Kirklees Metropolitan Council

Moorlands Grange

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 27 July 2016 and was unannounced. This meant the provider or staff did not know about our inspection visit.

We previously inspected Moorlands Grange on 21 March 2014, at which time the service was compliant with all regulatory standards inspected.

Moorlands Grange is a residential care home in Netherton, Huddersfield, providing accommodation and personal care for up to 40 older people. There were 36 people using the service at the time of our inspection. Moorlands Grange also provides short-term residential care for older people who need support with personal care after being in hospital or have had a change in circumstances whilst appropriate care packages are reviewed and implemented. People using this aspect of the service stay on the 'Hawthorn Suite', which is made up of 16 ground floor bedrooms. Moorlands Grange also has 24 bedrooms which are used to provide intermediate care for people who have been assessed as needing additional support before returning home. Most people using this aspect of the service stay on the 'Oakmoor Suite' and had access to an externally employed, on-site health care team who provided nursing, physiotherapy and occupational therapy support where required.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like directors, 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.

There were sufficient numbers of staff on duty in order to safely meet the needs of people who used the service and to maintain the premises. We observed call bells responded to promptly throughout the inspection. All areas of the building were clean and well maintained, including external areas.

Staff were trained in safeguarding and displayed a good knowledge of safeguarding principles and what they would do should they have any concerns. People who used the service and their relatives expressed confidence in the ability of staff to protect people from harm.

Effective pre-employment checks of staff were in place, including Disclosure and Barring Service (DBS) checks, references and identity checks.

The storage, administration and disposal of medicines was safe and in line with guidance issued by the National Institute for Health and Clinical Excellence (NICE).

Risk assessments took into account people's individual needs and staff displayed a good knowledge of the risks people faced and how to reduce these risks.

People received the treatment they needed through prompt and regular liaison with nursing, physiotherapy and occupational therapy staff.

Mandatory staff training was regularly updated to ensure staff had a good working knowledge of people's needs, whilst the Care Certificate modules were used to help refresh staff knowledge.

Staff received regular supervision and appraisal processes as well as regular team meetings.

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 checked whether the service was working within the principles of the MCA. Staff displayed a good understanding of capacity and consent and we found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS.

The atmosphere at the home was homely and welcoming. People who used the service, relatives and external stakeholders told us staff were caring and we observed this in practice.

Detailed care plans were in place and staff had ensured sufficient information about each person was readily accessible and appropriately shared with health care staff to ensure people's needs were met. Daily records, handover documents and weekly multi-disciplinary team (MDT) meetings were used to ensure staff and partner agencies were aware of changes to people's needs. We saw regular reviews took place with the involvement of people and their family members.

One-to-one time was offered to people by volunteers and some people were content with the level of activities provision. More could be done however to improve the planning and provision of social and recreational activities for people who used the service.

People who used the service, relatives and external professionals we spoke with had confidence in the staff team and the registered manager. We found the culture to be consistently focussed on ensuring people were supported to regain and maintain their independence as they returned home.

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.

Staff knowledge of safeguarding responsibilities and procedures was good and people who used the service and their relatives expressed confidence and trust in the ability of staff to keep them safe.

The administration of medicine was safe and in line with issued by the National Institute for Health and Clinical Excellence (NICE).

Risks to people were assessed and individual plans were in place to help staff reduce these risks. Staff displayed a good knowledge of the risks people faced.

Is the service effective?

Good

The service was effective.

Staff had received a range of training to ensure they could meet people's needs; training needs were well managed and regularly refreshed.

People had regular on-site access to support from an external health care team, whilst personal care needs were effectively met by the staff at Moorlands Grange.

Where people's needs changed staff communicated this effectively to each other and sought external advice where appropriate.

Is the service caring?

Good

The service was caring.

People who used the service, their relatives and external professionals gave unanimously positive feedback about the caring attitudes of staff.

Staff interacted with people in a calm and patient manner at all times and upheld their dignity, in line with the commitments of

the registered provider's literature.

People's preferences and beliefs were listened to and respected, for example their religious beliefs.

Is the service responsive?

Good

The service was responsive.

People experienced a smooth transition to and from the service, receiving a high standard of personal care and relevant support from external healthcare professionals to ensure their changing needs were met.

People's opinions on the service were routinely met through a feedback session on leaving the service as well as auditing processes.

