Oceancross Limited

Grace Lodge Nursing Home

Inspection report

Grace Road
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Liverpool
Merseyside
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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

Grace Lodge is a purpose built home which provides accommodation for up to 65 people who require nursing or personal care. The home is built on two levels with a passenger lift and staircases available for access to the first floor. There are 59 single and three companion bedrooms, each with en-suite facilities. All the rooms are connected to a nurse call system. The home has a rear garden for residents' use.

This was an unannounced inspection which took place on 15 and 16 December 2016.

The service was last inspected in July 2015 and at that time was found to be in breach of two of the regulations under the Health and Social Care Act 2008 (HSCA). The breach of regulations was due to concerns with the safe management of medicines and the application of the Mental Capacity Act 2005 for people who may lack capacity to consent to their care and treatment. The service had been rated as 'Requires improvement'.

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 HSCA and associated regulations about how the service is run.

At this inspection we found the home to be meeting all of the regulatory requirements.
Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 [MCA] were followed, in that an assessment of the person's mental capacity was made and decisions made in the person's best interest. We had some discussion, however, how this could be further improved by evidencing assessment around individual decisions; this would meet best practice and follow the principles of the MCA.

The registered manager had made appropriate referrals to the local authority applying for authorisations to support people who may be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS). DoLS is part of the MCA and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. We found the applications were continuing to be monitored by the registered manager.

We were given very positive feedback from the people we spoke with who were living at Grace Lodge. They told us they enjoyed living at the home and they were well cared for.

We reviewed the way people's medication was managed. We saw there were systems in place to monitor medication so that people received their medicines safely.

There were enough staff on duty to help ensure people's care needs were consistently met.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We found recruitment to be well managed and thorough.

The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally by staff and from visiting senior managers for the provider. These were effective in managing the home and were based on getting feedback from the people living there.

Care was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training and this was on-going. All of the staff we spoke with were clear about the need to report any concerns they had.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed where obvious hazards were identified. We found the environment safe and well maintained.

Activities were organised in the home and these were appreciated by the people living at the home.

We saw written care plans were formulated and reviewed on-going. We saw that people were involved in the care planning and regular reviews were held.

We observed staff interacting with the people they supported. We saw how staff communicated and supported people. Staff were able to explain each individual person's care needs and how they communicated these needs. People living at Grace Lodge told us that staff had the skills and approach needed to ensure people were receiving the right care. People were satisfied with living in the home and told us they felt the support offered met their care needs. People we spoke with said they were consulted about their care and we saw some examples in care planning documentation which showed evidence of people's input.

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when needed. We saw an example during the inspection was that the registered manager and staff liaised well with community services to support people.

We saw people's dietary needs were managed with reference to individual needs. Meal times were a main feature of life in the home and we saw there was good staff support for people at this time.

People told us their privacy was respected and maintained. When we observed staff interacting with people living in the home they showed a caring nature with appropriate interventions to support people.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw that a record was made of any complaints and these had been responded to.

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.

We found good systems in place to ensure medicines were managed safely. These were consistently monitored. This was an improvement from the last inspection.

Staff had been thoroughly checked when they were recruited to ensure they were suitable to work with vulnerable adults.

There were enough staff on duty to help ensure people's care needs were consistently met.

We found that people had had risks to their health monitored. Assessments and care plans contained necessary detail to help ensure consistent outcomes for people's health.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There was good monitoring of the environment to ensure it was safe and well maintained. We found that people were protected because any environmental hazards had been assessed and effective action to reduce any risk had been taken.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were not always consistently followed. We discussed the need to further evidence assessment of individual decisions.

Staff said they were supported through induction, appraisal and the home's training programme.

The home supported people to provide effective outcomes for their health and wellbeing.

We saw people's dietary needs were managed with reference to individual needs. Meal times were relaxed and well-paced with support offered by care staff.

Is the service caring?

Good

The service was caring.

People told us staff were caring and provided good support.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff had time to spend with people and engage with them.
People told us their privacy was respected and maintained.

There were opportunities for people to provide feedback and get involved in their care and the running of the home.

Is the service responsive?

Good

The service was responsive.

There were some daily activities planned and agreed for people living in the home.

Care was planned with regard to people's individual preferences. We saw written care plans were formulated and regularly reviewed.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Good

The service was well led.
There was a registered manager in place.

