Samily Care Ltd

Denewood House Care Home

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 the 28 April and 03 May 2016. The first date was unannounced and the second date was announced. Denewood House Care Home provides care and support for up to 21 older people. On the days of the inspection 19 people were using the service. The home has a ground floor and a first floor with rooms that have ensuite toilet and wash basin facilities. There is a communal garden area enclosed at the back of the home.

The home was last inspected on the 23 and 26 January 2015 and found not to be meeting the standards in relation to consent and good governance. We found that there were not suitable arrangements in place for establishing a person's best interest in line with the Mental Capacity Act (MCA) 2005 and people were not being protected from inappropriate or unsafe care arising from a lack of proper records. At this inspection improvements had been made.

The manager, who was a registered manager, had been working at the service since 2013 and was registered as the manager in January 2015. 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.

The service was safe because there were sufficient staff to meet people's needs. The registered manager provided details of how staffing had been reviewed and new staff recruited using the appropriate procedures to fill vacancies within the team. A document called the dependency document was used to review the staffing levels required according to people's changing needs.

People were at reduced risk of abuse because staff knew how to recognise signs of abuse and identify people at risk from harm and had received training in safeguarding and protecting adults from harm. This was reflected in staff training records which showed when staff had received their updates on how to protect people and information collected from their personal training manuals. Staff understood the correct procedures to use when reporting abuse which included reporting concerns to their manager and recording details about incidents or poor practice.

Risks were managed and addressed. Where risks were apparent, action had been taken to address and reduce the risk. For example, one person had experienced a series of falls which led to changes in their care. Healthcare staff were contacted and a review of their care needs was agreed. Staff understood the risks to people and followed the guidance provided to keep people safe.

Plans were in place for how staff responded to emergencies. Emergency evacuation procedures were regularly reviewed and staff were kept up to date on the procedures to follow. Accidents and incidents were recorded, monitored and reflected on to take account of changes that were needed. Staff reported and recorded details in the accident log and peoples' care records.

People's medicines were administered safely and on time. People were told what their medicines were used to treat.

The service was effective because consent was sought from people as staff carried out their work and staff were working within the principles of the Mental Capacity Act (MCA) 2005.

People received care and support from staff that were trained , experienced and confident in their roles. People told us that staff understood their needs and were skilled at delivering their care. One person commented "They (the staff) know what support I need; I'm confident in them when they come to help".

The home manager and registered manager confirmed that staff practice was observed regularly to maintain the quality and safety of care people received and this formed part of their regular supervision and yearly appraisal.

People received the level of support and assistance they needed to enjoy their meals and receive a balanced diet. Staff sat with people who needed support and helped them with their meals while describing and discussing the quality of the food. Staff offered people options and checked if they required more servings.

People were supported to maintain good health and received on-going in-put from healthcare staff. During the inspection we met two visiting health care staff and saw other healthcare professionals who had been requested to carry out health checks and appointments with people.

The service was caring because people were treated in a respectful manner when staff carried out people's care. Staff were heard explaining procedures to people and reminded them of how to walk, move and maintain their safety. Explanations were clear and unhurried and people were given time to move within their capabilities.

Staff gave us examples of how they protected people's dignity and respected their privacy. One staff member explained that some people preferred time on their own in their rooms, especially after lunch and this was understood and respected by staff. Other examples included "asking not telling people" when carrying out care and making sure people's windows were closed and curtains drawn when intimate care was performed.

The service was responsive because people received care that was centred on their needs and reviewed periodically as their needs changed. Records showed that people were assessed before coming to live at the home and soon after they arrived. People, their families and where appropriate other health and social care professionals were involved in discussions about their needs.

People could chose from a variety of activities offered at the service and some people chose to make visits into the local community to participate in local social events.

Details about the level of independence were recorded in people's care plans. This included whether they required one to one support or the help of more than one staff member to wash, bathe and move about. Some people needed assistance to eat their meals safely. This included making sure people were positioned safely or according to the instructions from the Speech and Language Therapist .

Complaints and concerns were acknowledged, investigated, explored and addressed. We looked at two complaints. These had been investigated and considered. Advice was sought from other agencies where

appropriate and actions were taken to resolve people's concerns. Written responses were sent following each investigation.