The provision of activities was not always person-centred and improvements needed to be made to how people's recreational and social needs were met.

Is the service well-led?

Good

The service was well-led.

The registered manager and staff had successfully developed and maintained a caring culture in a time of change that focussed on supporting people to return to their homes and maintain their levels of independence.

Quality assurance and auditing systems were comprehensive and ensured high standards of care were maintained and opportunities to improve were identified.

People who used the service, their relatives, staff and external professionals we spoke with described management and staff as accountable and approachable.

Moorlands Grange

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.

We visited the service on 27 July 2016 and the inspection was unannounced. The inspection team consisted of one Adult Social Care Inspector.

We spent time speaking to people who used the service and observing interactions between staff and people who used the service. We spoke with six people who used the service. We spoke with seven members of staff: the registered manager, the service manager who had responsibility for overseeing a number of services, the deputy manager, three care staff and the cook. We also spoke with three members of the external health care team: the team leader, a nurse and an assistant pharmacist. Following the inspection we spoke with three relatives, a social worker and a community officer who worked with the service to ensure people's needs were met on returning to their home.

During the inspection visit we looked at five people's care plans, risk assessments, five staff training and recruitment files, a selection of the home's policies and procedures, quality assurance systems, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service. We also examined notifications received by the Care Quality Commission. We spoke with professionals in local authority commissioning and safeguarding teams, and the local Healthwatch. No concerns were raised regarding the service by these professionals.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service, relatives and external professionals we spoke with all expressed confidence in the ability of staff to protect people from a range of risks. One person who used the service told us, "I'm safe here – they look after me." One relative told us, "We have no concerns in terms of safety and we saw they looked at all the risks when [Person] went in there," whilst one social care professional said, "Overall impressions are good – there have never been any concerns about neglect or other risks." During our inspection we also observed people who used the service behaving in a calm manner with staff who were caring for them, which indicated they had a good level of trust in them.

We reviewed risk assessments and found them to be accurate and tailored to people's individual need. When we spoke with staff they were aware of the specific risks faced by people and how they should reduce these risks by following the actions set out in the risk assessments. One person was at heightened risk of falls having experienced them before using the service. We saw a range of preliminary information had been gathered to ensure staff knew how to reduce the risk of a recurrence. This included control measures such as the servicing of hoisting equipment, staff training in moving and handling and an awareness of the risk of clutter. The plan then went into more detailed instructions on how to speak slowly to the person in a reassuring manner and how to assist them to mobilise. When we spoke with relevant staff they were able to describe how they supported people to minimise such risks.

In addition to their own risk assessments staff used recognised risk assessment tools such as waterlow. Waterlow is a pressure ulcer risk assessment/prevention tool used and understood by caring and nursing professionals to reduce the risk of pressure sores.

We saw the storage, administration and disposal of medicines was safe and adhered to guidance issued by the National Institute for Health and Clinical Excellence (NICE). Staff had been appropriately trained to administer medicine and had their competency to do so regularly assessed. We saw people's medical records contained their photograph, any allergy information and emergency contact details. We reviewed a sample of people's medication administration records (MARs) and found there to be no errors. We saw, for example, where people required Alendronic acid, this was administered and recorded as prescribed. Alendronic is a drug to help people with osteoporosis and if not administered correctly can cause significant harm.

We saw controlled drugs were securely stored. Controlled drugs are drugs that are liable to misuse. We reviewed a sample of people's administration records of controlled drugs and found it was accurate and records corresponded to the controlled drugs remaining.

With regard to 'when required' medicines such as paracetamol, we found the registered manager had been advised to improve this aspects of medicines administration and they showed us a sample 'when required' medicines plan. This documented why people might require such medicine and how staff should offer this to the person, as well as what side effects they may see. This demonstrated the registered manager took on board advice from external professionals. Staff displayed a good understanding of people's 'when required'

medicines and how they would communicate the need for such medicines to staff. Staff also displayed a good knowledge of the topical medicines (creams) people required. We saw body maps were used to show exactly whereabouts on a person the cream should be applied.

We saw the treatment room was tidy and kept locked when it was unoccupied. Medicines were housed in a locked cabinet and a locked fridge was also in use. We saw room and fridge temperatures were regularly recorded to ensure they were within safe limits. We saw the service was intensively supported by pharmacists assistants who spent a proportion of their working week at the service, and that the relationship with these staff and the dispensing pharmacist was effective. This demonstrated people were not put at risk through the unsafe management of medicines.

