Eastgate Care Ltd

Belle Vue Lodge

Inspection report

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Nottinghamshire
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Date of inspection visit:
30 August 2017

Date of publication:
20 October 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This inspection was carried out on 30 August 2017 and was unannounced. We last inspected this service in July 2015. We found the service was meeting the requirements of the regulations.

Belle Vue Lodge is a care home registered to provide personal and nursing care. Accommodation is provided over two floors, arranged into separate units. It is situated in Nottingham and accommodates up to 59 older people, many of whom are living with dementia. At the time of our inspection there were 56 people using the service.

The service had a registered manager in post. 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.

Belle Vue Lodge had a calm atmosphere and people told us they felt safe. Staff had been trained in safeguarding (protecting adults from abuse) and understood the importance of protecting the well-being of people who might not be able to say if something was wrong.

The risks to people's safety and well-being had been assessed and minimised. Staff knew what action they needed to take to keep people safe. Staff followed risk assessment guidance in order to keep people safe.

There were enough staff on duty to keep people safe and meet their needs. Staff had time to interact and socialise with people as well as providing personal and nursing care. Staffing levels were responsive to the needs of people. The registered manager followed the provider's staff recruitment policy to help ensure the staff employed were suitable to work with people who use care services.

People were supported to take their medicines when they needed them and as prescribed. Staff undertook training to help ensure people's medicines were administered safely.

Staff had completed training to support people effectively. However, we found that staff would benefit from further specific training in dementia and managing complex behaviours. This would enable staff to respond consistently when people were distressed, agitated or confused.

The registered manager had reduced the number of agency staff working within the service to ensure people received effective care from staff who were known to them.

Staff told us they felt supported in their roles and the registered manager and senior staff provided staff with clear guidance and leadership.

People's capacity to make decisions and choices had been assessed. Staff understood the importance of

offering people choices. They followed the principles of the Mental Capacity Act when supporting people to make decisions and providing people with care.

People had their health needs assessed and care plans were put in place to meet their needs. Where appropriate, people were referred to external health professionals for support and guidance to ensure they remained as healthy as possible. Care records did not always reflect that people were receiving care and support in line with professional guidance.

Staff were caring, compassionate and attentive in their approach to meeting people's needs. Staff used different ways of enhancing communication and used their knowledge of people to develop positive relationships. People and relatives were involved in making decisions about their care.

Experienced staff knew people well and used the knowledge they had to tailor their care and support. Care plans did not always include the information staff who were new to the service needed to provide personalised care that reflected people's preferences.

People had opportunity to be involved in a range of one-to-one and group activities. People were supported to go out into the wider community through day trips and events.

People and their relatives were confident to raise concerns and complaints about their care. The registered manager supported people to raise concerns and complaints in a number of ways and used information to bring about improvements in the service.

There were arrangements in place to regularly assess and monitor the quality of the service. The registered manager and staff were working to an action plan and a number of improvements had been made. These included an increase in staffing levels and reduction in the use of agency staff. Staff were clear about the roles and responsibilities. People, relatives and staff were supported to share their views about the service. The registered manager had used this information to improve care. This showed that the service was well-led.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by sufficient numbers of staff to keep them safe. People's needs were met in a timely manner. People's risk of harm had been assessed and was reviewed regularly. There were processes in place to ensure people's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not always cared for by staff who had the specific skills they needed to meet people's needs consistently. Staff understood the principles of the Mental Capacity Act 2005 and their role in supporting people to make decisions and choices.

Records did not always reflect that people were given sufficient food and drink to maintain their health in line with healthcare guidance. People had access to healthcare professionals whenever necessary.

Is the service caring?

Good

The service was caring.

There was good communication between people and staff. People's privacy and dignity were respected. Staff had sufficient knowledge about people to provide them with the care they preferred.

Is the service responsive?

Good

The service was responsive.

