Interhaze Limited

The Hunters Lodge Care Centre

Inspection report

Hollybush Lane
Oaken, Codsall
Wolverhampton
West Midlands
WV8 2AT

Tel: 01902847575
Website: www.interhaze.co.uk

Date of inspection visit:
20 December 2018
21 December 2018

Date of publication:
14 February 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 20 and 21 December 2018. The first day of our inspection visit was unannounced.

The Hunters Lodge Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home is registered to provide accommodation with nursing care or personal care for up to 90 people, some of whom are living with dementia, have physical disabilities or mental health problems. The accommodation is provided within three separate units located on the same site: Kitwood Unit, Terrace Unit and Pavilion Unit. Each of these units is designed to cater for people with specific categories of needs. For example, Pavilion Unit provides care and support to younger adults with mental health problems. At the time of our inspection, there were 73 people living at the home.

There was a registered manager in post who was present during our inspection. 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.

At our previous inspection in July 2017, we rated the service as 'Requires Improvement' and identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the ineffectiveness of the provider's quality assurance systems and procedures. As a result of the inspection, we asked the provider to send us a report explaining the actions they were going to take to improve the service. At this inspection, we found the provider was now meeting the requirements of Regulation 17, although improvements were still needed in the monitoring of recruitment practices and staff training provision.

The management team had not always adhered to the provider's recruitment policy and safe recruitment practices through carrying out consistent per-employment checks on prospective staff. Some staff raised concerns regarding the adequacy of the night-time staffing levels on Terrace Unit, and we identified issues regarding staff deployment on the same unit. Some improvements were still needed in relation to the management of people's medicines, including closer monitoring of medicines fridge temperatures. The provider had not fully promoted people's rights under the Mental Capacity Act 2005 when introducing infra-red motion sensors across two of the home's units. Mealtimes at the service still needed to be better organised to prevent significant delays in some people's meals, and ensure people were effectively supervised and encouraged to eat. Staff training and supervision meetings had lapsed over recent months.

People told us they felt safe living at the home. Staff recognised their role in protecting people from any

form of abuse or discrimination, and were aware of the different forms and potential indicators of abuse. The provider had systems and procedures in place to manage the risks associated with the home's physical environment, the equipment staff used and people's individual care and support needs. Staff recorded and reported any accidents or incidents involving people who lived at the home. The provider had measures in place to protect people, visitors and staff from the risk of infections. This included the provision of appropriate personal protective equipment for staff use.

People were supported by staff to make choices about what they ate and drank each day, and had input into the home's menus. Any complex needs or risks associated with people's eating and drinking were assessed and managed, with advice from nutrition specialists. Prior to people's care starting, the management team met with them and, where appropriate, their relatives to assess their individual needs. Staff and management then worked with a range of community health and social care professionals, with the aim of ensuring positive outcomes for people. Staff and management recognised the need to promote equality and diversity, and consider people's protected characteristics, in the planning or delivery of their care. All new staff underwent the provider's induction training to help them settle into their new roles and understand what was expected of them at work. Staff helped people to access professional medical advice and treatment if they were unwell. Steps had been taken to adapt the home's environment to people's individual needs, including those who were living with dementia.

Staff approached their work with kindness and compassion, and they knew people well. People and relatives were supported to express their views and be involved in decision-making that affected them. People's individual communication needs had been assessed, recorded and kept under regular review. Staff understood the need to treat people in a respectful and dignified manner, and protect their personal information.

People received care and support that took into account their individual needs and preferences. The management team took steps to involve people and their relatives in care planning and review meetings. People's care plans were individual to them and covered important aspects of their care. People had support to pursue their interests and participate in recreational and social activities at the service, although some staff felt the provider's 'wellbeing and lifestyle facilitator' (activities coordinator) was overstretched at present. People and their relatives understood how to raise any concerns or complaints about the service, and the provider had a complaints procedure in place to ensure these were handled fairly. Staff and management took steps to identify people's preferences and choices for their end-of-life care, in order that they could work with community professionals to meet these.

The registered manager demonstrated a good understanding of the requirements associated with the provider's registration with CQC. Most people and relatives described positive relationships and open communication with an approachable management team. Staff were enthusiastic about their work and felt well-supported and valued. The community health and social professionals we spoke with felt staff and management were receptive to, and normally acted on, their recommendations. The management team encouraged people and relatives' involvement in, and feedback on, the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The management team had not always adhered to safe recruitment practices.