We spoke to two members of staff about their experience of safeguarding training and both were able to articulate a range of abuses and potential risks to people using the service, as well as their prospective actions should they have such concerns. This demonstrated appropriate safeguarding training had been delivered and that staff were able to identify situations where it would be applicable. We saw that safeguarding was a topic regularly discussed at staff supervisions and contact information regarding safeguarding professionals was readily displayed in communal areas. Commissioning professionals we spoke with confirmed staff had acted promptly in the past where they had had a safeguarding concern.

We reviewed staff records and saw that in all of them pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks had been made. We also saw that the registered manager had asked for at least two references and ensured proof of identity was provided by prospective employees' prior to employment. This meant that the service had in place a robust and consistent approach to vetting prospective members of staff, reducing the risk of an unsuitable person being employed to work with vulnerable people.

One person who used the service told us they felt staff were, "Sometimes a bit slow in getting to me," but we found the overwhelming consensus of opinion of people who used the service, relatives and external professionals, was that staffing levels were appropriate and that staff responded promptly to people's immediate needs. The registered manager showed us how they calculated staffing levels through a tool that took into account needs of people and skills of staff. During our inspection we saw call bells were answered promptly. This meant people using the service were not put at risk due to understaffing.

The registered manager confirmed there had been no recent disciplinary actions or investigations. We reviewed the disciplinary policy and found it to be clear.

With regard to infection control, we found the service to be clean throughout, including people's own rooms, the kitchen, communal areas, sluices and laundry. The kitchen had been given a '5 out of 5' score from the Food Standards Agency (FSA), meaning the cleanliness was considered 'Very good' by an external agency. Personal Protective Equipment such as aprons and gloves were readily available throughout, as were hand washing facilities. One relative said, "The only smell you get when you come in is the smell of the food." Another relative told us, "The place is spotless," whilst an external healthcare professional said, "It has always been clean and tidy." This meant people were protected from the risk of acquired infections.

We saw incidents and accidents were clearly documented and recorded in such a way that made it easy to identify any trends that might develop. We saw there had been no major incidents or accidents since our last inspection.

Maintenance records showed that Portable Appliance Testing (PAT) was undertaken recently, whilst the

periodic electrical inspection was in date. All lifting and hoist equipment had been serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). There was documentation evidencing the servicing of the gas boiler. We saw that fire extinguishers had been checked recently, fire maintenance checks were in date and the call bell systems were regularly tested and serviced, as was the emergency sprinkler system. We saw the service employed a handyman and that the registered manager and other staff undertook checks of the premises to ensure its upkeep. Water temperatures were regularly checked to ensure people were not at risk of scalding, whilst periodic inspections and the flushing out of rarely used water sources were undertaken to protect against the risk of water-borne viruses such as legionella. This meant people were prevented from undue risk through poor maintenance and upkeep of systems within the service.

We saw contingency plans were in place for a range of circumstances such as a fire, or an electrical or gas failure. We saw there were personalised emergency evacuation plans (PEEPs) in place, which detailed people's mobility needs. These were easy to follow and easily accessible and were supported by a map of the building. This meant members of the emergency services would be better able to support people in the event of an emergency.

Good

Is the service effective?

Our findings

We found people were supported by staff who had the skills, knowledge and training required to meet people's needs, as well as a good awareness of those individual needs.

People who used the service, relatives and external professionals we spoke with expressed confidence in the knowledge and ability of staff. One relative said, "Staff seem on top of things," whilst another said, "I can't fault it – they provide stability and care." One person who used the service said, "The staff are very nice and helpful." One healthcare professional stated, "They are up to speed with people's needs and give us detailed information when we need it." One commissioning professional told us, "We have weekly MDT meeting to review patients and service needs and find that the staff in Moorlands grange fully participate in these. We are very happy with the level of care provided and the services willingness to work with us on any improvements identified." We saw evidence of these MDTs (multi-disciplinary team meetings) and found them to be one means by which staff ensured they held up to date information about people's care needs, but also that they shared that information with other relevant partners.

Another way staff ensured information regarding people's needs was accurate and up to date was through the daily handover process. We found this to be comprehensive, with both care staff and external health care staff clear on how the process worked. We found the relationship between these teams to be strong and effective. When we tracked one person's care needs from the care plan through to this document we found it contained the most recent updates and staff were aware of the person's changing needs. We also saw the registered manager and the team leader of the health care team that provided occupational therapy and nursing support to people who used the service met at least weekly to help ensure people's needs were met.