People's care plans were regularly reviewed and amended to reflect people's changing needs. Care plans did not always include the information staff who were new to the service needed to provide personalised care. Staff encouraged people to take part in group and one-to-one activities. People and their relatives knew how to make a complaint if they needed to and

support was available for them to do this.

Is the service well-led?

Good

The service was well-led.

Staff received support and guidance from managers within the service. People, relatives and staff were supported to share their views about the service and these were used to drive improvements. There was a quality assurance audit process in place which helped to ensure people were provided with quality care.

Belle Vue Lodge

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 30 August 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor and an expert by experience. A specialist advisor is a person with professional expertise in care and/or nursing. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience's area of expertise was the care of people living with dementia.

We gathered and reviewed information about the service before the inspection, including information from the local authority and previous reports. We also reviewed notifications we had been sent. Notifications are changes, events or incidents that providers are required by law to tell us about. The provider had completed a Provider Information Return (PIR) detailing key information about the service, what they did well and any improvements they planned to make.

We used a variety of methods to inspect the service. We spoke with six people using the service and five people's relatives. We also spoke with the registered manager, the deputy manager, the clinical lead, a registered nurse and ten care staff. Due to their mental health not all the people using the service were able to share their views with us so we spent time with them and observed staff interactions and how people were supported in the communal areas.

We looked at care records and associated risk assessments for seven people. We observed medicines being administered and sampled medicine records for ten people. We looked at recruitment files for five staff. We also looked at records relating to the day-to-day management of the service including quality assurance.

Good

Is the service safe?

Our findings

People who we spoke with told us they felt safe using the service. Comments included, "I feel safe, they [staff] are very careful," "I feel safe. I trust the staff and they talk to me," and "I am alright here, I feel safe. I let them know what I am doing and I am alright." Relatives who we spoke with shared mixed views on the safety of their family members. One relative told us, "I have been worried in the past about safety, we had some issues but they have been sorted now. I have spoken to the [registered] manager about them. Since then it has been fine." Another relative said, "There were some issues in the beginning but these have been sorted now. I think [name of family member] is safe. She is alright and well."

Staff were trained in protecting people from abuse and understood the signs of abuse and how to report any concerns they might have. The provider's safeguarding (protecting people from abuse) policy told staff what to do if they had concerns about the welfare of any of the people who used the service.

Staff demonstrated they understood their safeguarding responsibilities and the importance of protecting people who might not be able to say if something was wrong. Staff who we spoke with were able to describe the types of abuse, what they would look out for and how they would escalate their concerns to their manager or to external agencies if they felt they needed to.

People and relatives felt there were adequate numbers of staff available in the service. Some relatives expressed concern regarding the number of agency staff that had been used as they did not feel they had the knowledge to meet people's needs effectively. Staff told us they felt there enough staff around and staffing levels had improved since new staff had started working at the service, reducing the need for agency staff. The registered manager told us they had recruited to most staffing vacancies which meant that agency staff were no longer used in the service.

The provider used a dependency tool to calculate staffing hours at the service. The registered manager told us they regularly reviewed people's needs and found that further staffing was required to meet people's changing needs. As a result they had requested that the registered provider increase the staffing numbers and this had been agreed and implemented. This included floating care staff who worked across units to provide support as and when required and two nurses, one based on each side of the building. We looked at the staffing rotas and saw the service was maintaining the planned level of staffing on a regular basis. This meant staffing levels were flexible to respond to people's changing needs.

We saw staff were busy but had time to speak with people and check that people across all areas of the service were safe. There were staff present in communal areas so that people who needed reassurance were helped to find where they wanted to go or were provided with assistance in a timely way. Where people were assessed as requiring one-to-one support from staff, we saw this was provided consistently. This ensured that people were supported by the appropriate number of staff required to keep them safe.