There were a series of on-going audits and quality checks to ensure standards were being maintained and the culture of the home was being supported. These were effective in identifying any issues and planning the development of the home.

The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that the service could be developed with respect to their needs and wishes. These included regular meetings and other formal

processes to collect feedback.

Grace Lodge Nursing Home

Detailed findings

Background to this inspection

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

This was an unannounced inspection which took place on 15 and 16 December 2016. The inspection was undertaken by two adult social care inspectors and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We were able to access and review the Provider Information Return (PIR) as the manager sent this to us as part of the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the service.

During the visit we were able to meet and speak with 12 of the people who were living at the home and eight visitors / relatives. We spoke with 12 of the staff working at Grace Lodge including nursing and care staff, ancillary staff, the registered manager, training manager and the provider representatives.

We spoke with and received feedback from a visiting health care professional.
We looked at the care records for five of the people staying at the home including medication records, three staff recruitment files and other records relevant to the quality monitoring of the service. These included safety and quality audits including feedback from people living at the home.

We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Good

Is the service safe?

Our findings

We had previously visited this home in July 2015 and found the home to be in breach of regulations in respect of the management of medicines. We asked the provider to take action to address these concerns. On this inspection we checked to make sure requirements had been met and we found improvements had been made to meet necessary requirements. This breach had been met.

At this inspection we saw medicines were now being managed safely. We saw the staff had access to a medicine policy and procedure to refer to and they told us they had received medicine training following the last inspection.

During our inspection we observed part of a medicine round and this was conducted safely by the staff member. The staff member remained with the person until they had taken their medicines and then signed the chart to say the medicines had been administered.

We found medicines to be stored safely when not in use. Some medicines need to be stored under certain conditions, such as in a medicine fridge, which ensures their quality is maintained. If not stored at the correct temperature they may not work correctly. The temperature of the drug fridge was recorded daily. This helped to ensure the medicines stored in this fridge were safe to use.

We checked 11 medicine administration records (MARs) and staff had signed to say they had administered the medicines. MARs were clear and we were easily able to track whether people had had their medicines. This included meal replacement drinks; thickening agents used for people who had difficulty swallowing and were at risk of choking; and the application for topical preparations (creams). Body maps recorded the area of the body to apply the cream.

Controlled drugs were stored appropriately and we saw records that showed they were checked and administered by two staff members. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. We checked a number of medicines, including a controlled medicine and found the stock balances to be correct.

During the inspection staff told us how they supported people who wished to administer their own medicines. This included the completion of a risk assessment to ensure they could undertake this practice safely. A risk assessment for one person could not be located at the inspection and the registered manager told us this would be rectified. We saw the person concerned was receiving appropriate support from the staff to undertake this practice safely.

People had a plan of care which set out their support needs for their medicines. For the administration of 'as required' (PRN) medicines there was information available to support staff when administering these medicines. Reference was made to medications in people's plan of care and following discussions with the registered manager they informed us they would ensure people had a more detailed plan of care to support the use of PRN medicines. On the second day of the inspection we were shown a plan of care which had

been completed for a person who had been prescribed PRN medicines. The registered manager had taken swift action to address this. We saw PRN medicines were subject to regular review with GPs and monitored closely by the staff.

There were 59 people living in the home at the time of our inspection. There were two floors to the home and both were staffed with a nurse and six care staff. At night both floors were staffed with a nurse and two care staff. The registered manager was normally in addition to these numbers. There were ancillary staff such as, an administrator, kitchen staff, and domestic / laundry cover. There was also a member of staff employed 18 hours a week to help provide planned activities for people. We saw that extra staff cover was provided if needed, depending on care needs. For example, one person had been closely monitored for periods on a one to one basis to ensure their safety and this had been well managed.

Staff interviewed confirmed that the home was well managed in terms of staff numbers and support. We were told staffing had improved over the past year. Not only had basic staffing numbers been increased for the day shift but there was now less use of agency staff as the home had recruited and regular staff are now more stable.