Staff training was efficiently managed and we saw the deputy manager produced a matrix to track who was due to refresh certain training courses. They took this information from the online training portal the service used to deliver training to staff. We saw all staff had received a range of training that equipped them to help meet people's needs. Staff had received training in First Aid, Fire safety, Food Hygiene, Moving and Handling, Dignity/Respect/Person Centred Care, Mental Capacity Act, Infection Control, Dementia Care, and Safeguarding.

We saw the registered manager had delivered the Care Certificate to new members of staff and had also used modules of the Care Certificate to refresh individual areas of existing staff knowledge. The Care Certificate is the most recent identified set of standards that health and social care workers adhere to in their daily working life.

We saw evidence of good health outcomes for people who used the service. The registered manager told us the focus of the service was to, "Enable people to get back into their community," and we found the service successfully supported this goal. For instance, one person moved to the service following a fall. The service ensured they had access to an occupational therapist who complete a range of exercises intended to help them regain the ability to get up the front steps to their house. The social worker involved confirmed the

service had ensured occupational therapy colleagues had ample space and facilities to help improve this person's mobility and that they were able to return home as a result. We also saw a thank you letter from a previous resident of the service which stated, "I have just tried out my new walker – I can walk quiet a distance now, when summer comes it will be a joy to be outside – My grateful thanks to one and all." This demonstrated that staff successfully supported people to regain their independence through tailored supported that included on-site access to physiotherapy and occupational therapy.

We saw people were supported to access health care services such as GPs, Speech and Language Therapy (SALT) appointments, dentist appointments, optician appointments and chiropody services.

We saw staff kept daily notes regarding people's wellbeing and updated a range of care plans specific to each person's needs, for example continence care, mobility, behaviours and communication. Care files contained detailed descriptions of what tasks people could complete independently at admission and what they required help with. This meant occupational therapy staff were better placed to help people regain levels of independence through targeted support. There was a 'File completion checklist' in each care file and the records we viewed were accurate and up to date.

With regard to nutrition we saw people were given a choice of meals. We saw snacks and refreshments were offered during our inspection. One person who used the service said, "The cook today is very good, but the food is always lovely." One relative told us, "The food is to a high standard and there is always a varied menu." We spoke with the cook who demonstrated a good understanding of the varying specialised diets people required. We saw this information was clearly displayed in the kitchen, along with allergy information, to ensure people received meals that met their needs. Nobody using the service at the time of inspection required a halal diet but we saw this was an option should people choose it, as were alternative low-sugar desserts for people with diabetes.

We saw there was ample space for people to dine comfortably and observed staff interacting with people during lunch in a patient, attentive and unhurried fashion. We saw the Malnutrition Universal Screening Tool (MUST) was used. MUST is a screening tool using people's weight and height to identify those at risk of malnutrition. We saw people had been given a fortified diet where they were at risk of malnutrition.

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 checked whether the service was working within the principles of the MCA. We found related assessments and decisions had been properly taken and the provider had followed the requirements in the DoLS. The registered manager and staff we spoke with demonstrated a good understanding of the principles of the MCA and the importance of DoLS. We saw people's capacity was assessed on a decision-specific basis, rather than blanket decisions being made about people's capacity. Where one person decided to make a decision that others may consider unwise, we saw this decision was respected by the registered manager. We saw mental capacity assessments were regularly reviewed. We also saw appropriate documentation had been submitted to the local authority regarding the DoLS.

With regard to the premises we saw the registered provider had ensured aspects of the environment were dementia-friendly, such as contrasting hand rails and walls, clear signage and light, bright corridors. We saw all bedrooms were equipped with a spacious en-suite and there were additional ample bathing facilities throughout for people who would prefer a bath. The building had a large wheelchair accessible lawned outdoor space with seating and we saw this being used throughout the inspection. In addition to the main kitchen there was also a satellite kitchen on each floor, one of which had cooking facilities so that occupational therapists could use the space to assess people's abilities with regard to cooking before they went home.

All staff we spoke with confirmed they received support and supervision from their immediate line manager and from the registered manager. We saw evidence of staff supervisions occurring regularly, as well as annual appraisals and team meetings. Staff supervisions were themed to ensure relevant topics were discussed with staff on a one-to-one basis, such as safeguarding.

