North East Care Homes Limited

Stainton Lodge Care Centre

Inspection report

Stainton Way
Hemlington
Middlesbrough
Cleveland
TS8 9LX

Tel: 01642590404

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 26 July 2016 was unannounced. This meant the registered provider did not know we would be visiting. A second day of inspection took place on 27 July 2016 and was announced.

The service was last inspected in July and August 2015. At that inspection we found the service did not ensure the requirements and principles of the Mental Capacity Act 2005 were followed and did not have effective checks in place to monitor and improve standards at the service. These were breaches of our regulations. We did not take enforcement action but required the service to submit a plan telling us how they would be compliant with the regulations. When we returned for this inspection we found the issues identified had been addressed.

Stainton Lodge Care Centre is a nursing home. It provides care and treatment for up to 73 people who either have complex mental health needs or are older people living with a dementia. The service is located adjacent to Stainton Way, another service operated by the registered provider. The service is divided into two units across two floors. People with complex mental health needs live on the ground floor and older people living with a dementia live on the first floor. At the time of our inspection 34 people were using the service.

There was a manager in place, and they were in the process of applying to be the 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.

People and their relatives told us the service kept them safe. Risks to people were assessed and plans put in place to minimise the chances of them occurring. These were reviewed on a monthly basis to ensure they accurately reflected people's current support needs. Risks to people arising from the premises and equipment were also assessed and reviewed.

Systems were in place to record and monitor accidents and incidents. Where these occurred a report was completed setting out what happened and the remedial action taken. Plans were in place to support people in emergency situations. There was a business continuity plan in place to help ensure people received a continuity of care in emergency situations.

Medicines were managed safely. People were supported to take their medicines at their own pace, with staff explaining what the medicines were and what they were for. People were given a choice over whether they wanted their medicines. People we spoke with said they received the medicines when they needed them.

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring. Where issues had been raised records confirmed they had been investigated and dealt with appropriately.

The manager carried out checks to ensure there were enough staff employed to support people safely and recruitment procedures minimised the risk of unsuitable staff being employed.

The service was working within the principles of the Mental Capacity Act 2005. 32 people were subject to DoLS authorisations at the time of our inspection. Where this was the case this was recorded on the person's care plan, along with details of the expiry date and whether the authorisation had any conditions attached.

Some of the care plans we looked at contained detailed information on people's capacity, however, we also saw that some care plans lacked this detail.

Staff had not always received mandatory training but such training was planned. Staff also received additional training in specialist areas such as pressure sore care, stroke care and behaviours that challenge. Staff said training had improved since the manager joined the service. Newly recruited staff completed an induction process before they were allowed to support people without supervision.

Staff received support through supervisions and appraisals. Records of supervisions and appraisals confirmed that staff were free to raise any support issues they had, which were acted on.

People were supported to access food and nutrition and gave positive feedback on the food at the service.

People were supported to access external professionals to maintain and improve their health. Care records contained evidence of appropriate referrals to professionals such as tissue viability nurses, epilepsy nurses, district nurses, psychiatrists, chiropodists and the falls team.

The service was clean and neutrally decorated though was not always adapted to support people living with a dementia. The manager and deputy manager said they wanted to re-decorate the service to make it dementia friendly, including putting people's photographs on their bedroom doors and installing sensory aids.

People were not always able to tell us what they thought of the service but from our observations we saw they were treated with dignity and respect.

Throughout the inspection we saw staff delivering support with care and kindness. This helped to create a relaxed and homely atmosphere.

There was an advocacy policy in place offering guidance to people and staff on accessing advocacy services and this was displayed publically in the reception area.

Nobody was receiving end of life care at the time of our inspection but the manager described how this would be arranged if needed.

Care and support was delivered based on people's assessed needs and preferences. Most care plans reflected people's personal preferences. However, we saw that some plans lacked this level of detail and asked the manager about this. The manager said all care plans were being reviewed so they had a consistent level of detail.

Care plans were regularly reviewed to ensure they reflected people's current support needs, and we saw evidence that people and relatives were involved in these reviews.