Staff were made aware of the risks which could compromise the quality of the service people received. Care plans, risk assessments and reviews showed details about the care support and treatment people required and staff had received record management training. Some records called daily records used by staff at the service revealed that the level of details recorded were improved since our last inspection but varied in quality and quantity.

Leadership was visible during the inspection where we met the provider, the registered manager and the home manager. Staff, people living at the home and their relatives all confirmed the availability and accessibility of the management team at other times. One person commented, "There's always someone at the top about" while a relative said, "The managers are often available in the office and will come out to help".

Staff spoke of a strong and developed team that worked together to support each other. Staff told us that the managers were responsive to their ideas and suggestions and that they were available when needed.

Management meetings took place where discussions involved staffing levels, admissions, progress and improvements. Checks called audits took place to ensure that the service was regularly monitored and developments continued.

People and their relatives told us that managers were readily available if they wanted to speak with them and that staff were positive when carrying out their roles and responsibilities.

An annual quality assurance survey, used to gather feedback, showed that people and their families had been asked for their views and experiences about the service. Several outcomes arising from the survey showed that actions had been implemented.

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. There were sufficient staff to safely meet people's needs. The registered manager provided details of how staffing had been reviewed and new staff recruited using the appropriate procedures to fill vacancies within the team.

People were at reduced risk of abuse because staff were informed of how to recognise signs of abuse and identify people at risk from harm. Staff told us how they would report concerns about abuse.

Medicines were managed safely by staff who had received training, support and assessment to carry out the procedure. Staff wore tabards which alerted members of the team that they were carrying out this activity and to avoid them being distracted.

Risks to individuals and staff were managed through assessment and review. Where risks were apparent, action had been taken to address and reduce the risk.

The service was clean and well maintained with sufficient resources available to help prevent the spread of infection.

Is the service effective?

Good

The service was effective. People received care and support from staff that were trained and experienced and confident in their roles. Staff received regular training and refreshment courses some of which included topics like understanding strokes, Parkinson's and diabetes.

Staff at the service were working within the principles of the Mental Capacity Act (MCA) 2005. They had made contact with the relevant teams and services to seek advice. Where appropriate, people's consent was sought before care was provided.

People received the level of support and assistance they needed to enjoy their meals and receive a balanced diet. Staff sat with people who needed support and helped them with their meals.

People were supported to maintain good health and received

on-going in-put from healthcare staff.

Is the service caring?

Good

The service was caring. People were treated with kindness. Healthcare professionals told us they saw staff demonstrate a good level of care and kindness towards people.

People received responsive support at sensitive times. Staff took action to comfort those who were tearful or upset. One person was prone to crying and staff engaged regularly with them to provide emotional support.

Staff provided accounts of how they protected people's privacy and respected their wishes and this was reflected as staff worked with people at the service.

Is the service responsive?

Good

The service was responsive. People received care and attention according to their assessed needs. Activities were provided to encourage people to maintain their interests and prevent social isolation.

Complaints and concerns were acknowledged, investigated, explored and addressed. Actions were taken to resolve people's concerns. Positive comments were seen when relatives wrote to acknowledge the service people received.

Is the service well-led?

Good

The service was well led. The service was led by a management team which included a home manager, the registered manager and the provider who were visible at the home during the inspection. Weekly reports sent from the management team to the provider along with management meetings were used to improve the service.

People were benefitting from improvements being fostered at the service to promote a positive atmosphere. People and their families were consulted through surveys and provided feedback to improve their experience of living at the home.

Service checks called audits were regularly used to monitor and maintain a safe and clean environment. These checks were also used to review records, check maintenance and to ensure medicines were being administered safely.

Staff were made aware of the risks which could compromise the

quality of the service people received.

Denewood House Care 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 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.

The inspection took place on the 28 April and 03 May 2016 and was carried out by one inspector. The first date was unannounced and the second day was announced. The service provides care and support for up to 21 older people living at Denewood House Care Home. At the time of our inspection there were 19 people living at the home.

The service had a registered manager. 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.

Before the inspection we reviewed information we held about the service. A 'notification' is information that services have to provide to the Care Quality Commission about changes and serious events. This included notifications we had received from the provider about incidents, safeguarding concerns and other relevant changes to the service.