The observations we made evidenced staff were available. We observed staff attending to people and supporting them with meals and drinks. People we spoke with said staff supported them well with their personal care needs and there was generally staff around although occasionally they had to wait for staff to attend during busy periods. People told us, "Sometimes I can't get a drink because they're so busy'', "I would like a bath a bit more often, but I have to have help and they haven't got enough staff [for more frequent baths]. I'm not complaining though – I do understand", "You don't wait long – there's always somebody around. I'm always ringing [call bell] of a night and I don't have to wait long" and a relative commented, "[Person] says they're great – always in and out. When I came the first time I pulled the call bell and staff were in within seconds. They're on their toes." Overall the feedback was consistent in that people felt there was enough staff.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked for copies of appropriate applications, references and necessary checks that had been carried out. We saw checks had been made and these were thorough to ensure staff employed were 'fit' to work with vulnerable people.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. These assessments were reviewed regularly to help ensure any change in people's needs was assessed to allow appropriate measures to be put in place. One person had been assessed as being at risk regarding their mobility and had been carefully assessed to ensure they could maintain as much mobility and independence as possible whilst ensuring the remained safe.

We made observations of people living at the home and they appeared relaxed in the company of the staff. People said they felt safe. One person's relative told us, "As soon as they [person] steps out of the room, they ask 'Where are you going?' and make sure they're okay [safe]." Another relative said, "Yes, I'm confident [person] is safe here."

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training and this was on-going. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority

safeguarding team were available to staff. There had been two safeguarding incidents since the last inspection. Both of these had been reported through and there had been liaison with the safeguarding authorities so that people's right to safe care had been respected.

Arrangements were in place for checking the environment to ensure it was safe. For example, health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. The PIR for the service stated: "The home has a comprehensive maintenance matrix in place that allows the management team to easily identify when routine maintenance interventions are required and to plan accordingly to ensure the home is fully compliant and safe. We looked around at the general environment and did not see any obvious hazards. The home was well maintained; we saw the general environment was safe.

A 'fire risk assessment' had been carried out and updated at intervals. We saw personal emergency evacuation plans [PEEP's] were available for the people resident in the home to help ensure effective evacuation of the home in case of an emergency. We spot checked safety certificates for electrical safety, gas safety and these were up to date. We saw an audit for infection control had been carried out in November 2016 by Liverpool Community Health and the home had scored 96% and were 'compliant'; any recommendations made had been actioned by the home. We raised some questions with the registered manager following observations which questioned whether staff were using individual slings for people when hoisting them as this has implications for infection control. The registered manager addressed this positively with staff at a meeting during and following the inspection. This showed good attention with regards to ensuring safety standards in the home.

We saw how accidents and incidents were monitored in the home. All accidents were recorded and sent for review by the registered manager with input from the provider's representative. Statistics for accidents and incidents were recorded and discussed at senior level for analysis and to see if any trends could be identified.

Requires Improvement

Is the service effective?

Our findings

We looked to see if the home was working within the legal framework of the Mental Capacity Act (2005) [MCA]. The 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.

At the last inspection in July 2015 the home had been in breach with respect to regulations appertaining to consent. There had been no consideration of best practice with respect to the principles of the MCA and no assessments carried for people who may have lack capacity to make decisions regarding their care. On this inspection we found improvements had been made. There was evidence that staff had received training in the MCA and the principals involved and there better understood. We saw in the care files that consent for key decisions such as involvement in care planning and administering medication were discussed with people and consent gained.

The home also introduced an assessment tool for people who may lack capacity and we saw this completed in people's care files. We discussed the fact that these assessments were still rather 'generic'; i.e. did not clearly identify the individual decision that was being made / assessed and more often than not several key issues where identified on one assessment. For example, we saw that some people had bedrails in place in their best interest to maintain safety, which had been carefully assessed for risk. There had been no individual assessment, however, regarding consent to this when people had been confused or had question marks over their ability to consent.

The registered manager and managers for the provider said they would ensure further developments so that individual 'key' decisions were better evidenced when assessing mental capacity. The provider contacted us after the inspection visit and stated, "We will be looking at developing this further to incorporate mental capacity assessment for individual decisions rather than grouping them and we'll be reinforcing this through further training."

People told us that staff were careful to always explain the care and asked permission when carrying out care. One person told us, They always tell me what's going to happen [when being supported] or when they give me my tablets." Another person said, "They are very polite [when giving support] and check I'm ok with everything."

We saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made and we could see that people had been consulted and when necessary the person involved had been assessed regarding their capacity to make this decision by the GP.