People were supported to access activities they enjoyed. During the inspection we observed music and reminiscence sessions, which people clearly enjoyed. People and their relatives spoke positively about activities at the service, though staff thought more activities could be offered.

There was a complaints policy in place and this was publically advertised in the reception area of the service.

The manager had a clear vision of the culture and values of the service. Staff shared the manager's positive vision for the service.

Staff spoke very positively about the manager, saying they had significantly improved standards and supported staff to feel included in how the service was run.

Feedback was sought from people, relatives, staff and visiting professionals through an annual questionnaire.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service. Records confirmed that where an issue was identified, an action plan was developed to ensure remedial action was taken. The registered provider organised monthly quality assurance checks of the service, which were carried out by a management company.

The manager understood their role and responsibilities, and was able to describe the notifications they were required to make to the Commission.

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.

Risks to people were assessed and plans put in place to minimise the chances of them occurring.

Plans were in place to support people in emergency situations.

Medicines were managed safely.

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring.

Recruitment systems were in place to minimise the risks of unsuitable staff being employed.

Is the service effective?

Requires Improvement

The service was not always effective.

The service worked within the principles of the Mental Capacity Act 2005 but care plans for mental capacity were not always consistent.

Staff had not always received mandatory training, but such training was planned.

The premises were not always adapted for people living with a dementia.

People were supported to access food and nutrition and gave positive feedback the food at the service.

People were supported to access external professionals to maintain and improve their health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect by staff who knew them well.

Staff delivered support in a kind and caring way.

Procedures were in place to arrange advocates and end of life care should they be needed.

Is the service responsive?

Good

The service was responsive.

Care and support was delivered based on people's assessed needs and preferences.

People were supported to access activities they enjoyed.

There was a complaints policy in place and this was applied when issues arose.

Is the service well-led?

Good

The service was well-led.

The manager and staff spoke positively about the culture and values of the service.

Staff spoke very positively about the manager, saying they had significantly improved standards and supported staff to feel included in how the service was run.

Feedback was sought from people, relatives, staff and visiting professionals.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service.

Stainton 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.'

This inspection took place on 26 and 27 July 2016 and was unannounced. This meant the registered provider did not know we would be visiting. The service was last inspected in July and August 2015 and at that time was found to be in breach of two of our regulations.

The inspection team consisted of one adult social care inspector and two experts-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information we held about the service, including the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales.

The registered provider was not asked to complete 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 contacted the commissioners of the relevant local authorities and the local authority safeguarding team to gain their views of the service provided by the service.

During the inspection we spoke with six people who used the service, four relatives and one external professional who was visiting. People were not always able to tell us what they thought of the service so we carried out observations of how care and support was delivered.

We looked at three care plans, medicine administration records (MARs), handover sheers and other documents involving the day to day running of the service. We spoke with 11 members of staff, including the

manager, deputy manager, activities co-ordinator, nursing and care staff and kitchen and housekeeping staff. We looked at four staff files, which included recruitment records.

Good

Is the service safe?

Our findings

People and their relatives told us the service kept them safe. One person told us they felt safe, and that if they didn't feel safe they would let the manager know. A relative of a person using the service said, "I know [person] is safe here."

At our inspection in 2015 we found checks to ensure that risk assessments were regularly reviewed were not always effective. We required the service to submit a plan telling us how they would be compliant with our regulations. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in 2015.

Risks to people were assessed and plans put in place to minimise the chances of them occurring. People were assessed for risk in areas including moving and handling, nutrition, falls and pressure ulcers. Where people had specific risk areas these were also assessed. For example, one person enjoyed smoking and a risk assessment was in place. Where an assessment identified risk a plan was developed to reduce the possibility of it occurring. The service used recognised tools such as MUST and the Braden Scale to assess risks to people. Malnutrition Universal Screening Tool (MUST) is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Risk assessments were reviewed on a monthly basis to ensure they accurately reflected people's current support needs. We did see a gap in the reviews of one person's risk assessments. We told the manager about this, who said the gaps were "completely unacceptable" and would be investigated.