We spoke with health and social care representatives to get information about their experience of the service. We requested and received information from the service called a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We gathered this information from the provider during the inspection.

We spoke with six people living at the home and four relatives and visitors. We spoke with the provider, the registered manager and the home manager. We also spoke with seven staff including those from care, catering and housekeeping services. We had contact with four health and social care professionals for who worked in partnership with the service and provided support to people living at the home.

We observed care using the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed three people's care plans and their risk assessments and four Medicine Administration Records (MAR). We looked at daily records about the care people received which included records about food and drinks people were offered and how frequently they were made comfortable or moved when in bed. Other records included accidents and incidents, activities people were offered and body charts for recording the application of medical skin creams. We also reviewed management records including minutes from meetings, policies, health and safety records and service quality checks.

Good

Is the service safe?

Our findings

There were sufficient staff to safely meet people's needs. The registered manager provided details of how staffing had been reviewed and new staff recruited using the appropriate procedures to fill vacancies within the team. This included requesting applicants to complete recruitment records like application forms and requesting evidence of their personal identification, their right to work and seeking job and character references. Safe recruitment included checking that applicants had not been barred from working with adults. A new team structure meant that staff were identified as key workers to individuals although staff worked as a team to deliver care.

Staff worked flexibly to deliver care. Four care workers and a senior staff member provided support in the mornings while three care workers and a senior worked a late shift. Some staff chose to work 8am till 2pm and 2pm till 8pm while other staff preferred to work full shifts of 8am till 8pm. Two staff worked 8pm till 8am to cover the night shift. In addition to the care staff, the home manager worked during the week and on occasions at weekends to provide management support. The registered manager worked between Denewood House and another home to provide support, leadership and advice. The home manager commented that staff levels had been assessed using a dependency document which we were shown and included activities of daily living and people's physical, behavioural and social needs.

People told us that while it could take staff time to respond to call bells they were able to meet their needs. One person said, "It can be busy at times especially in the morning and around lunch time but staff do answer the bells". Staff told us that at busy points or when they were short of staff people may have had to wait longer than usual but that staff responded as soon as was possible. We heard call bells raised but these were responded to within minutes. Several staff commented that if they needed help the manager would provide assistance. This was confirmed by the home manager and the registered manager. The registered manager explained that the less mobile people were supported on the ground floor where this was possible, as the layout of the building meant that without a lift people would have experienced difficulty in moving about the home. This also meant that staff could work closer together to provide the right level of support people needed.

People were at reduced risk of abuse because staff were informed of how to recognise signs of abuse and identify people at risk from harm and had received training in safeguarding and protecting adults from harm. This was reflected in staff training records which showed when staff had received their updates on how to protect people and information collected from their personal training manuals. Staff understood the correct procedures to use when reporting abuse which included reporting concerns to their manager and recording details about incidents or poor practice. One staff member said, "If I was worried I'd contact social services and yourselves". Appropriate referrals had been sent to the relevant teams when safeguarding events had been identified. Three people told us they felt safe, one commented, "It's very safe here, you see who comes through the door". A relative told us they had no concerns in terms of people's safety and described the staff as "informed and aware". There were details made available in the main reception area and office which outlined how staff could raise safeguarding alerts.

Medicines were managed safely by staff who had received training, support and assessment to carry out the procedure. Staff wore tabards which alerted members of the team that they were carrying out this activity and to avoid them being distracted. One person said "They wear that apron when giving out the medicines; that's so they don't get disturbed". Someone else said, "Staff chat to me about my pills and ask if I need pain-killers". A relative explained they felt confident their family member received medicines when they needed them and commented that staff could often tell when their family member was in pain or discomfort.

People were told what their medicines were used to treat. Staff were seen explaining the type of medicine to people and checking whether they required tablets for pain relief from conditions like arthritis and strokes. One person was prescribed a medicine that was not familiar to the staff member and they sought additional information about this to inform their knowledge.

When staff administered the prescribed dosage they checked the identification of people and remained beside them until the medicine had been taken. Some people, who had more difficulty swallowing their medicines, were prescribed these in liquid form to ensure people received their medicines in comfort and with greater ease.

Medicines were stored securely in the medicine trolley which was kept locked between individual administrations. Packets and bottles were clean and the instructions were visible for staff to read. Dates were recorded on each medicine packaging to show when they were opened and staff checked the expiry dates of each.