People can only be deprived of their liberty so that they can 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw there had been applications for 36 people living at the home and currently one had been assessed and authorised by the local authority. We saw these were being monitored by the home.

We observed staff provide support at key times and the interactions we saw showed how staff communicated and supported people and asked their consent to care. When we spoke with staff they were able to explain each person's care needs and how they communicated these needs.
We reviewed the care of six people on our inspection as well as asking about aspects of other people's health care and how effective this was. The information sent to us before the inspection in the PIR told us, 'Necessary referrals to other services are sent and followed up. This ensures that specialist input is sought to improve outcomes [for people].

Each person's care file included evidence of input by a full range of health care professionals. If people had specific medical needs we saw these were well documented and followed through. For example we looked at the management of pressure ulcers. This is when an area of skin and underlying tissue breaks down, often due to pressure. Information around the treatment of pressure ulcers was recorded in a wound care file. For a person who had a pressure ulcer we saw staff had assessed the affected area and a body map identified the position of the ulcer. A plan of care recorded the grade of the ulcer and current treatment plan which we saw was followed by the staff. The higher the grading of a pressure ulcer the more injury to the skin and tissue. We saw evidence of input from a health care professional who was overseeing a treatment plan for a pressure ulcer. Staff had a good understanding of pressure ulcer care and the current treatment plans. This was supported by the documentation we looked at during the inspection.

We also reviewed a plan of care for a person who had a 'PEG' feed. This is called enteral feeding and refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. We saw staff were following the prescribed feed regime and had recorded the feeds on the person's fluid intake chart. Staff told us as part of the care they rotated the PEG which was needed to decrease pressure on the skin and lessen the risk of infection. There were some minor gaps in the recording of this which we brought to the attention of the staff. The staff advised us this would be better documented in the future to provide evidence of this care.

We spoke with a visiting health care professional who was reviewing a number of people in the home. We were told that the service was very good at supporting people's health care needs. We were told an example of one person who had been acutely ill. The prescribed care by the visiting professional had been carried out 'to the letter' and the person had been supported to make a full recovery.

People living at the home told us staff had the skills and approach needed to ensure they were receiving the right care with respect to maintaining their health. We looked at the training and support in place for staff. The Provider Information Return (PIR) told us: 'All of our staff undergo a comprehensive 12-week induction programme which equips them with the skills and knowledge they require to carry out their job role effectively. All staff are required to complete all the mandatory training units. In addition, we arrange and make available service specific training on topics such as dementia, diabetes, wound care and advanced care planning'.

We saw that all new staff had completed an induction based on standards form Skills for Care. We discussed the 'Care Certificate' which is the Government's recommended blue print for staff induction. The training officer told us that the induction programme covered the skills for care standards. We discussed the need to

audit the induction programme against the Care Certificate to show evidence of this. We spoke to one staff who had completed the induction and had also gone on to complete further training. We were told, "I found the induction very good. Covered everything."

The registered manager confirmed that care staff had qualifications in care such as QCF (Qualifications Credits Framework) and we saw evidence that nearly 60% had completed these courses and attained a qualification. Some staff had received additional training in specific areas as described in the PIR.

We asked about staff meetings and we were told that issues get discussed on a regular basis. Staff we spoke with at the inspection reported they were asked their opinions and felt the registered manager and team leaders listened and acted on feedback they gave. All of the staff we spoke with told us they had regular supervision sessions with the registered manager and this provided good support. One staff commented "We all lead off each other. All opinions are just as valid."
We received mainly positive feedback regarding the food in the home. Comments included: "It's very good and there's enough of it. You can choose within reason", "I'm a picky eater so I don't always eat the food. I like a roast, don't like pies, but they'll make an omelette for me if I ask. If I want a drink I just press my bell and the staff come and I say can I get a cup of tea, please" and "It's all right and there is enough of it."

We observed lunch in two larger dining rooms/areas and one small quiet area. There were sufficient carers, including senior carers, available to support people who needed assistance with eating or drinking. They were attentive and respectful when giving support and also checked on people who were eating independently but might need some support; this was done in a friendly and polite way. Two people were being supported in the separate quiet area. One carer explained that, although one person could no longer ask for a preference, when they were previously able to express a preference they always had chosen to eat in this area, so this was maintained.