Staff understood the need to remain alert to and report any form of abuse.

Steps had been taken to protect people from the risk of infections.

Is the service effective?

Requires Improvement

The service was not always effective.

People's rights under the Mental Capacity Act 2005 were not always fully promoted.

Staff training and staff supervision meetings had lased.

People had support to access professional medical advice and treatment if they were unwell or in pain.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by staff who had taken the time to get to know them well.

People and their relatives were able to express their views to staff and management.

People's rights to privacy and dignity were promoted by staff.

Is the service responsive?

Good

The service was responsive.

People received personalised care that took into account their individual needs and requirements.

People had support to participate in social and recreational activities.

People and their relatives were clear how to raise any concerns or complaints about the service.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Improvements were needed in the provider's monitoring of staff training provision and recruitment practices.

The management team promoted an open and inclusive culture within the service.

Staff felt well-supported and valued by the management team.

The Hunters Lodge Care Centre

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 20 and 21 December 2018. The first day of the inspection visit was unannounced. The inspection team consisted of three inspectors, two Experts by Experience and a specialist advisor who is a nurse specialist in dementia care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We took this information into account during the planning of our inspection of the service.

Before the inspection site visit, we reviewed the information we held about the service, including any statutory notifications received from the provider. A statutory notification is information about important events, which the provider is required to send us by law. We also contacted the local authority, the local clinical commissioning group and Healthwatch for their views on the service. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care services.

During our inspection visits, we spoke with 13 people who used the service, seven relatives, four community health and social care professionals and the registered manager. We also spoke with the deputy manager, two unit managers, the clinical lead, a nurse, five senior care staff and six care staff. In addition, we spoke with the provider's wellbeing and lifestyle facilitator, a maintenance worker and a member of the domestic

staff team.

We looked at a range of documentation, including 14 people's care and assessment records, staff training and supervision records, medicines records, incident and accident reports and three staff recruitment records. We also looked at staff rotas, the home's menus, complaints records, selected policies and procedures, certification related to the safety of the premises and records associated with the provider's quality assurance.

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

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2017, we rated this key question as 'Good'. At this inspection, we found that whilst the provider was not in breach of any regulations, they needed to make improvements to ensure people's safety. The rating of this key question is now 'Requires improvement'.

The provider had a staff recruitment and selection policy in place, which required that appropriate checks were completed on the suitability of prospective staff before they started work at the home. These checks included a minimum of two written references and an Enhanced Disclosure and Barring Service (DBS) check. The DBS carries out criminal records checks to help employers make safer recruitment decisions. However, we found the management team had not consistently adhered to the provider's recruitment policy and safe recruitment practices.

One member of staff had been allowed to start work before their employment references had been received. Whilst evidence of a recent DBS check had been obtained for the person, this did not include a check against the DBS's Adults' Barred List. Another staff member had been permitted to start their online training on the premises before the results of their Enhanced DBS check had been received, and without a DBS Adult First check in place. We were not assured this staff member had been under supervision during this period, to monitor their contact with the people living on the unit. A DBS Adult First check enables an employer to check an individual against the DBS Adults' Barred List while waiting for their full DBS check results. In addition, clear information about prospective staff members' employment histories had not always been obtained, preventing the management team from exploring any gaps in employment with them.

We discussed these issues regarding the vetting of prospective staff with the registered manager. They assured us they would address the specific recruitment concerns raised with them as a matter of priority. They told us they would also take steps to ensure safe recruitment practices were consistently adhered to moving forward. We will follow this up at our next inspection.

Following our inspection, the registered manager informed us they had met with the staff members in question to obtain details of their full employment histories, and had reapplied for one staff member's references and Enhanced DBS check. They also informed us they had completed a risk assessment in relation to the use of DBS Adult First checks on prospective staff.

