development and review of their care plans. However, when we spoke with people, they were knowledgeable about the plans for their care and we observed staff talking with people about their care arrangements. Staff told us people's care plans were written and reviewed with the people themselves but they did not document the involvement.

Information was available for people about how they could access and receive support from an independent advocate to make major decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them at times when important decisions are being made

about their health or social care. At the time of the inspection this information was on a noticeboard in the foyer of the home, which could make it difficult for people to access. However, the manager told us this was because there had recently been some decoration of the area where this information was usually placed and, once completed, it would be returned.

People were supported to be as independent as they wanted to be. Records included reference to the assessed level of each person's ability to undertake everyday tasks, such as carrying out elements of the own personal care. Records also showed people had been given the option of whether they would like a male or female member of staff to support them.

We saw staff treat people with respect. Whenever staff entered a room or walked by a person they said hello and asked them how they were. This resulted in warm and friendly interactions between staff and the people they cared for. It was clear that people liked the staff and interacted well with them.

We observed staff respect people's privacy throughout the inspection. We noted in the care plan of one person who, on occasions, presented behaviours that may challenge, had stated they were a private person and they would respond better to a member of staff who they were familiar with. Staff spoken with could explain how they respected people's privacy. They told us they knocked on people's bedroom doors before entering and they ensured they kept them covered as much as possible during personal care.

People told us they felt their privacy was respected by staff, however one person said they felt some improvements could made. They said, "They [staff] do knock on my door, but tend to knock and enter rather than wait till I say ok."

Staff treated people with dignity. When discussing people's personal care needs staff lowered their voice and spoke discreetly to ensure others could not hear what was being discussed. A relative spoke positively about the way staff cared for their family member. They said, "They're [staff] ever so careful with [my family member]. In the hoist they make sure [my family member] is decent and covered up."

The manager told us dignity champions were in place. Dignity champions have a designated additional role to ensure that people receive compassionate, person centred and dignified care. The manager told us they were in the process of sending out dignity questionnaires to people to gain their views on whether they feel they and others are cared for and supported by staff in a dignified way.

The manager told us that people's relatives and friends were able to visit them without any unnecessary restriction. We observed relatives visiting people throughout the day.

Good

Is the service responsive?

Our findings

People spoke positively about the activities they took part in and how they were supported by staff to do things that were important to them. One person told us they were able to do what they wanted to. They told us they liked to follow horse racing and staff had ensured they received the racing papers when they wanted them. Another person said, "There seem to be activities, but I would rather read, there's some bingo, arts and crafts and a sing song." A relative told us their family member was reluctant to take part in activities but staff tried to involve them as much as possible. However one person said, "It's very nice (at the home) but I'd like a few more things to do, I can't sit doing nothing."

We observed a small group of people, and in some cases accompanied by relatives, engaging in making preparations for Easter decorations. The activities coordinator encouraged people to take part and some people decided to do so. People told us they felt able to make the choice of whether to take part if they wanted to.

Others spent time in their rooms or watching television in the communal areas. There was a pleasant communal area in the centre of the home where people from all four units could meet to talk, play games or listen to music. A pool table, books and magazines and a bar where people could buy drinks was provided. Throughout the inspection we saw this area was rarely used. The manager told us attempts had been made to integrate all four units in the home by introducing a 'breakfast club' and 'Sunday lunch club'. We saw signs throughout the home advertising when these events were taking place. However, the manager told us this had proved difficult as many people preferred to spend time in the communal areas within their own units. The manager told us they would continue to plan events to encourage people to meet socially within the home and to avoid becoming socially isolated.

Staff told us it was not always easy to involve all people in activities due to the type of service provided at the home; with some people staying for a short period of time and others longer. This was because many people on short term stays preferred to spend time in their rooms or doing their own activities. Staff told us they always respected people's wishes if they did not wish to take part.

People's care records were written in a person centred way. This contained information obtained from people and/or their relatives when they first came to the home and included guidance for staff about how to support people in the way they wanted. Care plans for people receiving long term care were detailed and were reviewed monthly. In the assessment and intermediate care units, assessments and care plans were briefer and contained less information about people's individual preferences. They generally contained sufficient information to enable staff unfamiliar with the person to support them. The care plans were based on the activities of daily living and they had been reviewed on a weekly basis to identify the person's progress towards independence.

However, we did find a small number of examples where more detailed information was needed. For example guidance for staff to support a person with diabetes was limited and for two other people records did not contain guidance for staff on how to support them with a condition following input from an external

healthcare professional. We raised this with the manager. They told us they were aware that some care plan records required more detailed information and would ensure they and their team leaders reviewed them to ensure they contained up to date information for all.

The staff we spoke with had a good understanding of people's care needs. They could explain how people liked to be cared for and supported, and our observations throughout confirmed this. We saw staff involve people with the decisions about their own care and respect their choices.