Risks to people arising from the premises and equipment were also assessed and reviewed. Maintenance staff carried out monthly checks of fire alarms and fire fighting equipment, emergency lights, water temperatures, wheelchairs and hoists and window restrictors. Required test certificates in areas such as electrical testing fire fighting equipment, controlled waste, hoists and legionella were also in place.

Systems were in place to record and monitor accidents and incidents. Where these occurred a report was completed setting out what happened and the remedial action taken. These were reviewed on a monthly basis by the manager, who said they checked to see if, "any repeating patterns are evident."

Plans were in place to support people in emergency situations. Each person had a personal emergency evacuation plan (PEEP). The purpose of a PEEP is to provide staff and emergency workers with the necessary information to evacuate people who cannot safely get themselves out of a building unaided during an emergency. The PEEPs were stored near the front door so they were easily accessible in emergency situations. There was a business continuity plan in place to help ensure people received a continuity of care in emergency situations that disrupted the service, such as loss of utilities or equipment failure.

Medicines were managed safely. Medicines received into the service were checked against existing stocks, and any surplus medicines were returned to the pharmacy or appropriately disposed of. Each unit had its

own treatment room and these were used to safely and securely store medicines. The temperatures of these storage areas (including medicine fridges) were checked on a daily basis to ensure they were appropriate.

Each person had a medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered. The MARs contained the person's photograph to help staff ensure they were giving medicines to the correct person. MARs also recorded any known allergies the person had.

We reviewed five people's MARs and saw they accurately recorded when people received their medicines and did not contain any gaps. Discontinued medicines had been removed from MARs, which helped staff to ensure people received only the medicines they were taking. Protocols were in place for people using 'as and when required' medicines to guide staff on when the person might need them.

We observed a medicines round. People were supported to take their medicines at their own pace, with staff explaining what the medicines were and what they were for. People were given a choice over whether they wanted their medicines. People we spoke with said they received the medicines when they needed them.

Some people at the service were using controlled drugs. Controlled drugs are medicines that are liable to misuse. We saw that controlled drugs were securely stored and recorded.

Staff had access to a medication policy that provided guidance in a number of areas, including self-medication, recording medication errors and capacity to take medicines. The manager, deputy manager and nursing staff carried out regular checks of medicine documentation to monitor medicines management.

Staff understood safeguarding issues and procedures were in place to minimise the risk of abuse occurring. There was a safeguarding policy in place. This set out the types of abuse that can occur in care settings and provided guidance to staff on how these could be identified. Staff described how they looked out for signs of abuse and said they would be confident to report any concerns they had. One member of staff told us, "I have just refreshed my safeguarding training" and "I wouldn't have any qualms about reporting abuse." Another said, "If I had any concerns I would report it to the manager or the nurse in charge. You make sure people are safe and always assume they are telling the truth." Where issues had been raised records confirmed they had been investigated and dealt with appropriately. Staff also said they would be confident to whistle blow if they had any concerns. Whistleblowing is when a person tells someone they have concerns about the service they work for. One member of staff said, "I have had whistleblowing training and I would blow the whistle so loud." This meant procedures were in place to help protect people from harm.

The manager carried out checks to ensure there were enough staff employed to support people safely. A system was used to calculate staffing levels based on people's levels of dependency, which were reviewed on a monthly basis. The manager said they had increased staffing levels since starting at the service, including care staff and an administrator. On the mental health unit day staffing (during the week and at weekends) levels were one nurse and four support staff. Night staffing levels (during the week and at weekends) were one nurse and three support staff. On the older persons unit day staffing levels (during the week and at weekends) were one senior carer and three care assistants. Night staffing levels (during the week and at weekends) were one senior carer and two carers. Sickness or planned absence was covered either by staff at the service or by using staff from the other service operated by the registered provider on the same site.