We looked at how the provider ensured there were sufficient numbers of staff to help people stay safe and meet their individual needs. Most people, relatives and staff we spoke with were satisfied the staffing levels maintained across the three units were safe. One relative told us, "There always seems to be enough staff when we come in the afternoons." However, three members of staff expressed concerns over the adequacy of the current night-time staffing levels on Terrace Unit. One of these staff members told us, "I think we need more staff during the day, and at night there is not enough. Most people are mobile, so it is a problem." At present, the unit's night-time staffing arrangements consisted of two night care staff supporting 23 people, who were living with dementia, across the unit's three floors. In addition, we were not assured day-time staff deployment on Terrace Unit was effective in ensuring people in the unit's three ground-floor communal

lounges were appropriately monitored. We saw people, who, on occasions, displayed behaviours which impacted negatively upon one another, were left unsupervised in the unit's communal lounges for periods of ten minutes or more. The unit manager confirmed staff were not individually allocated to monitor people's wellbeing in the communal lounges, but that this responsibility fell upon all staff on duty.

We discussed these concerns regarding staffing arrangements on Terrace Unit with the registered manager. They indicated staffing levels across the three units were monitored and adjusted as needed, through use of the provider's monthly dependency tool. Following our inspection, they informed us the provider was recruiting additional staff in order to increase night-time staffing levels on Terrace Unit. They had also met with the unit manager of Terrace Unit to review staff deployment and ensure people were better monitored in the unit's communal lounges.

The provider had systems and procedures in place designed to ensure people received their medicines safely and as prescribed. People's medicines were administered by nurses and trained care staff who underwent annual competency checks and maintained up-to-date medicine administration records (MARs). Creams and liquid medicines were marked with an opening date to enable staff to monitor medicine expiry dates, and monthly medicines stock checks were completed to check people had received their medicines as intended.

However, we identified the need for some improvements in the provider's management of people's medicines. Controlled drugs stock checks on Terrace Unit were carried out monthly, whilst the National Institute for Health and Care Excellence (NICE) recommends these are done at least once a week. Following our inspection, the registered manager confirmed these checks were now being completed on a weekly basis. We also found medicines that required cold storage on Terrace Unit could have been compromised, because the temperature of the medicines fridge had fallen below the recommended limits on nine occasions within the last month. This issue had not been reported to the unit manager. They informed us they would introduce additional temperature monitoring, and arrange for this appliance to be repaired or replaced if it was operating outside of the recommended range.

People told us they felt safe living at the home. One person explained, "I feel safe … We are well looked after …There are a couple of staff members who are particularly good, and I would talk to them if I had any worries or concerns." Another person said, "I am safe; why wouldn't I be? I have the girls [staff] here to look after me." Other people described how the call bells installed in their personal rooms helped them feel safe, as they could request help from staff when they needed it.

Staff recognised their individual responsibilities to protect people from any form of abuse or discrimination. They showed insight into the different forms and potential indicators of abuse, such as sudden behaviour changes or unexplained marks or bruising. They told us they would immediately report any witnessed or suspected abuse to the management team. One staff member said, "If I had any safeguarding concerns, I would report them to the management team. I'm confident they would take appropriate action." The provider had safeguarding procedures in place and had reported abuse concerns to the relevant external agencies, such as the local adult safeguarding team, in line with these.

The provider had clear systems and procedures in place to manage any risks to people associated with the home's physical environment and the equipment in use. This included regular checks on the operation of the home's fire alarm system and fire safety measures, and monthly checks on hot water temperatures, window restrictors and first aid supplies.

The risks associated with people's individual care and support needs had also been assessed, and kept

under regular review, using recognised assessment tools. These assessments considered, amongst other things, people's risk of falls, any complex needs and risks associated with their nutrition and hydration, behaviour issues, and people's vulnerability to pressure sores. Plans had been implemented to manage identified risks to individuals and keep them safe. This included the use of pressure-relieving equipment, skin checks and support with repositioning to maintain people's skin integrity. Staff confirmed they read and referred back to people's risk assessments as needed, and showed good insight into people's individual needs. They explained they were kept up to date with any changes in the risks to people or themselves through, amongst other things, consistent daily handovers between shifts.

Staff were aware of the provider's procedures for recorded and reporting any accidents or incidents involving people who used the service. We saw the management team monitored these reports to identify causes or trends and take action to prevent things happening again. One relative praised the management team's thorough investigation into a fall suffered by their loved one, confirming a plan was in place to minimise the risk of further falls.