Good

Is the service caring?

Our findings

One person who used the service said, "The staff can't do enough for you. They are really kind." Another person said, "The staff are lovely. I get on with them all." One relative told us, "All the staff are very good." Another said, "I've worked in care homes and I must admit, this is the best – I go in once a week and the staff are really good, always attentive." When we spoke with external health and social care professionals they were similarly positive, describing staff as, "Very welcoming," and stating, "People I work with who have gone there have had a good experience. When people have needed to go back they look forward to it – that's a good sign."

We found there was a relaxed and welcoming atmosphere despite the focus on people being at the service for relatively short timescales. One person told us, "I'm getting used to it. It's not quite your own home but people are very friendly and they are helping me get back on my feet." We saw a range of thank you cards which expressed a similar balance of praise for the caring attitudes of staff and the outcomes for people the service endeavoured towards, for example, "Just a note to say many thanks for all the care I received during my stay. Everyone was so kind and helpful." Another card read, "I've never have believed anyone could have got me back on my feet so quickly." Another said, "I wanted to say what a fabulous job you and your team were doing with my [relative] and how impressed my family were with the care and respect they received, coupled with the real hope they were given for the future."

We observed numerous warm and dignified interactions between staff and people who used the service during the inspection. For example, we saw care staff knock on people's doors and wait for a response before entering, whilst we saw a member of care staff gently encourage a person sat in a living room to attend lunch. The manner in which the staff member spoke was respectful, calm and unrushed. This meant that people were treated with dignity.

One member of staff told us, "You don't always get to build bonds because people are here for such short periods of time. That's the one area where it's not always as good." Staff we spoke with did however show a good degree of knowledge of people's specific needs and interests. We found, within the context of the majority of people who used the service only being at the home for a short time, staff made positive relationships with them and displayed a good understanding of their needs and preferences. We saw this was reflected in people's care files, which contained a good level of detail about people's life histories, like and dislikes.

The Service User Guide stated that all faith denominations were welcome and we saw a Church of England minister regularly attended the service, whilst halal meal options were available. At people's admission to the service their religious beliefs were discussed and we saw these were respected in practice.

We saw there were no restrictions to visiting hours and relatives we spoke with confirmed they were welcome to visit the service at any time. This meant people using the service and their families felt more able to consider the service a home and were not restricted in their visiting hours.

We saw the registered manager had taken steps to ensure respecting people's dignity and behaving in a caring manner was part of the culture of the service. For example, they had discussed the 'Mum test' during themed supervisions with staff. The Mum Test is something CQC inspectors consider and means considering whether they would be happy for someone they love and care for to use a service. This showed the registered manager used external regulatory frameworks to inform how they encouraged staff to maintain people's dignity. There was a dignity-themed poem and wall art in the main entrance hall and the registered manager had recently appointed two dignity champions. Whilst they had yet to make a specific impact through their role and more needed to be done to define how they would contribute to maintaining standards of dignity, this demonstrated the registered manager valued people's dignity and was taking steps to ensure it was protected and upheld.

We saw that information regarding advocacy services was readily available. At the time of our inspection no one who used the service had an advocate but we saw more informal means of advocacy through, for example, involving relatives in the review of care plans. This meant that people were invited to be supported by those who knew them best.

We saw rooms were pleasantly decorated and personalised to a degree to people's tastes, for example with their own photographs. We found care plans to contain comprehensive levels of information regarding people's likes, dislikes and personal histories. When we spoke with staff they were able to tell us about people's needs and preferences in detail.

We saw people's personal sensitive information was securely stored in locked cabinets and on a password-protected computer system, in line with the confidentiality policy.

Good

Is the service responsive?

Our findings

People's changing care needs were monitored and supported through ongoing review and the involvement of external healthcare professionals. We saw a range of feedback from people who had previously used the service confirming their mobility needs had been well met. Similarly, where people's needs changed quickly we saw staff responded well. For example, we saw one person had developed a rash and that this had been recorded in their daily notes, with the information shared with care staff via the handover process, as well as with an external nurse to ensure the person's topical medicines were meeting their needs.