A visiting relative told us staffing levels had improved in recent months. They said, "There's always someone

to hand." A visiting external professional said, "I think it is well staffed." Staff we spoke with said staffing levels were sufficient to support people safely. One member of staff told us, "I think staffing levels are okay" and confirmed that they had increased recently. Another member of staff said, "I'd say we have enough staff. We cope fine."

Recruitment procedures minimised the risk of unsuitable staff being employed. Applicants completed an application form requiring them to set out their employment history. Proof of address and identify was sought and written references (including, where possible, from previous employers) obtained. Disclosure and barring service checks were carried out before applicants were offered jobs. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to minimise the risk of unsuitable people from working with children and vulnerable adults. Before nursing staff were recruited their professional registration was checked with the Nursing and Midwifery Council (NMC). One member of staff told us how they were recruited, saying, "They checked references, two, and DBS. I was interviewed."

The service was clean and tidy. Throughout the day we saw housekeeping staff cleaning communal areas and people's rooms, and all staff clearing away equipment that was not in use and other trip hazards. A member of the housekeeping staff said they were provided with all of the equipment they needed to keep the premises clean, and this was safely and securely stored. Staff had easy access to personal protective equipment (PPE) such as gloves and aprons, which were appropriately used to assist with infection control.

Requires Improvement

Is the service effective?

Our findings

At our inspection in 2015 we found the service did not ensure the requirements and principles of the Mental Capacity Act 2005 were followed and checks to monitor standards at the service were not always effective. We required the service to submit a plan telling us how they would be compliant with our regulations. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in 2015.

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. 32 people were subject to DoLS authorisations at the time of our inspection. Where this was the case this was recorded on the person's care plan, along with details of the expiry date and whether the authorisation had any conditions attached.

Some of the care plans we looked at contained detailed information on people's capacity, how it affected their health conditions and guidance to staff on how this impacted on their ability to make decisions. They also contained evidence of capacity assessments and best interest decision meetings. People who were subject to Community Treatment Orders (CTOs) were supported to exercise their right to challenge these where they wished to.

However, we also saw that some care plans lacked this detail. For example, in one person's plan a mental capacity assessment had been carried out using a template developed by the registered provider but not all sections had been completed. This meant the extent of the person's mental capacity was not clearly recorded in their care plan, though staff we spoke with were knowledgeable about it. Another person who was living with a dementia and had recently moved into the service did not have a mental health care plan in place. Staff said this was being completed, and were again knowledgeable about the person's needs and how they could be supported using the principles of the Mental Capacity Act.

Staff were understood the legal framework and principles of the Mental Capacity Act and could describe how this was used to support people. One member of staff said, "We have multi-disciplinary team discussions on what is in the person's best interests" and "Even when the person hasn't got capacity they're involved all the way along with consent. We discuss… what we're doing and involve them at every stage."

Staff had not always received mandatory training but such training was planned. Mandatory training is training the registered provider thinks is necessary to support people safely. This training included topics

such as health and safety, infection control, medication awareness and first aid. A chart was used to record and monitor staff training, and this showed that staff had not always completed mandatory training. For example, only 16 staff had completed first aid training and only 19 had completed medication awareness training. The manager said mandatory training was covered on the induction process that all staff completed and plans were in place to increase completion of mandatory training. Documents confirmed that mandatory training was arranged for July 2016, and during our inspection some staff were completing first aid training.

Staff also additional training in specialist areas such as pressure sore care, stroke care and behaviours that challenge. As with mandatory training we saw that staff had not always completed this, though the manager said they were focusing on training that was most directly relevant to the needs of the people using the service. We saw evidence that where people had specific support needs training was arranged to enable staff to support them effectively. For example, some training was advertised to enable staff to assist one person with behaviours that challenge to be supported to have blood samples taken.