The food seen was sufficient – soup or cauliflower cheese followed by sandwiches or cheese and biscuits – given that a cooked breakfast is on offer each day. Although no pudding was served, service users had access to fruit on request (oranges or bananas). The evening meal was also a cooked meal and offered two choices. People ate with some enjoyment and most finished their meal.

People spoken with and visitors stated that a menu choice of two was offered each day for both main meals and there was a choice for breakfast also. Asked what would happen if they didn't want either choice, several stated that they would be offered an alternative.

All of the people we visited in their rooms had a range of drinks and snacks brought in by visitors, and in several cases had fridges in their rooms, where they were able to keep a personal choice of foods to supplement choices offered by the home and in some instances to provide visitors with a snack.

Good

Is the service caring?

Our findings

We observed incidental and planned interactions between people living at Grace Lodge and staff throughout the day. Although always engaged in tasks, the staff members were kind, gentle, friendly and understanding in their approach. For example, we saw one carer in a lounge area following the 'instructions' of a person in making them more comfortable in her chair. This person was very specific about what they wanted and the carer was both patient and respectful, checking that the person was entirely happy.

Five people and there visitors responded positively when asked about the care they received, with some acknowledgement made of the pressure of time and its effect on staff's capacity for this. Comments included, "Very friendly and very attentive. No problem if we want something for [relative], such as juice – they come straight away", "Friendly", "Very well. I've no complaints – they do their best for you. Staff are very nice, always busy but they do check and ask me how I am. They haven't got time to come to chat, though", "I can't fault them. Everything I've seen has been top dollar. Nothing's an effort to them", "Absolutely brilliant – can't fault them. The staff are always happy, cheerful, and nothing's too much trouble", "I've got no complaints. If they've got time [they will talk]" and "They are very, very caring."

We made some observations of how staff interacted with people. Staff were seen to have very positive relationships with people and encouraged a good communal atmosphere. The interactive skills displayed by the staff were positive and people's sense of wellbeing was evident when being supported. Throughout the inspection we made many observations of staff supporting people who lived at the home in a timely, dignified and respectful way.

We found a good culture of support for people in the home based around the shared community values. The provider was very involved and members of the board both worked in the home or visited regularly. They got involved in 'residents meetings' as well as ensuring they looked at [together with the registered manager] any feedback from questionnaires sent out. We saw some of these and the feedback was positive. Any comments made for improvement had been responded to so people felt listened to.

All of people spoken with told us they felt they were listened to and staff acted on their views and opinions. We saw that meetings were held on a regular basis with the people living at the home. Surveys were also sent out to canvass opinions and get feedback. These were given out and collated by the provider. We saw the feedback was very positive including comments such as, "Staff always treat me with respect" and "Staff have been very kind when dealing with any concerns I have."

The PIR stated: 'Effective and compassionate end of life care is a vital aspect of the care and support that we provide to both service users and their families'. We saw information had been recorded around people's wishes for end of life care. End of life care relates to the care provided for a patient anywhere within the last year of life, up to and including death. Discussions with staff demonstrated their understanding of people's and their relatives' wishes around end of life care. Anticipatory care plans were in place and these recorded people's wishes about future care. For example people's preferred place of care and/or not wishing to be admitted to hospital. This information had been shared with health professionals involved with the person's

care and treatment so that the person's wishes were known and respected.

Good

Is the service responsive?

Our findings

People living at the home had individual care plans. These contained information and guidance for staff on people's health and social care needs, their preferred routine, daily records of the care and given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

We saw care plans for areas of care which included mobility, nutrition, personal hygiene, falls, people's routine and medicines. Clear and detailed care plans are important to ensure consistency of approach and to assure people's needs are met. The care plans we saw provided this assurance. They recorded good detail so that staff support was provided in a way the person wanted and needed to maintain their health and wellbeing. For example, for a person whose mobility was poor, a full assessment and mobility care plan was seen which was clear and easy to follow. The staff carrying out the assessment had completed an assessor's course and also was involved in training the staff in the home.

The importance of thorough care planning was highlighted on the provider PIR: 'Person centred care planning begins prior to admission to the home. A qualified member of staff visits the potential service user at their current location to undertake a comprehensive pre-admission assessment. This is a key part of the care planning process as it is used to firstly assess whether we have the requisite skills, equipment and facilities to meet the person's needs'.