External social and healthcare professionals we spoke with were complimentary about the ability of the service to provide care to people at relatively short notice and ensure their needs were met. One told us, "The transition was smooth and they had a lot to put in place." We spoke with one relative who was particularly complimentary about the flexible and sensitive nature of the transition of their relative, stating, "They're coming home on Sunday. I think the service has been great. [Person] has been there for three weeks and has really come on. They've been in 4 hospitals and 7 different beds before this so I feel they've provided real stability and care. The physio and occupational therapy support they've had whilst there has made a difference."

We saw a pre-admission assessment had been completed in every care file we looked at, documenting people's physical health and mobility, moving and handling needs, any allergies, dietary requirements and sensory needs. More detailed assessments were taken on people's admission to the service so that more detailed care plans and risk assessments could be put in place. Each person also had a 'A Day in My Life Document' and a ''Week in My Life' document, which gave more details about people's likes, dislikes, interests, hobbies and dietary preferences.

We saw the registered manager had liaised with pharmacists with a view to making people who wanted to self-medicate have a more 'homely' experience by having their medicines stored in their room (i.e. rather than having a large medicines trolley wheeled to them). Whilst this had not yet happened this demonstrated the registered manager had explored ways to continue to improve how people were supported to regain independence.

We saw each care plan we reviewed contained a photograph and had been reviewed monthly, with the involvement of people who used the service and their relatives. One relative told us, "Every time they call the doctor they get in touch with me. Yes, they ask me how much I want to be involved." There was a range of care plans and risk assessments going into a level of detail that ensured effective care was supported through clear documentation. We saw evidence that people had been promptly referred to external specialists when their needs changed. We spoke with the team leader of the health care team who based themselves in an office at the home and saw information sharing between the health team and care staff providing personal care to people was good.

We saw the service had a complaints policy in place but that no complaints had been received recently. We saw that the complaints procedure was clearly displayed in communal areas. When we asked people who

used the service and their relatives if they knew how to complain and who to they were clear about this. This meant people were supported by a range of means through which to raise concerns and were confident in doing so.

We saw the provision of activities for people who used the service was not as well planned. The service did not have an activities co-ordinator in place and did not yet have a person-centred approach to planning activities. In the registered provider's PIR they acknowledged the provision of person-centred activities would be an area they would look to improve in the coming year.

One external professional told us, "I don't feel there is enough stimulation – that's the only thing where I feel they could improve." Another told us, "My concern is that people can be sat in their rooms and not socialising or doing much. I know some people will always choose to do this but more could be done. People's social wellbeing can have an impact on their recovery so I think this is an area they could tighten up." One person who used the service said, "There isn't a lot to do between meals, really."

Most people who used the service told us they were content with the provision of activities and interests, with one person saying, "I like to relax and watch TV." Others told us, "It's nice to be able to sit outside and relax," whilst we saw evidence staff had regularly played chess with people who used the service. A hairdresser visited the service twice a week and people confirmed they enjoyed using this service. We saw the service produced a 'Daily Chat,' a document with news items from this day in history as well as puzzles – we observed people reading this and enjoying the puzzle/crossword section. We also saw the service had five volunteers who provided a befriending service for people who used the service, and that the registered manager planned to enlist more volunteers.

We found there was limited provision of person-centred activities and, whilst the majority of people we spoke with chose to spend time sitting outside or in their room, more could be done to provide person-centred recreational and social options for people who used the service.

The registered manager acknowledged this was an area to improve, stating it was difficult putting in place person-centred activities when people were often using the service for such short periods of time. They agreed to find ways to make the provision of optional activities more person-centred.

We saw there were no questionnaires or surveys as such of people who used the service but the registered manager had found a way to routinely gather people's feedback about the service. They did this by holding a 'discharge' meeting with people leaving the service and their relatives. Representative comments included, "[Person] enjoyed their stay and playing games with staff," "No complaints, care was brill, would love to come back," "Absolutely brilliant food and service," and, "You've been very good to me, staff have looked after me well." These responses were then discussed with staff at team meetings and, where the feedback was positive, which was the majority of the time, comments were put on a 'feedback tree' in the entrance hall so visitors could see what people who had used the service thought of it. The risk in this approach to gathering feedback would be if someone raised concerns on departing the service there would not be an opportunity to resolve their concerns in a timely fashion. We saw however sufficient evidence throughout the inspection of people having opportunities to raise any concerns they had directly with staff and that these concerns would be taken seriously.

Good

Is the service well-led?