Risks to people had been assessed as part of their care plan. This included the risk of falls, assistance with mobility and behaviours that may challenge. Risk assessments included the risk of harm for people and

measures staff needed to take to reduce risks. For example, where people required support with their mobility or to transfer, the level of support they required was clearly recorded together with details of any equipment, included sizing and guidance for usage. Staff demonstrated they ensured people had the equipment they needed to reduce the risk of falls, such as walking sticks and frames.

Risk assessments directed staff to notify the registered manager if they felt there were any changes to the risks people faced and these were acted on. For example, where one person had experienced several falls since moving to the service, records showed the registered manager had taken steps to reduce the risk of falls. This included referral to a falls prevention team and increasing staff support and supervision during the daytime. This demonstrated that the registered manager had responded to reduce the risk of the person experiencing harm.

The registered provider was maintaining records of accidents and incidents which occurred in the service. Staff completed accident and incident report forms which were reviewed by senior staff before being logged onto a central monitoring system. Reviews of accidents records included staff actions, for example staff undertaking two-hourly observation checks on the person following a minor accident or referring to the falls clinic. The central system meant staff could capture the details of accidents and incidents to see if there were any patterns emerging which the provider could use to prevent further harm.

There were personal emergency evaluation plans in place in case of emergency such as fire. The plans were reviewed regularly and coded to reflect people's level of mobility and indicate the support they required to leave the building promptly. Plans detailed equipment needed and number of staff required to support the person. We saw there were evacuation sledges by each stairwell and staff confirmed they were aware of how to use these. This meant staff had the information they needed to support people in the event of an emergency.

The recruitment records we looked at demonstrated there were appropriate recruitment processes in place. We viewed the recruitment files for five staff and saw checks had been undertaken before staff started working at the service. Checks included evidence of previous employment, proof of identity and a check with the Disclosure and Barring Service (DBS). This helped the registered provider to ensure staff were suitable to work with people who use care services.

We looked at the way medicines were managed in the service. People we spoke with told us they were happy with the support they received to take their medicines. We observed part of a medicines round and saw that people were given time to take their medicines and staff ensured records were completed accurately once they had administered medicines. Medicines were stored safely and securely. There were checks in place to ensure the temperature of the storage areas remained constant so that the condition of medicines was maintained. Medicine administration records (MAR) we looked at had been completed correctly.

Some people required medicines on an 'as and when required' or PRN basis. There was information recorded about these medicines to guide staff about when and why the medicines should be administered. Where people were receiving their medicines covertly, for example disguised in food or drink, without their knowledge, there were clear procedures in place to support that the practice was in the person's best interests. This included mental capacity assessments, best interest decisions and appropriate authorisations.

Records showed staff had the training they needed to administer medicines safely. Registered nurses were responsible for administering medicines for people with nursing needs whilst senior staff had responsibility

for administering medicines to people with non-nursing needs. Staff confirmed they had completed the training they needed and had their competency assessed to ensure they remained competent to support people to take their medicines safely.

Requires Improvement

Is the service effective?

Our findings

People who we spoke with said they were happy with staff who regularly worked in the service and felt that they were well looked after and staff knew them well. One person told us, "I think that staff are well trained, they do what I ask." Another person said, "I think they [staff] are trained and have done their studies and they know one another." Relatives told us they felt staff who regularly worked in the service were well trained but had concerns about agency staff. One relative told us, "A lot of staff know exactly what they are doing. The problem comes with agency staff and the quality of agency staff is disgraceful at times. Permanent staff are good, there are some super people [here]." Another relative said, "The regular ones [staff] are trained yes, but agency ones [staff] don't appear to be. You cannot get continuity."

We discussed agency staff with the registered manager. She told us she was aware of people and relatives concerns regarding the use of agency staff which had also been raised as a concern by staff. She explained agency staff had been used to ensure staffing levels remained safe whilst staff positions were vacant. The registered manager had responded to concerns by increasing the overtime rate for permanent staff whilst vacancies were recruited to. She told us that nearly all staffing vacancies had now been filled and new staff were starting to work at the service. These measures had resulted in a marked reduction in the use of agency and at the time of our inspection, the service was not using any agency staff. This meant people now received consistent support from staff who knew them well.