Staff said training had improved since the manager joined the service. One member of staff said, "I think the training now is good. We get mandatory training and also person specific training which I think is fantastic. Even for things we can't do as support workers we get training on so that we have knowledge" and "I feel like we're learnt more in the last four months since [the manager] arrived than we did in the whole time before." Another told us, "We're just in the process of updating the training. There are always loads of training opportunities." A third member of staff said, "The training is good. Really good, and in-depth. We get training specifically for people (and their support needs)." A visitor we spoke with said staff were knowledgeable and skilled to meet their relative's needs. They said, "If something happens they deal with it professionally."

Newly recruited staff completed an induction process before they were allowed to support people without supervision. This consisted of an introduction to the service's policies and procedures, training in areas such as moving and handing and safeguarding and shadowing experienced staff. One member of staff who had recently completed the induction spoke positively about it.

Staff received support through supervisions and appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The registered provider's policy was that staff should receive six supervisions a year and an annual appraisal. This had not always occurred in 2015 but the manager had plans in place to ensure this happened in 2016. One member of staff said, "We get supervisions and appraisals and they're okay. It's a chance to say whatever is on your chest." Records of supervisions and appraisals confirmed that staff were free to raise any support issues they had, which were acted on.

People were supported to access food and nutrition. People were assessed for any specific nutritional support needs they had when they moved into the service, and these were regularly reviewed using recognised tools such as the Malnutrition Universal Screening Tool (MUST). MUST is a screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. People were weighed on a monthly basis to help monitor their nutritional intake. The cook was knowledgeable about people's nutritional needs and preferences and was able to describe how the menu was adapted to meet these. This included adapting dishes to people's individual requirements (such as soft diets or diabetic diets) and always ensuring alternative were available if people wanted to choose something that was not on the daily menu.

There was a dining room on each floor of the service, and most people chose to eat their meals in these. The dining rooms were pleasantly arranged for meals, with tables set with tablemats, condiments, cutlery, crockery, serviettes and a menu. However, we did note that the menus were typed in a relatively small font

and asked staff how appropriate these were for people living with a dementia where pictorial menus may have been more accessible. At the end of the inspection the manager agreed these would have been more effective at ensuring people had a better understanding of the meal choices available and would be looked into.

Where people needed support with their meals this was given in an unhurried way and at the person's own pace. People gave positive feedback about the food at the service. One person said it was nice and always warm enough for them. A relative we spoke with said the food always looked nice and people were always provided with drinks and snacks outside of mealtimes.

People were supported to access external professionals to maintain and improve their health. Care records contained evidence of appropriate referrals to professionals such as tissue viability nurses, epilepsy nurses, district nurses, psychiatrists, chiropodists and the falls team. This meant people were supported to access the relevant clinician when they needed to.

The service was clean and neutrally decorated though was not always adapted to support people living with a dementia. Doors and handrails were not colour-coded or marked in a way that would help people living a dementia recognise them. Communal areas lacked personalisation that might help people to orientate themselves to where they were. Lighting in corridors on the first floor was on a timed sensor system, which meant if people did not move for a period of time they would turn off. Throughout the inspection we saw this led to people sitting in chairs in the dark until they moved again and could also have been confusing to people living with a dementia. We saw some sensory wall decorations in areas of the building that were not currently in use but not in occupied areas. The manager and deputy manager said they wanted to re-decorate the service to make it dementia friendly, including putting people's photographs on their bedroom doors and installing sensory aids. The manager said the lighting sensor would be adapted immediately to ensure it did not switch off.

Good

Is the service caring?

Our findings

Two people we spoke with said staff treated them with respect. A relative we spoke with said, "They always call [person] by their name and are respectful." People were not always able to tell us what they thought of the service but from our observations we saw they were treated with dignity and respect.

Throughout the inspection we saw staff speaking with people politely and respectfully, using their preferred names and approaching them and talking with them directly. Where people indicated they wanted support, or where staff thought they might need it, staff approached them and asked quietly and discreetly how they could help. Staff knocked on people's doors before entering their rooms, and explained to people how they were going to assist them. For example, we saw one person being helped to walk from their room for lunch in the dining room and the member of staff who was with them explained where they were going.