The provider had taken steps to protect people, visitors and staff from the risk of infections. We found the care environment and the specialist care equipment in use to be clean and hygienic. The provider employed domestic staff to support staff in ensuring standards of hygiene and cleanliness were maintained, following set cleaning schedules. Staff were provided with, and made use of, appropriate personal protective equipment (disposable aprons and gloves) to reduce the risk of cross-infection. Antiseptic hand gel dispensers and hand-washing facilities were available to facilitate good hand hygiene. In addition, the management team had appointed a member of staff as 'infection control champion' to monitor and identify any potential improvements in infection control practices at the home.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2017, we rated this key question as 'Requires improvement'. At this inspection, we found the provider still needed to make improvements to ensure people's care was delivered in line with current legislation and best practice guidance. The rating of this key question remains 'Requires improvement'.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. The staff we spoke with understood the need to seek people's consent before carrying out their routine care and to respect their right to make their own decisions. One staff member explained, "With people who can't verbalise consent, we [staff] will always explain what we want to do. You can tell by facial expressions whether they are consenting or not." The provider had systems and procedures in place to enable staff and management to record people's consent to their care, along with any individual mental capacity assessments and best-interests decisions carried out. We saw examples of mental capacity assessments in the care files we looked at, in relation, for example, to the use of 'stair gates' to restrict people from entering others' personal rooms.

At our last inspection, we found the provider's approach to supporting people with their decision-making was not consistent. At this inspection, we found the provider and management team were still not fully promoting people's rights under the MCA. The provider had taken the decision to introduce infra-red motion sensors in people's personal rooms, across two of the home's units, with the aim of reducing the risk of falls. In the majority of cases, it was not clear people had consented to the introduction of this equipment, or how the decision to install this had been made in their best interests as the least restrictive option. The registered manager acknowledged this had been an oversight on their part, and that they would address this without delay. Following our inspection, they informed us they were in the process of recording the relevant mental capacity assessments and best-interests decisions.

The management team had submitted applications for DoLS authorisations based upon an individual assessment of people's capacity and their care and support arrangements. Where DoLS authorisations had been granted, they assured us they reviewed any associated conditions, in order to comply with these.

Most of the people and relatives we spoke with have confidence in the overall competence of staff. The provider had developed a programme of training designed to give staff the skills and knowledge they

needed to work safely and effectively. This included training on safeguarding adults, health and safety, managing challenging behaviour and promoting privacy and dignity. However, the training records we looked at indicated staff training had lapsed. Not all staff had completed the provider's mandatory training or attended their periodic refresher training. We discussed this concern with the registered manager. They acknowledged that staff training needs had not been consistently monitored and addressed over recent months. They assured us they had a training plan in place to bring staff training back up-to-date, and that training would be more closely monitored moving forward. We saw they had recently issued a formal reminder to staff to complete any outstanding online training. The staff we spoke with did not raise any concerns regarding the training provided to enable them to fulfil their duties, and we did not observe any unsafe work practices during our inspection.

Staff also attended one-to-one meetings, 'supervisions', with a member of the management team. The purpose of these meetings was to enable staff to discuss any additional training or support they needed, and receive constructive feedback on their work performance. Supervision records indicated a number of staff had received regular supervisions over the last six months. One such staff member told us, "I haven't had supervision in a while; it is overdue." The registered manager acknowledged staff had not consistently received their two-monthly supervisions. They assured us they had a plan in place to bring staff supervisions fully up to date and to ensure they were arranged on a consistent basis moving forward. We will follow this up at our next inspection. We also found the clinical lead received their clinical supervision from a non-clinical supervisor, as opposed to someone from their professional background. We discussed this issue with the management team who indicated they would explore alternative arrangements for their clinical supervision.

People and their relatives spoke positively about the quality of the food and drink served at the home. One person told us, "The food is very nice … I don't eat a lot, but it is tasty." A relative said, "The food seems alright … The Sunday lunch they do here looks lovely - really cracking." People told us, and we saw, staff supported them to choose between the options available for each of the day's three main meals. The management team had introduced pictorial menus to assist this process. The home's menus had been developed incorporating feedback from people themselves. Surveys were issued to people before kitchen staff introduced the new season's menus. Any complex needs or risks associated with people's eating and drinking were assessed and addressed, with input from nutrition specialists, such as dieticians and the local speech and language therapy team. This included the provision of thickened fluids, texture-modified meals, and diets suitable for people with diabetes. We saw people had access to plenty of drinks and snacks in between their meals.