Training records showed that staff who were new to the service followed an induction programme. The registered manager told us staff were required to undertake three days essential training at head office which covered areas such as safeguarding and manual handling. This was followed by 'shadow' shifts where new staff worked alongside experienced staff. This enabled staff to introduce themselves to people and observe how people preferred their care and support to be provided. All staff were expected to complete the Care Certificate. The Care Certificate is a set of nationally recognised standards which supports staff to develop the skills, values and behaviours they need to support people using care services.

Staff we spoke with shared mixed views about the training they had undertaken. Comments included, "All the staff here are brilliant and helped me to settle in really well. Not having a brilliant induction, things were a bit crammed, I think I should have had more introduction to the role," "I had three days induction and two shadow shifts. I have a lot of care experience and previous training which helped. I have completed dementia training but this wasn't very in-depth, I had completed specific training before I started to work her and have a good awareness. Other staff are not so knowledgeable," and "My induction was three days mandatory training and six days shadowing to get to know people. My training included an overview of dementia awareness." Staff who were experienced working in the service spoke positively about opportunities to develop their skills and knowledge through specialist training courses, such as supporting people whose behaviours may challenge.

We observed how staff responded when people who were living with dementia became agitated, distressed or confused. We saw that although staff were quick to support people and demonstrated compassion in their response, they did not use consistent approaches. For example, where one person became agitated as

they were not aware of their environment, we saw one member of staff collude with them to reduce their anxiety. This helped to reduce the person's anxiety but they became anxious again a short while later. We saw a different member of staff approach the person and correct them as to their current environment and why they were no longer at home. The person did not appear to be distressed by this response but their anxiety continued. These different approaches demonstrated that staff did not consistently understand the needs of people living with dementia.

We raised these concerns with the registered manager who agreed that the person should have received a consistent response from staff to reduce their anxiety and told us they would review dementia training to ensure staff had the skills they needed to meet people's needs.

Some people using the service demonstrated behaviours that could challenge. When we asked staff how they supported people with behaviours that may challenge, only a small number of staff told us they had completed training to provide them with the specific skills and knowledge they needed to respond effectively to such behaviours. Staff who were new to the service told us they relied on experienced staff to guide them in their response. We observed an experienced member of staff respond to reduce a person's agitation in a timely manner. They were able to communicate effectively with the person to provide reassurance and reduce the person's agitation. Staff we spoke with told us this knowledge was passed on through staff working together as a team. We discussed this with the registered manager who told us they were aware of this training gap and had responded by requesting training from head office. The registered manager contacted us after our inspection visit to inform us that this training had been approved and all staff were due to undertake specialist training in supporting people with behaviours that may challenge in November 2017. This would help to ensure that all staff were provided with the information and skills they need to support people in a consistent manner.

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We looked at how people's consent to care and treatment was sought in line with legislation and guidance. People who we spoke with told us staff asked if they could help them and let them know what they were going to do before doing it. Staff demonstrated a good understanding of people's right to consent and make choices about their care, including their right to decline care and treatment. One staff member told us, "Where people can make decisions and choices, we support people to do this. Their mental capacity is assessed before admission. I know some people are on DoLS authorisations. Where people decline care, we try different approaches as sometimes people will respond better to some faces or voices than others. If people continue to decline, we accept this but notify the nurses to follow up." Another staff member told us, "I always explain things [to people] and check they are happy with what I am going to do before assisting them."

Records showed, where appropriate, people had mental capacity assessments in place with regard to making certain decisions. People who appeared to lack mental capacity to make certain decisions had been referred to the DoLS team for assessment. The registered manager was in the process of completing

applications where people lacked mental capacity to make decisions and were at risk of being deprived of their liberty. We saw that where a DoLS authorisation included conditions, for example continuous supervision, this was provided in the form of one-to-one staffing. Authorisations were kept under review and new applications made in a timely manner. This showed that the principles of the MCA were being followed at the service.