Records relating to medicine administration were completed accurately. Staff checked each medicine and dose against the Medicine Administration Record (MAR) which indicated the correct time of administration. MAR charts were completed, dated and signed and where medicine had not been administered when due, a reason was indicated.

Risks to individuals and staff were managed through assessment and review. Where risks were apparent, action had been taken to address and reduce the risk. For example, one person had experienced a series of falls which led to changes in their care. Healthcare staff were contacted and a review of their care needs was agreed. Staff understood the risks to people and followed the guidance provided to keep people safe. For example, one person was at risk from choking and staff explained posture safety when helping them with their food. Staff exchanged informal information with each other verbally at the change of shifts and daily records were used to record some of the care people had received.

Plans were in place for how staff responded to emergencies. Emergency evacuation procedures were regularly reviewed and staff were kept up to date on the procedures to follow. Accidents and incidents were recorded, monitored and reflected on to take account of changes that were needed. Staff reported and recorded details in the accident log and peoples' care records. These were updated and checked by the home manager. Senior staff and the management team maintained safety throughout the home by ensuring safety checks took place and contracts for services were updated. Fire safety equipment had been maintained and a local contractor regularly visited to address any maintenance issues.

The home was kept clean and well maintained. Communal areas and people's rooms were clean and a maintenance book recorded faults and breakages that required repair. These were checked, followed up and completed on a regular basis. People were protected from the risk of infection because staff used disposable aprons and gloves when carrying out a range of care activities. Different aprons were worn when food was being prepared and served and staff used hand gels to reduce the risk of infection. In the kitchen

area there was a strict hygiene policy where staff were reminded to wash hands and wear the appropriate aprons.

Staff understood their roles and responsibilities in keeping the home clean and protecting people from infections. Housekeeping staff had been increased and staff received support in following the home's cleaning plan. There were sufficient resources to maintain cleanliness across the home. One staff member said "There's always enough cleaning materials, I just let the managers know when low". Another staff member explained that they followed a cleaning routine and when they had completed they used their initiative to maintain other areas of the home. Cleaning and hygiene resources included hand gel sites, glove and apron dispensers throughout the home and correct linen bags for soiled linen. Housekeeping staff and managers checked the home to maintain a safe level of cleanliness.

In people's rooms, sinks and toilets were kept clean and in good working order. Some rooms on the first floor took time to run hot water which we reported to the home manager and the registered manager and these were reported to maintenance for review.

Good

Is the service effective?

Our findings

At the last inspected the service was found not to be meeting the standards in relation to consent. We found that there were not suitable arrangements in place for establishing a person's best interest in line with the Mental Capacity Act (MCA) 2005.

At this inspection improvements had been made to how best interest decisions were made in line with the MCA and changes to how records were produced and updated meant that most records better reflected the care people had been assessed to receive.

Consent was sought from people as staff carried out their work. As staff supported people we heard them communicating and explaining their actions clearly and confidently before and while carrying out their responsibilities.

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, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that staff at the service were working within the principles of the MCA and they had made contact with the relevant teams and services to seek advice. For example, one person had a best interest decision made involving staff, health and social care professionals and the MCA team to decide that they were to be supported and cared for in bed with bed rails for their protection.

An application to deprive one person of their liberty had been granted. Applications to deprive people of their liberty had been made for six people across 10 months to ensure people received safe care within the principles of the MCA.

Staff gave examples of the care people needed according to their level of ability or medical condition and this matched information we read in people's care plans. For example, some people had best interest decisions which staff described and were familiar with when talking about people's needs.

People received care and support from staff that were trained and experienced and confident in their roles. People told us that staff understood their needs and were skilled at delivering their care. One person commented "They (the staff) know what support I need; I'm confident in them when they come to help".

One relative told us that staff understood the assistance their family member needed and had liaised with them to improve the support the person received.

New staff were given support from the home manager and more experienced staff until they were confident to deliver the care people needed. They completed an induction which included learning about different aspects of care-giving and were required to respond to questions from an induction work book which was marked before final completion. New staff were expected to complete the new Care Certificate. The care certificate have replaced the social care induction programme. Staff received regular training and refreshment courses some of which were practical like moving and handling and health and safety while others were completed using workbooks and video learning. Training also included topics like understanding strokes, Parkinson's and diabetes.