Our findings

Staff we spoke with and external health and social care professionals confirmed the registered manager had ensured a good level of care had been maintained whilst the service moved from a predominantly long-term residential service to a service focussing on short-term stays for older people who wanted to return to their home. The registered manager had a range of relevant experience in health and social care.

All relatives we spoke with confirmed the registered manager was approachable and accountable, with one stating that they had a, "Hands-on" approach to the service. One relative said, "I think they set the tone and they get the balance right between having the place somewhere between clinical and homely." We asked a commissioning professional about the standard of management. They told us they had no concerns and that they regularly gathered feedback about the service from relatives, which was, "Overwhelmingly positive." Other external professionals we spoke with were complimentary about the knowledge of the registered manager. We observed the registered manager supporting people who used the service during the inspection and found them to have a good knowledge of people's individual needs.

We spoke with the service manager who oversaw and number of services and who visited regularly. We found them to have a good understanding of the challenges faced by the service and where they could improve. Accountability for these improvements was set out in an annual 'Team Business and Improvement Plan.' We reviewed this and saw it scrutinised whether the previous year's goals had been achieved and acknowledged areas where there were risks to the organisation that needed mitigating, for example difficulties in maintaining the external space and the increased dependency and complexity of some people's needs. We saw the registered manager had begun the process of addressing these issues, for example by sourcing additional help to maintain the outdoor area and ensuring the dependency tool used to plan staffing levels would take account of greater levels of complexity to ensure more staff could be deployed if needed. We saw there was a clear organisational plan in place for the coming year which set out how core objectives would be met and who was responsible.

This focus on accountability continued when we looked at auditing procedures in the service. The registered manager and other staff undertook a range of audits on a monthly basis, including medicines audits, care plans, health and safety, infection control, falls, environmental and finance. We saw the registered manager had acted on previous advice from external professionals to increase the levels of checking they undertook regarding people's finances.

We saw audits were used to remind staff of best practice and ensured all aspects of the service underwent a good degree of scrutiny to ensure the service maintained a high level of care for people who used the service. For example, we saw one audit identifying that an en-suite room was messy and that some paintwork required repainting. Another audit identified that two documents detailing people's needs had not been correctly filled in and ensured that this was completed. We saw the audit put in place corrective actions with a completion date and that these actions were completed. This demonstrated the approach to auditing was as an effective means of identifying and making improvements.

There was also a 'reception area' audit in place, which ensured the area visitors entered contained appropriate information about advocacy, the latest infection control results, the complaints process, the latest CQC report and that notice boards were up to date.

We saw the process of auditing itself was subject to review and that care file audits had recently been amended to include a section to ensure the auditor, "Speaks to service user about the service and record what they have said." We saw these documents had only recently been introduced but people had made comments such as, "It's very good here, I'm well looked after and the food is nice," and, "The staff are nice." Whilst this system had not been in place long it demonstrated the registered manager was aware of the need to ensure people who used the service may not do so for a long time and there was therefore value in using the auditing process as another means of gaining feedback.

During the inspection we asked for a variety of documents to be made accessible to us, including policy documentation and care records. These were promptly provided, accurate and up to date. We also saw a good degree of organisation of key information in the office and best practice guidance such as the National Institute for Health and Clinical Excellence (NICE) guidance, 'Using quality standards to improve practice in care homes for older people.' We saw appropriate notifications had been made to CQC.

When we spoke with staff they were consistent in their description of the values of the organisation, in that their aim was to ensure people were supported to regain and maintain independence so they could return home. Their understanding of the aims of the organisation were as per discussions with the registered manager, service manager and the registered provider's literature. This demonstrated the registered manager had successfully led a culture that had moved from providing longer-term care to more flexible, short-term care, without detriment to people who used the service. We found staff morale to be good although two members of staff expressed concerns about the future of the service given the potential for increased demand on them should people with increasingly complex needs use the service.

External professionals we spoke with were similarly complimentary about both the registered manager's involvement in the service and the way they organised and supported staff. One said, "It's a well-led service. Everything is well organised." Another said, "[Registered manager's name] is great – really on top of everything." Staff also confirmed they received a good level of support from the registered manager, whether it be through training, supervision meetings or ad hoc queries or support they needed.

We found the registered manager had ensured the service did not become isolated through continued liaison with external professionals but also through ensuring the home remained part of the wider community, for example through hosting events such as an 'Action for hearing loss' session for people who used the service and the wider community, and through inviting local school pupils to the service.