Where people had a 'do not attempt cardiopulmonary resuscitation (DNACPR) order in place, these had been completed correct, signed by relevant parties and dated. There was evidence that these were regularly reviewed to ensure they reflected the person's current needs and wishes.

We spent time in communal areas during lunchtime to help us to understand people's mealtime experience. People shared generally positive views about their meals. Comments included, "The food varies. It can be good and on some occasions it can be excellent," "The food is eatable but you don't get a lot," "I can never fault the food. You get lots of choice," and "The food is alright. I get choices and it's varied. I can have juice whenever I want." People were provided with options as to where they wanted to eat their meals. This included meals in the atrium (central part of the building) which was set up in restaurant style, the dining/lounges in individual units or in people's own rooms.

People were supported to choose what they wanted to eat from a four-weekly menu. Copies of menus were available in the communal areas for each unit and staff supported people to choose their meals by either describing menus or showing people pictorial menus. We saw one member of staff remind the person what they had chosen for lunch by showing them the pictorial choice. The person replied, "Oh yes, I like that, it looks nice." The cook was provided with information regarding people's dietary needs, including cultural preferences, through a nutritional matrix. This was a chart which detailed people's current needs, such as soft food or low fat. Records showed this was updated regularly.

The service offered protected meal times to people which meant visitors were not encouraged during key meal-times. This was to ensure people were able to focus on their meal and staff were able to encourage people to have sufficient to eat and drink without distractions.

People who required support to eat their meal received help on a one-to-one basis from staff. We saw three members of staff sitting and interacting well with the people they were assisting and engaging in conversation. People were supported to eat at their own pace and the atmosphere was calm and quiet. This helped people to enjoy a positive eating experience. People were offered a choice of drinks to accompany their meal. To support the dining experience in the atrium, people were offered a choice of soft drinks or champagne with their meal.

People and their relatives had requested a coffee bar area in the atrium (central area) of the service and we saw this had been provided. This meant people and their relatives could help themselves to food and drink when they wished. This gave people more independence and contributed to the homeliness of the service. During the day tea, coffee and a range of cold drinks and snacks were served at regular intervals when people requested them. These arrangements helped to ensure that people had access to plenty of fluids.

Records showed that people's nutritional and hydration needs were assessed when they began using the service. Care plans provided information for staff such as likes, dislikes, cultural preferences, specific dietary needs and the level of support required at meal times. People who needed specialist support with their eating and drinking were referred to the dietician and/or the SALT (speech and language therapy) team.

Records were available for staff to detail both food and fluid intake for people identified as at risk of losing

weight. However, we found records had not been completed accurately or correctly. For example, two people had been identified as requiring a supplement to enable them to maintain a safe weight. Records did not show if staff had offered or if the person had accepted the supplement. Another person's care plan included guidance from a dietician that they should be encouraged to eat small snacks through the day and at least one culturally specific meal per day. We saw no evidence that this had been provided. Where staff had completed records in part, there were gaps which indicated that the person may not have received their supplement. Where people were at risk of dehydration, staff had recorded daily fluid intakes but records did not indicate if the total number of fluids met the target daily intake for each person. Records did not provide evidence that staff were providing support for people to have sufficient food and drink in line with dietary guidance.

We raised these concerns with the registered manager who showed us records that confirmed staff monitored people's weight on a regular basis and responded to any significant loss of weight through appropriate referrals. The registered manager told us they would review records and meet with staff to ensure they supported people with specific dietary needs in line with professional guidance. They told us they would ensure records reflected that people were having sufficient to eat and drink.

We looked at how the service supported people to maintain good health. People's healthcare needs were assessed when they started to use the service. Care records showed people had access to a range of healthcare professionals including GPs, district nurses, chiropodists, opticians and mental health practitioners. If staff were concerned about a person's health they discussed it with them and nurses on duty and, where appropriate, referred them to the relevant healthcare professionals.