We found mealtimes at the service still needed to be better organised to prevent significant delays in some people's meals arriving, and to ensure people were effectively supervised and encouraged to eat. For example, during the lunchtime meal on Kitwood Unit, one person seated at a table for three waited over 30 minutes for their meal to arrive whilst others at the table ate. This resulted in them interfering with another person's meal. During the same mealtime, we also had to draw staff's attention to another person who was potentially putting themselves at risk by eating a non-food item. Following our inspection, a relative shared concerns with us regarding the lack of support their loved one had to maintain their food and fluid intake. At the time of this report, these concerns remain under investigation by the local safeguarding team.

Before people moved into the service, the management team met with them and, where appropriate, their relatives to assess their individual needs, and ensure the provider was able to effectively meet these. A community professional told us, "They [management] meet clients at hospital for an initial assessment. It is a very positive experience for clients and families." This enabled the provider to develop personalised care plans designed to achieve positive outcomes for people. After people's care started, staff and management

worked with a range of community health and social care professionals, including GPs, district nurses, social workers, occupational therapists and mental health professionals. This collaboration was designed to ensure people received joined-up care and had access to appropriate specialist care equipment.

Staff and management understood the need to promote equality and diversity, and avoid any form of discrimination in the planning or delivery of people's care. Staff received training on equality and diversity, and praised the inclusive culture within the service. One staff member told us, "We accept everyone equally. There is a positive culture in respect of diversity. I think everything is fine; people can be who they are." Another staff member said, "It's all about inclusion and supporting people in the lifestyle of their choice. I think we are a very inclusive home … People are not discriminated in my view."

Upon starting work at the service, all new staff completed the provider's induction training to help them settle into their new roles and understand their associated duties and responsibilities. During this period, staff participated in initial training and had the opportunity to work alongside more experienced colleagues. Staff were satisfied with their induction experience. One staff member told us, "They made me feel really comfortable. It was my first care job. I did online training, read through people's care plans and shadowed permanent staff." The registered manager assured us the provider's staff induction programme took into account the requirements of the Care Certificate. The Care Certificate is a set of minimum standards that should be covered in the induction of all new care staff.

Staff monitored people's general health, and helped them to access professional medical advice and treatment if they were unwell. A local GP visited the home on a twice weekly basis to monitor people's health needs, and follow up any concerns identified by people, their relatives or staff. People's care records included information about their medical history and long-term medical conditions to give staff insight into this aspect of their needs. However, we found one person's epilepsy care plan was not sufficiently clear, lacking information about the type of seizures they experienced and the known triggers for these. We discussed this issue with the registered manager who assured us they would address this as a matter of priority.

We looked at how the provider had adapted the units' environment to meet people's individual needs. Across all three units, people had sufficient communal space to participate in group activities, eat in comfort, meet with visitors or spend quiet time alone. There was evidence some consideration had been given to the needs of people who were living with dementia. For example, dementia-friendly signage had been installed to help people identify their personal rooms and other key areas. Dementia-friendly wall-mounted activities boards had also been installed. Internal keypad locks were in place to prevent people from accessing potentially-hazardous areas, such as the medicines rooms and sluices.

Good

Is the service caring?

Our findings

At our last inspection in July 2017, we rated this key question as 'Good'. At this inspection, we found people were still treated with kindness and compassion. The rating of this key question remains 'Good'.

People and their relatives told us staff approached their work in a kind and caring manner. One person said, "We have a bit of fun here. I get on well with everyone including the staff. I like to have a chat with the staff; they are very nice." Another person told us, "The staff are very good, very friendly and they mix with us as much as they can. They are helpful and pleasant." A relative commented, "The staff are kind. I haven't seen anything to make me worry and I do watch."

During our time at the service, we saw staff supported people in a gentle and caring manner. They prioritised people's needs and requests, and responded in a calm and patient manner if people became upset. One person explained, "I can go to talk to staff if I don't feel good. They are patient and they calm you down. They are good at communication." Staff knew the people they supported well and showed good insight into their individual personalities and needs. People were clearly at ease in the presence of the staff supporting them, and freely approached staff members for help. Staff took the time to ask people if they were comfortable and whether they needed anything further.