Some of the people using the service had limited ability to verbally communicate. People's care records contained information for staff on how they should communicate with each person and guidance for communicating with people living with a mental disability. We observed the staff communicate effectively with people living with dementia.

People and relatives told us they felt able to make a complaint if they needed to and the complaint would be acted on by staff and the manager. One person told us, "They [staff] do listen; I know where the complaints procedure is." Another person said, "I would talk to the manager or a senior carer about a problem." A relative we spoke with told us about a specific complaint they had made recently and the staff and manager reacted quickly and the issue had now been resolved.

A complaints procedure was provided for people. This explained how people should expect their complaint to be dealt with, and, if they were not happy with the outcome or the way it had been dealt with, offered alternative methods for having their complaint heard.

Staff could explain what they would do if someone wanted to make a complaint. A member of staff told us they would report any concerns or complaints to the person in charge of the shift. They also told us they would reassure the person that they would address the concerns.

We viewed the complaints register and saw the manager had ensured that when a complaint had been made this was dealt with quickly and people were responded to in a timely manner. The relatives and the people we spoke did not raise any concerns with us about how their concerns or complaints were handled by the registered manager.

Good

Is the service well-led?

Our findings

During our previous inspection on 18 June 2015 we identified a breach of Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014. This was in relation to a lack of robust quality monitoring processes in place to identify and act on risks to people using the service and records relating to the running of the service were not always up to date. Additionally, there was not a full time registered manager in post and an application to rectify this had not been made to the CQC. Following that inspection an action plan was sent to the CQC which explained how improvements would be made.

During this inspection we saw improvements had been made in each of these areas. A new manager was now in place. They had an application to become registered with the CQC in place. A new quality monitoring process had also been put in place. Audits were now completed on a weekly and monthly basis in a number of areas such as; reviewing of medicines, accidents and incidents, staff numbers, the environment in which people lived, complaints, care plan records and safeguarding reviews. The manager told us they or their team leaders carried out these audits and the results of them were used to drive improvement at the home.

The manager told us they had also requested their team leaders to carry out regular 'spot checks' of staff performance as well group observations to ensure staff were carrying out their roles in the way in which they were expected to. The manager told us they were confident that these changes and a more focused approach to quality assurance had increased the quality of the service that people received and reduced the risk to people's health and safety.

We received mixed feedback from people when we asked them if they were involved with the decisions about the development and improvement of the service. Few could recall having been invited to give formal feedback by the way attending meetings or completing questionnaires, but all felt the staff and manager were always available to discuss any concerns they may have about the service.

Records showed regular meetings had been held with people and their relatives to discuss the possible closure of the home and people told us they welcomed being involved and kept up to date.

The manager told us a survey had recently been sent to people and their relatives and the results were currently being analysed. They also told us a questionnaire was in place to gain people's feedback on the quality of the food provided and changes, if needed, would be made to address any concerns raised.

Staff understood the values and aims of the service and could explain how they incorporated these into their work when supporting people. One staff member said, "We try to give people all the support they need. We want them to be happy and feel at home." Another member of staff said, "It's a really good place to work. We work as a team and all pull together. I love it."

People were encouraged to maintain links with people within the local community. The manager had introduced a 'coffee morning' for people from the local community to attend and meet people living at the home. There was also a process in place where the local probation service was invited to bring people to the

home who were in the process of providing community service. The manager told us appropriate checks and assessments of risk had been carried out to ensure the people attending the home did not place the safety of people at risk. The manager also told us the visitors sat and talked with people living at the home, they also played pool, listened to music and played games. The manager felt this was a positive experience for people and they enjoyed it.

People were supported by staff who had an understanding of the whistleblowing process and there was a whistleblowing policy in place. Whistleblowers are employees, who become aware of illegal activities taking place in a business either through witnessing the behaviour or being told about it.

The manager told us they had an 'open door' policy and welcomed people, staff and relatives to discuss any concerns they had directly with them. They told us that as they had only been in position for a just over a month they were planning on meeting the people who used the service, relatives and staff to introduce themselves. They told us they wanted to do this to ensure all people felt able and comfortable to raise any concerns that they may have. People, relatives and staff did not raise any concerns about the manager and told us they felt she was approachable and available if needed.

The manager had a clear understanding of their role and responsibilities. They were confident that although they were new to this home, their experience of managing other adult social care homes would enable them to carry out their role effectively. They told us they continually looked for ways to improve their and their staff's skills, and ensured that staff were made aware of the risks to people's health, safety and welfare. Regular team meetings and team leader meetings were held to enable the manager to discuss any on-going risks to people and the service as a whole. Plans were put in place to address the risks and were then reviewed at the beginning of the next meeting to ensure they had been completed.

The manager ensured they had the processes in place when they became registered with the CQC to meet all of the terms of the registration appropriately. The manager had also ensured that the CQC were notified of any issues that could affect the running of the service or people who used the service.