The home manager and registered manager confirmed that staff practice was observed regularly to maintain the quality and safety of care people received and this formed part of their regular supervision and yearly appraisal. This was reflected in records which showed that staff were observed and assessed when carrying out new skills like administering medicines. Records of staff training, showing when training was due and when completed, was maintained by the management team. One staff member explained the training they had received which had included hygiene, cleanliness and the prevention of infection, health and safety and moving and handling. We were shown a list of the training staff were expected to complete as part of their ongoing development.

People received the level of support and assistance they needed to enjoy their meals and receive a balanced diet. Staff sat with people who needed support and helped them with their meals while describing and discussing the quality of the food. Staff offered people options and checked if they still required more servings. Some people used plate guards to encourage them to be independent. Where one person found this difficult a staff member provided help and later described the reason for their intervention, to prevent the meal from cooling and becoming less enjoyable. People had drinks and refreshments throughout the day and a relative said "Water jugs are always filled up here". One person said, "The food is hot and they ask what I would like", someone else told us they were offered alternatives if they declined the main meal.

A menu in the communal lounge highlighted the dishes of the day. Some people chose to have their meals in their room but were offered a choice of hot and cold foods. In care records information was documented on people's preferences and their special dietary requirements including the assistance they needed and instructions from Speech and Language Therapy team (SALT). People with complex dietary needs were identified by staff who prepared people before their meals were offered. This included the seating and the appropriate posture people needed to adopt before and during meal times to ensure they swallowed food safely. Instructions from SALT included the texture, consistency and type of foods for individuals who were at risk of weight loss or who required higher calorific foods. The catering staff were fully informed of each person's nutritional needs and had guidance charts to ensure people received the correct meals and appropriate foods. People were weighed and monitored regularly using nationally recognised tools and guides to identify any risk of malnutrition.

There were sufficient supplies of food available to catering staff to meet people's needs.

People were supported to maintain good health and received on-going in-put from healthcare staff. During the inspection we met two visiting health care staff and saw other healthcare professionals who had been requested to carry out health checks and appointments with people. Healthcare staff told us that staff were prompt at contacting them for support and followed advice and suggestions about the health support people needed to keep them well. Two relatives told us that health professionals were regularly in contact

with their family members and records showed that people were seen by a range of specialists. Contact was also maintained with health teams by telephone to discuss changes or concerns raised about changes to people's health and to discuss treatments.

Good

Is the service caring?

Our findings

People were treated in a respectful manner when staff carried out people's care. Staff were heard explaining procedures to people and reminded them of how to walk, move and maintain their safety. Explanations were clear and unhurried and people were given time to move within their capabilities. We saw one staff member supporting someone at their side and encouraging them to walk. They showed patience and awareness of the person's limited mobility and allowed sufficient time for the person to reach their chair. This showed that staff were aware of people's need for support and intervention.

One person commented "They (the staff) are kind and patient, you only have to ask" and another person said, "I get on well with the staff, they're a good bunch and do their best for us". Relatives were equally complimentary and shared with us that staff "showed a genuine interest in people" and "made time even when they were busy". Several relatives told us that visitors were not restricted to visiting times and were welcomed whenever they attended.

People were treated with kindness. Healthcare professionals told us they saw staff demonstrate a good level of care and kindness towards people. One healthcare professional said, "They (the staff) understand people's different needs and try to meet them. They show an interest in people and seem to know each of them well".

Several staff were seen encouraging people in the lounge to enjoy the afternoon activities and prompting people with light-hearted comedy and humour. This captured several people's attention and provoked laughter and further humorous exchanges. One person said, "They certainly know how to cheer you up".

Staff gave us examples of how they protected people's dignity and respected their privacy. One staff member explained that some people preferred time on their own in their rooms, especially after lunch and this was understood and respected by staff. Other examples included "asking not telling people" when carrying out care and making sure people's windows were closed and curtains drawn when intimate care was performed. One staff member explained that this was particularly important to remember for people on the ground floor whose rooms could be visible from the outside. One staff member commented on confidentiality explaining that staff had to be aware of protecting people's information when working together around the home. This meant staff had an understanding of how to protect people's personal information.