Most people and relatives we spoke with were satisfied with the opportunities they had to express their views to staff and management and be involved in decision-making that affected them. One relative referred to the conversations they had had with the management team regarding their loved one's care plans, and their likes and dislikes. People's individual communication needs had been assessed and recorded, and staff had been provided with guidance on how to promote effective communication with each individual. The staff we spoke with recognised the need to
monitor people's non-verbal communication where they had limited speech. The registered manager confirmed people were supported to access independent advocacy services, as needed, to ensure their voice was heard in decision-making.

The staff we spoke with recognised the importance of promoting people's rights to privacy and dignity. We saw they addressed people in a polite and respectful manner, and met their intimate care needs sensitively. The provider had procedures in place to protect people's confidential information held on site from unauthorised access, and we saw staff followed these. Staff gave us further examples of how they promoted people's privacy and dignity in their day-to-day work with people, including helping people to maintain their independence. One staff member explained, "When providing personal care, I explain exactly what I need to do, and ensure doors and curtains are closed. I also get people to do as much as they can for themselves." Another staff member told us, "We encourage people to do as much as they can for themselves, such as washing and dressing … We always ask for permission before doing anything. You get to know them [people] and would know instantly if they objected."

Good

Is the service responsive?

Our findings

At our last inspection in July 2017, we rated this key question as 'Good'. At this inspection, we found people still received care and support that reflected their individual needs. The rating of this key question remains 'Good'.

People told us the care staff provided was adjusted in line with their individual needs and preferences, and that there was flexibility in daily routines at the home. One person explained, "It's easy to live here; the staff make it easy. They allow you to do what you want to do, like watch TV, listen to music or go out." Other people referred to how they were able to get up whenever they chose on a day-to-day basis. The provider operated a 'key worker' system designed to ensure people's individual needs and requirements were considered and met. When allocated as a person's 'key worker', staff were, amongst other things, responsible acting as a first point of contact for the individual and their relatives, and ensuring people had enough clothing and toiletries.

Most people's relatives were satisfied with the opportunities they had to be involved in decisions about their loved ones' care and contribute towards their care planning. We saw evidence of relatives' involvement in care review meetings in the care files we looked at. The management team explained they made regular calls to people's relatives, to discuss their loved ones' care, as part of the provider's 'resident of the day' approach.

People's care plans were individual to them and dealt with key aspects of people's care and support needs. This included people's mobility, nutrition and hydration, pressure care, and the management of any challenging behaviour. Care plans were reviewed and updated on a monthly basis by senior care staff, through the provider's 'resident of the day' approach. They included information about people's life histories and known preferences regarding their care. In planning people's care, the management team had given consideration to people's religious beliefs and the support needed to pursue these. One person described to us how staff were helping them to identify a church they could attend in the local area. Staff told us they had the opportunity to read and refer back to people's care plans as needed. One staff member said, "We always get time to read care plans and risk assessments. They are kept in the nurses' station. I find them accurate and up to date."

We looked at the support people had to pursue their interests and participate in recreational and social activities at the service. People described to us some of the activities they enjoyed joining in with. These included singing along with visiting entertainers, socialising with friends at the home, relaxing in the garden in summer, and going out for a coffee or to do some shopping. A number of people spoke about their enjoyment of the recent Christmas party at the service. During our inspection, we saw people, amongst other things, participating in Christmas-related arts and crafts activities, and singing and dancing to songs performed by a visiting musician. The provider employed a 'wellbeing and lifestyle facilitator' who took the lead in organising people's activities on a day-to-day basis. A number of staff indicated this person was overstretched in trying to provide people with regular stimulation and activities across the three units. One staff member told us, "I have no concerns with the way this unit is managed, but we could do with more

activities and stimulation for people." We discussed this issue with the registered manager. They informed us the second wellbeing and lifestyle facilitator had been away from work for several months, and that they were currently in the process of recruiting additional activities staff.

We checked how the provider was meeting the requirements of the Accessible Information Standard. The Accessible Information Standard tells organisation what they need to do to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. We found people's communication and information needs had been considered in the planning of their care, and that staff adjusted their communication to suit individuals' needs. The registered manager confirmed communication aids and alternative accessible formats were used as necessary, to facilitate effective communication. This included the use of 'flash cards' to help establish people's wishes and requests.