When we spoke with people about their care planning we got mixed responses but most people and their relatives said they felt involved in their care and staff communicated well with them regarding changes. Some comments were: "I think they spoke more to my son [about care plan]", "My sister has sat down in [care planning] meetings with them. They keep her informed on exactly what they're doing", "Staff did it and I signed it. I've checked and re-signed it since, last week, for example" and "I'd like a bit more communication before they make a decision [about any changes to care] instead of being told after the event. I don't like it when they make changes to the care plan without telling you. But they [the owners] do respond if you tell them – they're quite approachable."

We saw care files were being reviewed by nursing and care staff regularly. We saw evidence of people being involved in their care planning; we saw that some people had signed their care plan and in others they had signed to say they had seen their care plan or it had been discussed with them.

We spoke with the activities coordinator, who worked four days a week, and asked what was offered to people in the way of planned activities. Activities were mainly craft and game-based, with the aim of providing activities for mental and manual dexterity, and well-being through reminiscence and singing activities.

The coordinator showed us a handwritten chart that recorded plans for each week and was shared with the office on each floor and in the main entrance area to inform staff members and relatives. A new method of recording what had actually taken place had been introduced that week, with the intention that carers also record where they had offered activities to people or taken somebody out, for example. We were told carers

could be asked to do such activities, in support of the service users.

The activities coordinator showed a coded recording system for recording activities input for people; this helped to monitor how much activity people were having. We were told that people were made aware of activities by staff directly approaching them or their relatives and inviting them to take part.

The main response from people spoken with was that they were aware of activities but did not chose to engage with most of them: "[Person] can't join in with the [craft] activities because she can't see", "Time passes; I don't mind", "Somebody always comes in and asks me if I want to go down but I'd rather stay here [own room]", "I like my telly. They do plenty to help stop you being bored – Bingo, shows, choirs", "They came yesterday and said they'd got some carol singers but it was my first visit so..." and "I go out in the garden in the summer, and I tell them the best way to grow stuff. Sometimes I go by myself on the Zimmer. The carer will take you if you ask them."

We saw a complaints procedure was in place and people we spoke with were aware of how they could complain. We saw there was a record of complaints made and these were audited and discussed at senior management level if needed. We saw that there had been three complaints investigated in 2016. Complaints had been investigated and responded to by the registered manager or the provider.

Good

Is the service well-led?

Our findings

There was a registered manager who was supported by members of the Board [owners]. All members of the Board were present throughout the inspection and attend the home on a daily basis. There was a clear management structure supporting the home with all levels of management and supervision having active input into the home. We were told by both registered manager and Board members that the provider had very clear systems in place to monitor standards and these included an emphasis on feedback from people living in the home.

The PIR for the home reinforced the shared approach to the running of the home: 'The manager is supported a team of registered nurses and two team leaders. With their hands on experience at ground level, they are able to support, supervise and provide guidance to the care assistants. The manager and the senior staff understand the need to be consistent in their approach and lead by example' and 'Over the last 12 months, the management have re-iterated the open culture that they wish to develop with the staff. This has been mentioned in all staff meetings that have taken place."

From the interviews and feedback we received, both registered manager and the board members were seen as open and receptive. One staff said, "We see all of the senior staff daily and we can raise any issues we have." Another staff commented, "The staff are the main strength; we all get on and there is good management."

We reviewed some of the quality assurance systems in place to monitor performance and to drive continuous improvement. The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally from members of the Board. For example, medication audits, care plan audits and various health and safety and environmental audits. We also saw a monthly audit carried out by the Board covering aspects of the homes running such as, accidents and incidents, notifiable incidents, infection control monitoring, wound care analysis, nutritional risk, staffing and any visits from external agencies such as the local authority. This had helped to ensure the home was being monitored in key areas.

We found a strong emphasis on collecting feedback from people and visitors to the home. We saw the results of a quality survey carried out in April 2016. This collated feedback from 30 people and their relatives regarding key aspects of the running of the home. We saw that the feedback was positive. Any issues identified that required further action were listed on the analysis and we saw that improvements had been made in areas such as staffing [for example].

These systems had assisted the registered manager and the Board to have clear priorities for the home.

The registered manager was aware of incidents in the home that required the Care Quality Commission to be notified of. Notifications have been received to meet this requirement.