Staff described the specific wishes of several people and conveyed an understanding of their personal circumstances including information about people's friends and relatives that visited and their likes and preferences. Examples included people's food choices, when they preferred a shower and several people's hobbies and past interests. Staff showed awareness of people's past and one staff member described how they had learnt more about peoples' interests when delivering personal care and talking with their relatives and visitors. In care records information about people's end of life wishes were recorded from conversations with people and their families.

We heard one staff member helping someone to choose their meal and another staff member spoke with someone about the activities planned for the week to help them decide on their interest and involvement. People who remained in their rooms told us that staff protected their privacy and treated them with respect. One person commented, "They (the staff) are always polite; they seem to understand and are respectful; they ask if I want the door open or closed". Relatives told us they saw staff treating people well and demonstrating respect. One relative said, "I can trust staff; they always treat my (family member) as if they were their own". They knock on the door to check who is in there first".

People received responsive support at sensitive times. Staff took action to comfort those who were tearful or upset. One person was prone to crying and staff engaged regularly with them to provide emotional support. Staff explained that some people had been bereaved or had found coming to live at the home a change they were not expecting. One staff member commented, "It can be a challenge and difficult for some" and "We do our best to help people settle, make new friends". One person seemed unsure of their surroundings and staff responded understandingly by guiding them to another area of the home and offering words of reassurance. This outlined how staff showed insight into people's emotional and social needs.

We heard positive terms of kindness used when staff assisted and supported people and saw staff encouraging and motivating people as they worked. One staff member was heard saying "That's ok, take your time, you don't need to rush" and when someone else was being assisted with their meal the staff member sat close by to describe their food and support them to eat. This demonstrated how staff adapted their approach to meet people needs and were positive about the changes that were needed to improve people's experiences.

Good

Is the service responsive?

Our findings

People received care that was centred on their needs and reviewed periodically as their needs changed. Records showed that people were assessed before coming to live at the home and soon after they arrived. People, their families and where appropriate other health and social care professionals were involved in discussions about their needs. These included the level of physical support they required, their risk factors including their likelihood of falling and their moving and handling assessments. For example one person was at risk of falling and was provided with equipment to alert staff once the person began to mobilize. Staff were made aware and provided details about the person's most recent care. This was confirmed from a review of their needs and from checking entries in the accident and incident log.

Details about the level of independence were recorded in people's care plans. This included whether they required one to one support or the help of more than one staff member to wash, bathe and move about.

Care plans and associated care records had been changed since the previous inspection to improve the information gathered, recorded and shared at shift handovers about people's assessed needs. Information used to identify people's needs including their personal histories, medical background and risk assessments had been reviewed and amended in line with these changes. This meant staff were better informed and communicated with each other about the changing needs of people they were supporting.

People were encouraged to maintain their interests, engage with social experiences provided at the home and enjoy outside visits with family and friends. For example, one person enjoyed socialising and regularly attended a weekly social event in the local community. Staff described how the person's care routine was adapted to accommodate this so that they could attend the event. The team were aware of the importance of this weekly activity and how this had helped to reduce the risk of social isolation and maintain a sense of place in the local community.

In the reception area and in other places around the home was information about the choice of activities available for people to join. These included a visiting musician, a pianist and a singing group who sang war time music. A local library service visited regularly to offer people a choice of reading material and a talking stories service provided books for listening instead of reading.

Complaints and concerns were acknowledged, investigated, explored and addressed. We looked at two complaints. These had been investigated and considered. Advice was sought from other agencies where appropriate and actions were taken to resolve people's concerns. Written responses were sent following each investigation. We read positive comments from letters of thanks that were received to acknowledge the service people had experienced.

Good

Is the service well-led?

Our findings

At the last inspected the service was found not to be meeting the standards in relation to good governance. We found that people were not being protected from inappropriate or unsafe care arising from a lack of proper records. At this inspection significant improvements had been made to how records were produced and updated. This meant that most but not all records better reflected the care people had been assessed to receive.

Staff were made aware of the risks which could compromise the quality of the service people received. Care plans, risk assessments and reviews showed details about the care support and treatment people required and staff had received record management training. Some records called daily records used by staff at the service revealed that the level of details recorded were improved since our last inspection but varied in quality and quantity.