Staff understood the importance of treating people with respect and maintaining their dignity. One member of staff we spoke with told us, "I always cover people for bed baths, and always close the door when in the bathroom." Another member of staff said, "We always ask for permission to help." One person we spoke with was able to tell us how staff maintained their dignity. The person said, "They (staff) put a towel over me when they help me out of the shower."

One person we spoke with said, "They (staff) are nice and kind." Another person told us, "They (staff) are kind." Throughout the inspection we saw staff delivering support with care and kindness. Staff made an effort to talk and engage with people as they moved around the building, often sharing jokes with them as they did so. This helped to create a relaxed and homely atmosphere. For example, there was a pet cockatiel on the first floor and one person was enjoying spending time talking to it. A member of staff saw this and joined in, which the person clearly enjoyed. In another example we saw two people who enjoyed walking around the service with each other stopping and joking with staff whenever they encountered them. Elsewhere in the building we saw one person who enjoyed sitting next to the reception. Most people entering or leaving the building knew the person and stopped to chat with them.

A relative told us how staff had supported them to communicate with a person who was living with a dementia. The relative told us, "They have taught us how to enter [the person's] world rather than expecting [the person] to stay in ours". The relative told us they and the person had found this very valuable.

Staff told us how they promoted people's independence while at the same time ensuring they were ready to provide support if needed. One member of staff said, "You have to let people take risks. It's part of their choices. I might not think it is (a good choice) but that is not my choice." Another member of staff said, "I try to encourage independence. For example, I take people a selection of clothes for them to choose from, I show them the menu (at lunch), I ask if they want to wash their own hands and face." We saw examples of this throughout the inspection, such as when staff were supporting people at lunchtime.

Since our last inspection the service had received a number of written compliments from relatives of people using the service. One card from a relative said, "We will never forget your kindness, love and support" and

"This goes especially for the high level of care and compassion given."

At the time of our inspection three people were using advocates. Advocates help to ensure that people's views and preferences are heard. There was an advocacy policy in place offering guidance to people and staff on accessing advocacy services and this was displayed publically in the reception area.

Nobody was receiving end of life care at the time of our inspection but the manager described how this would be arranged if needed.

Good

Is the service responsive?

Our findings

Care and support was delivered based on people's assessed needs and preferences. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person.

Before people started using the service their preferences and needs were assessed across a number of areas, including mobility, nutrition, personal care, medication and mental health. Care plans were then developed on the basis of those needs. Most care plans reflected people's personal preferences. For example, one person's personal care plan detailed what they liked to do independently, what they liked to be supported with and how staff could most effectively do this. The same person's care plan contained guidance to staff on how the person used non-verbal communication to signal what they wanted. However, we saw that some plans lacked this level of detail and asked the manager about this. The manager said all care plans were being reviewed so they had a consistent level of detail, and people with the greatest level of support needs had their plans updated first.

Where people had a specialist care need plans were in place to help ensure they received person-centred support. For example, one person enjoyed smoking and a detailed plan was in place to help manage this. Another person had a wound care plan in place following an operation.

Daily notes and handovers were used to ensure staff always had the latest information on people's support needs. Daily notes, food and fluid charts and positioning charts were regularly completed. This assisted staff in providing responsive care.

Care plans were regularly reviewed to ensure they reflected people's current support needs, and we saw evidence that people and relatives were involved in these reviews. For example, one person's care plan detailed how they had been involved in a discussion of their mental health and the support they wanted with it. A visiting relative told us they had recently attended a review meeting where a person's care plan was discussed. The relative said, "I was asked for my views and whether there was any concerns about anything but I've no issues."

People were supported to access activities they enjoyed. The service had an activities co-ordinator, who said they found out about people's preferences by looking at their care plans and talking with them. There was no activities timetable in place when we inspected but the activities co-ordinator said this because they had just returned from annual leave. They said activities included games and physical exercise, pamper sessions, reminiscence activities and entertainers visiting the service. The activities co-ordinator said they also supported people to carry out daily living tasks, such as folding towels and sheets and helping people to tidy their rooms. The activities co-ordinator said they would like to arrange more outdoor trips for people. The manager had arranged for an unused plot of land at the side of the service to be used as a garden and hoped to involve people in developing this.