People and their relatives were aware how to raise any concerns or complaints about the service. One relative told us, "There haven't been any problems, but I would go to [unit manager] if there were." The provider had a complaints procedure in place designed to ensure complaints were handled fairly and consistently. A pictorial version of the provider's complaints procedures was on display to aid people's understanding of the process for raising any concerns. We looked at the most recent complaints received by the provider, and saw these had been investigated and responded to in line with the provider's procedure. The provider analysed any complaints received to identify any patterns or trends in these.

The provider had processes in place to identify people's preferences and choices for their end-of-life care. We saw evidence of the discussions held with people's relatives about their loved ones' future care requirements. The registered manager informed us they intended to adopt a more proactive approach towards initiating these discussions.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in July 2017, we rated this key question as 'Requires improvement'. At this inspection, we found the governance of the service needed to improve further to ensure people received safe, high-quality care. The rating of this key question remains 'Requires improvement'.

At our last inspection, we were not assured that the provider's quality assurance audits were effective, consistently reviewed or used to drive improvements in the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the provider was now meeting the requirements of Regulation 17. They had a rolling programme of audits in place, focusing on key aspects of the service such as the management of people's medicines, falls, moving and handling practices, and a range of in-house health and safety checks. We saw evidence of some improvements in the service since our last inspection, such as checks on the suitability of agency staff. However, we found improvements were still needed in the monitoring of certain aspects of the service, including recruitment practices and staff training provision. This was also the service's second successive overall rating of 'Requires improvement'.

During our inspection visits, we met with the registered manager who was responsible for the day-to-day management of the service, with the support of the deputy manager and two further unit managers. The registered manager demonstrated a good understanding of the requirements associated with their registration with CQC. This included the need to notify us about certain changes, events and incidents that affect their service or the people who use it. These 'statutory notifications' play a key role in our ongoing monitoring of services. The registered manager explained they kept themselves up to date with best practice guidelines and legislative changes by, for example, attending events organised by the local clinical commissioning group (CCG) and accessing care resources online. They felt they had the support and resources they needed from the provider to drive improvements in the service.

The people we spoke were satisfied with the overall quality of the care and support provided. One person told us, "It's absolutely brilliant. It's made a big difference to me being here. It's excellent for my needs; I feel myself again." Another person said, "I am glad I made the decision to come here." Most people and relatives spoke positively about their communication and dealings with the management team to date. They described a management team who were approachable, kept them informed and who were willing to listen to and act upon their feedback. One person told us, "Yes, I can talk to [unit manager]; I can talk to any of them [staff]. If there's a problem and you tell them, it gets sorted." A relative said, "The management are very good. They are approachable and if I have any queries, they will answer any questions we have." One person's relative expressed dissatisfaction with the management team's response to their loved one's personal care and lack of stimulation. We discussed these issues with the unit manager who assured us they were working with the relative in question to resolve their concerns.

Staff spoke about their work with enthusiasm, describing the strong sense of teamwork within the staff team. One staff member told us, "There is good teamwork from what I've seen so far … Other staff are

friendly and helpful." Another staff member said, ''This is a good company to work for. I'm not going anywhere; I love my job.'' Staff felt well-supported by a management team who were approachable, willing to listen and who valued their efforts. One staff member told us, "I do feel valued and listened to. The unit manager is very approachable, and things get sorted … We have regular staff meetings, where staff speak freely about issues." Another staff member said, "After your shift, [unit manager] will always thank you for everything you have done today."

The community health and social professionals we spoke with were confident, overall, that people received the care and support they needed from staff and management. One professional told us, "My impression is that clients are very positive and happy, as are the families. Staff engage well. Care plans are good, easy to follow and concise." Community professionals indicated they received appropriate referrals from the management team, and that staff and management were keen to work effectively with them. They felt staff and management were receptive to their advice and normally took this on board.

The provider took steps to involve people, their relatives and staff in the service. They achieved this by, amongst other things, organising regular meetings with people, relatives and staff and distributing annual feedback questionnaires to invite their feedback on the service. We looked at the results of the most recent survey and found respondents had generally commented positively on the service provided. The management made efforts to maintain and develop the service's links with the local community to benefit the people who lived at the home. As part of this, they organised open events at the home, such as fetes and cinema nights, and also welcomed local schools, churches and charities into the home.