The premises were designed to support people living with dementia. The building was divided into two sides and sub-divided into units. Each unit was decorated in a specific colour, with walls in contrasting colours to doors and floors. This was in line with dementia care guidance from organisations such as Age Concern. There were items of interest on walls. For example, one unit had sports equipment on the walls for people to touch whilst another unit had domestic equipment to stimulate interaction and discussion. People's doors included images of things that reflected who they were and their interests. For example, one person had an image of a teddy bear on their door because this was one of their favourite things. We observed people were free to move around the units and walk with purpose, under supervision if required. The premises were generally well maintained and we saw the maintenance person was on site during our inspection attending to jobs that had been reported as requiring attention.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us the staff were kind and caring. One person told us, "The staff are kind and caring, they all have different ways of approach." Another person said, "They [staff] listen to me. I can make my opinion heard. The staff are very friendly and caring." A third person told us, "They [staff] listen to me. They [staff] do respect I am independent. It's a good place, the staff are all very good." Relatives spoke about staff as being friendly and caring. They told us experienced staff knew their family member well which had a positive effect on the person's well-being.

We observed staff supporting people in the way they wanted. One member of staff responded to a request from a person to go outside for a cigarette. They were patient with the person whilst explaining why the person needed to wear a coat due to the weather. They assisted the person outside, respecting the person's wish to be independent and asked another staff member to accompany them into the garden for a chat as they were a little agitated. The person returned much calmer and happier.

Staff told us how much they liked working at the service and supporting people. One staff member told us, "I like working here. It is a good care home and people are happy. Staff feel appreciated." Another staff member said, "I like working here, helping people. The environment has a warm, friendly feel."

We saw good communication between people and staff throughout our inspection. Staff took time to listen to people and when they received repetitive requests they responded with patience and interest. Staff constantly checked people were okay and that they had everything they needed. They spoke with people in a respectful manner and called them by their preferred names. Where people's first language was not English, staff used picture cards, signs and gestures to support effective communication. For example, we observed the member of staff responsible for activities was able to converse with one person in their first language and the person responded positively to this.

Experienced staff demonstrated that they knew people well and were knowledgeable about people's past history, preferences and interests. They were able to engage people in conversations about their past history, providing prompts to enable people to reminisce about key events and experiences in their lives. We saw people responded positively to these conversations and engaged in good humour and banter with staff.

People and relatives were encouraged to express their views and be involved in making decisions about care, treatment and support. People were provided with a range of information which included a service user guide. This provided information about the local area, the aims and values of the provider and a summary of services provided by staff. This helped people to make informed decisions before they began to use the service.

Staff respected people's privacy and dignity and these values were promoted throughout the service. For example, dignity posters and information were available on communal notice boards to remind staff how they could support people to maintain their dignity. We observed staff knock on people's doors and

announce themselves before entering. This was supported by guidance on people's door which advised staff to either knock or leave the door open, in line with the person's preference. Where people had decided to remain in their beds, they were covered up and their privacy respected.

One member of staff had been appointed the lead for Equality and Diversity within the service. We asked what this meant and they told us, "My role is to challenge staff where needed to ensure we recognise that everyone is different and have respect for that." This helped to ensure that people received care and support in line with their cultural preferences and beliefs.

Good

Is the service responsive?

Our findings

People who we spoke with told us they were very happy with their care and felt well supported. Relatives told us they were mostly happy, although two relatives we spoke with felt that staff who regularly worked in the service provided more personalised care than agency staff.