While some daily records identified clear details about the level and type of care people received, this was inconsistent. For example, the care that one person received provided a detailed description of their care which aligned with the care plan and features identified from the person's assessment. However, another daily record provided limited information about how one person's needs were met and did not align to the details found in their care plan. For example, this person's care plan recorded that staff should closely monitor the person's food and fluid intake yet the daily records showed no evidence that this had been monitored and recorded.

One other record lacked sufficient detail about the quantity of fluid one person had taken across the shift. We drew this to the attention of the home and registered manager who told us that staff were regularly reminded of this. The registered manager told us they would address this with staff immediately and at the next team meeting. The registered manager explained they would provide a practical training exercise using plates, cups and beakers to help staff recognise the importance of recording and achieving this. We followed this up after the inspection and were told that staff had been made aware during shift handover sessions and a memo had been sent to staff to read and acknowledge. The registered manager told us that work had been done to help staff identify the volume of fluid in different drinking vessels including cups, beakers and glasses. This meant that staff would be better informed in recording the details of food and fluid intake at meal times.

The leadership was visible during the inspection where we met the provider, the registered manager and the home manager. Staff, people living at the home and their relatives all confirmed the availability and accessibility of the management team at other times. One person commented, "There's always someone at the top about" while a relative said, "The managers are often available in the office and will come out to help".

The service was led by a management team which included a home manager, the registered manager and the provider. The management team structured their roles around their individual and group leadership responsibilities. To achieve this, meetings were arranged between the home manager and the registered

manager and the registered manager and the provider. We were told by the provider and registered manager that meetings were fortnightly to discuss progress, development and improvements. Examples given were actions for general maintenance to repair faults reported by staff, new or revised policies and budgets. All three levels of management met regularly and worked towards achieving the goals identified at staff meetings and from feedback from people using the service and their families. For example, maintenance repairs, admissions and staffing levels were regularly discussed. Records showed that meetings were carried out and were structured around changes, emerging issues and general service level developments to improve the experience of people at the home.

The management team including staff had a shared understanding of the goals, aspirations, challenges, risks and their achievements, and worked together to realise these. Examples included planned changes to the back garden area to make this more suitable for people to enjoy and walk around. These plans included a raised bedded area to enable people with various levels of mobility to access and use. The plan was to encourage the planting of vegetables and other home grown foods.

People were benefitting from improvements being fostered at the service to promote a positive atmosphere. One person said, "Well they're (the staff) all very happy and helpful" and a relative commented that "staff had a positive attitude to their work". Staff told us that the team was more cohesive and although there had been a number of staff changes previously this had now settled down. This was confirmed by the management team who described the new team as 'stronger and working well together'. The management team promoted values through staff development and dignity training. The home manager explained they had recruited a more diverse workforce with a range of staff of different ages to add to the stability of the team. Staff reported that the management structure had improved and one staff member said, "We can go to both the managers about anything we're worried about; things are more open" and "They encourage us to talk about our ideas". Another staff member said "Their door is always open and if we need help they do respond". The home manager described being responsive to staff and told us they encouraged staff to discuss important matters as they occurred.

There was a whistle blowing policy and staff were aware of how to challenge and report their concerns. Regular staff meetings and handovers were used to share information and encourage staff communication.

Important links were made with the wider community and examples confirmed this. Senior staff invited services which provided audio and visual books to the home to provide more choice of literature and audio entertainment. A local visiting pet service attended regularly for those who had previously owned pets and to offer comfort to those who liked the company of animals.

Information from Denewood House Care Home was received by the Care Quality Commission in a timely manner. The registered manager and home manager shared relevant information with the Care Quality Commission and our records showed that notifications were sent promptly. A notification is the action a provider is required to take to inform us of changes to their regulated service and incidents that have occurred in them.

Service checks called audits were regularly used to monitor and maintain a safe and clean environment. These checks were also used to review records, check maintenance and to ensure medicines were being administered safely. The outcome of audits was used to identify outstanding actions and progress that had been made.

An annual quality assurance survey, used to gather feedback, showed that people and their families had been asked for their views and experiences about the service. Several outcomes arising from the survey

showed that actions had been implemented. These included external decoration of the home, a change of menu choices and the provision of a menu board for people to read before meals were served. This showed that actions were taken to respond to comments and feedback received about the service.