During the inspection we observed music and reminiscence sessions, which people clearly enjoyed. People

and their relatives spoke positively about activities at the service. One person told us they took part in the music activities. Another person said they enjoyed sitting in the lounge area reading books. A visiting relative told us, "[Named person] takes part in the reminiscence sessions and this gets [person] talking about the old days, like the old job they used to have." The relative went on to say the person enjoyed reminiscence sessions.

Staff said activities had improved in recent months but that they would like to see more being offered. One member of staff said, "The activities are not bad, it is better than it was. There is a lot more since the new manager came. At one point there wasn't really anything but there is something on every day now, like ball games, chair exercise and memory lane sessions." Another member of staff said, "I would like to see more (activities)" and "I am looking forward to the garden being finished."

There was a complaints policy in place and this was publically advertised in the reception area of the service. This provided guidance on how complaints would be investigated and the timeframes for doing so. Two complaints had been received since out last inspection, concerning the laundry service and the quality of food at the service. These had been investigated in line with the complaints policy and outcomes sent to the parties involved.

Good

Is the service well-led?

Our findings

The manager joined the service in February 2016 and was in the process of applying to be registered manager. The manager had a clear vision of the culture and values of the service, telling us, "I always say to staff you're honoured to be walking through those doors to work with these wonderful people. They've had fabulous, successful lives with wonderful families and are ill now and need our help. If you don't think like that we don't want you here."

Staff shared the manager's positive vision for the service. One member of staff told us, "The ethos now is about the people. It wasn't before. It's about giving a good standard of individual care, not one size fits all." Another said, "If a prospective family was looking (for a place for a person) I would say here we are an extended family. People are absolutely loved and cared for. It is our family here." Another member of staff said, "It's lovely. (I would be) more than happy to bring my nana in here. There is so much experience in this team."

Staff spoke very positively about the manager, saying they had significantly improved standards and supported staff to feel included in how the service was run. One member of staff said, "Since the manager joined we have seen positive changes so I am over the moon. They get things done. We always have PPE (personal protective equipment) now, staffing levels have gone up, repairs are done and the garden is getting done. We have had a lot of managers who haven't managed. Before the manager joined we kept having to ask for training. Now we get it. It's the same with supervisions and appraisals. It's all coming into place now." A visiting relative told us, "It's very well run."

Staff were supported through staff meetings, but also said they could raise any issues they had with the manager at any time. One member of staff said, "(The manager) is very helpful and always there, or popping over and talking with people. I'm more than happy to raise issues." Another member of staff said, "(The manager) is very approachable and if I don't know something I can always go and ask and they will explain."

Feedback was sought from people, relatives, staff and visiting professionals through an annual questionnaire. This had not been carried out in 2015, but when the manager started at the service they arranged a survey for 2016. The deadline for completion of the questionnaire was the end of August 2016 but some had already been returned and we saw these contained positive feedback. One relative's feedback said, "I am totally satisfied with every aspect concerning [named person's] care." We saw that some of the feedback included a request for more activities, and the manager said they would analyse and act on the results once the survey was complete.

The manager carried out a number of quality assurance checks to monitor and improve standards at the service. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. Monthly audits were carried out in areas including health and safety, infection control, medication, care plans and catering. Records confirmed that where an issues as identified an action plan was developed to ensure remedial action was taken. For example, the June 2016 mobility

audit identified that there was no wheelchair checklist available on the mental health unit and set out remedial action to be taken.

The manager had also developed a 'quality indicator' audit. This included a monthly check of areas such as pressure sore care, how people's weights were being monitored, bedrail use, accidents and incidents and complaints. The registered provider organised monthly quality assurance checks of the service, which were carried out by a management company. The manager also sent the registered provider weekly reports on the service, and said both of these helped their own quality assurance checks.

The manager understood their role and responsibilities, and was able to describe the notifications they were required to make to the Commission.