There was a member of staff employed to support people with their hobbies and interests, referred to as an activity co-ordinator. There were a range of activities advertised in communal areas which included visits from a therapy dog and visits to local places of interest, such as farms and visiting the cinema. The activity co-ordinator told us they were new to the service and were in the process of planning internal and external activities. These included shopping, visits to the cinema and pub trips. People and staff were preparing for a fete to be held the next day and to which relatives and the local community were invited. On the day of our inspection, we saw the activity co-ordinator had set up a game in one of the communal areas. However, few people participated. We saw more successful one-to-one activities where staff members were engaged in art and craft or nail care with people. People responded positively to these activities and looked happy, engaging in conversation with the staff member.

The activity co-ordinator told us they recorded activities that people had been engaged in to ensure they were provided with activities in line with their interests. For example, one person's care plan stated they liked to play a specific board game. We looked at the person's activity records and saw they had been supported to play the game on a regular basis. The activity co-ordinator told us they were developing community links with local schools and companies to expand the range of activities for people and develop relationships with the local community.

People had an assessment of their needs before using the service and this formed the basis of their care plan. Records of people's assessments, care plan and other key information was retained in a file in the registered manager's office. Staff had day-to-day access to 'mini care plans' which included a summary of the person's needs, interests and preferences as to how they preferred their are to be provided. Included in the mini care plan were a summary of the person's risk assessments and records required to monitor the health and well-being of the person. These care plans were retained in the individual units where people lived so staff had easy access to them.

Records showed that, wherever possible, people and their relatives had been involved in developing their care plan. However, three relative felt that the care records were not personalised to their family members. Comments included, "You can read [name of person] file and you would not know in some places that it was them that the care plan was referring. It could be any resident," and "I have filled in some forms. [Name of family member] likes certain one-to-one activities which I play with him. Some staff need to be encouraged to do the same," and "They [staff] encourage [name of family member] to play bingo but [name of family member] is not interested."

The registered manager told us they had recently recruited a new activity co-ordinator who was in the process of reviewing activities to ensure they were provided in line with people's individual preferences and

interests.

Staff who we spoke with demonstrated a good knowledge and understanding of each person and this was reflected in the care they provided. For example, we saw one staff member support a person to reminisce about their working life, including talking about specific events and incidents that made them laugh. Although the staff member demonstrated good knowledge about the person's history, the care plan did not include this personalised information. Another person who we spoke with was struggling to recall their history prior to using the service and was supported by prompts from staff to reminisce. This made them happy and prompted further memories which they shared with other people. However, this information was not included in the person's care plan. Where one person had a detailed personal profile to enable staff to get to know the person and have awareness of what was important to them, this had been provided by the person's family. For example, one person had a rummage box which included things that were important to them and images of favourite objects. Staff used this to communicate with the person.

Staff told us they got to know about people by reading care plans, working alongside experienced staff and spending time with people. This meant that although experienced staff were knowledgeable about people's needs and preferences, staff who did not work regularly in the service may not have the information they need to provide personalised care.

We discussed this with the registered manager who told us they would review information in care plans to ensure all staff were provided with the information and guidance they needed to deliver personalised care.

We saw that care plans were regularly reviewed and reflected changes in people's circumstances. Staff confirmed they were involved in reviewing people's care. This meant that care plans reflected people's current needs.

We looked at how the registered provider responded if people or their relatives wanted to make a complaint. There was information about how to do this in the service' statement of purpose and service user guide. The complaint's procedure had also been translated into people's first language to enable them to make complaints if they should need to. People and their relatives told us they were confident to raise concerns or complaints to senior staff or the registered manager. Most people had not had reason to make a complaint but where relatives had raised concerns or complaints, they told us they had been responded to in a timely way. One relative told us, "I have complained, I will say if something is wrong. Issues do get sorted out." Another relative told us, "If I am unhappy I will speak to [name of deputy manager] and it's sorted out. [Name of family member] is well cared for."

The registered manager supported people to share their concerns or complaints through a compliments and complaints box in the reception area. People also had access to an independent service through Age Concern UK called 'Worry Catcher.' This involved a volunteer visiting the site regularly and meeting people to support them to express any worries, concerns or suggestions they may have. The volunteer then passed this information on to the registered manager who reviewed and responded with action they intended to take in response to people's concerns. We saw where people had made suggestions or expressed concerns, for example about their care or activities, these had been reviewed and acted upon. Records showed where people or relatives had complained about any aspect of the service, the registered manager had taken action to investigate and resolve their concerns. This showed the registered manager and staff took concerns seriously and used them to bring about improvements in the care provided.

Good

Is the service well-led?

Our findings

There was a positive and calm atmosphere at the service. Staff were kind and helpful and constantly interacted with people. Most of the people and relatives we spoke with were happy with the service. One person told us, "The job they [staff] do with the majority of people is very good. [Registered manager) has some excellent points and changes have been made." Another person told us, "Head office needs to rubber stamp everything. They can get the job done here." Relatives comments included, "I would recommend this home 85%. They [staff] just need to improve the communication about [name of family member's] care," "People seem well looked after," and "This [service] ticks every box for me. This place feels right." One relative told us they thought the service was extremely safe and staff were very good. They had chosen the service after they had observed how the registered manager and staff interacted with people. Interactions were positive and caring which had helped them make the decision about their family member's care.

Staff told us they were well supported in their roles. One staff member told us, "I haven't been here very long but have found management to be very supportive. I'm happy here and I have been provided with extra training when I have asked for it." Another staff member told us, "We have support from senior staff and the [registered] manager is approachable. We are provided with information through staff meetings and feel valued. I often stay over my shift because I enjoy my work." Staff spoke positively about a culture of team work which involved respecting each other and providing support, guidance and advice for colleagues when needed. We looked at records of staff meetings held in July 2017 and saw these had clear agendas and areas such as best practice, changes and suggestions for improvements were discussed. Staff were also supported to share their views through staff surveys. Several staff had commented on the reliance on agency staff and as a result the registered manager and taken action to address these concerns.

There was a registered manager in post who was supported by a deputy manager who was experienced in clinical care and an administrator. A clinical lead had been recently appointed to support nursing staff who in turn supervised care staff. Staff we spoke with demonstrated awareness of the leadership structure within the service and were clear on roles and responsibilities. This helped to ensure effective leadership and communication within the service.

People and their relatives were supported to share their views about the service through quality surveys. We looked at surveys for 2017 and saw comments were generally positive about people's care. The registered manager shared the results of quality surveys together with action taken with people and visitors through a 'You said, we did' display in the reception area. For example, where people and relatives had requested a coffee bar area, this had been considered and a coffee bar/snack area was installed in the reception area. This showed that the registered manager used people's feedback to drive improvements within the service.

There were arrangements in place to regularly assess and monitor the quality of the service. The registered manager was supported by senior staff to undertake internal audits on areas such as medicines, housekeeping, care records, health and safety and accidents and incidents. The registered manager reviewed information from internal audits to produce monthly reports on key aspects of the service. These were checked by the area manager who was in regular contact with the registered manager and followed-up

any concerns. The registered manager was also required to complete a service improvement plan which was an action plan developed in response to any areas where improvements were required. Records showed the current action plan was being followed and improvements were made as a result, although not always to timescales outlined in the action plan. The registered manager told us actions had been delayed during staff recruitment but they were now focussed on completing the action plan.

The service had also had a quality monitoring visit from the local authority and the health authority in August 2017. The local authority told us they had identified some areas for improvement but had no concerns about the service. The health authority audit showed that the service was meeting the required standards. The registered manager had already started to bring about the required improvements as a result of these audits. This showed the service was committed to continuous improvement in order to provide high quality care.

The registered manager was aware of their legal responsibilities in notifying CQC of significant events and incidents within the service. We found they had made appropriate notifications and had worked in partnership with other agencies, such as safeguarding, in order to ensure people were safe within the service. The registered provider had ensured the service current CQC ratings were clearly displayed within the service and their website in line with legal requirements.