Prime Life Limited

Stoneygate Ashlands

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

This was an unannounced inspection carried out on 14 and 24 June 2017, both dates were unannounced.

Stoneygate Ashlands provides accommodation and personal care for up to 37 people. The service specialises in caring for older people including people living with dementia or those who require end of life care. The accommodation comprises individual en-suite rooms, and there were 36 people living in the service at the time of our inspection visit.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People felt staff were kind and caring, and their privacy and dignity was respected in the delivery of care and their choice of lifestyle. Most of the relatives we spoke with were also complimentary about the staff and the care offered to their relatives. People were involved in the review of their care plan, and when appropriate were happy for their relatives to be involved. We observed staff offered people everyday choices and respected their decisions. People's care and support needs had been assessed and people were involved in the development of their plan of care. Staff had a good understanding of people's care needs; access to people's care plans and received regular updates about people's care needs.

People were provided with a choice of meals that met their cultural and dietary needs. The catering staff were provided with up to date information about people's dietary needs, and sought the opinions of people to tailor their individual meal choices. Medicines were ordered, stored and administered safely and staff were trained to provide the medicines people required.

Care plans included the changes to peoples care and treatment, and people attended routine health checks. Staff sought medical advice and support from health care professionals. There were sufficient staff available to meet people's personal care needs and we saw staff worked in a co-ordinated manner.

There were sufficient activities provided over five days of the week, with additional volunteers helping in the 'gardening club'. The provider had engaged with a group from learning for the forth age (L4A) to identify and provide appropriate activities and pastimes. People were able to maintain contact with family and friends as visitors were welcome without undue restrictions.

Staff were subject to a thorough recruitment procedure that ensured staff were qualified and suitable to work at the service. They received induction and on-going training for their specific job role, and were able to explain how they kept people safe from abuse. Staff were aware of whistleblowing and what external assistance there was to follow up and report suspected abuse.

Staff told us they had access to information about people's care and support needs and what was important to people.
Staff knew they could make comments or raise concerns with the management team about the way the service was run and knew these would be acted on.

The provider had a clear management structure within the service, which meant that the staff were aware who to contact out of hours. The registered manager undertook quality monitoring in the service, which was overseen by a director of the company.

The provider had developed opportunities for people to express their views about the service. These included the views and suggestions from people using the service and their relatives. We received positive feedback from visiting professionals with regard to the care offered to people and professionalism of staff. Staff were aware of the reporting procedure for faults and repairs and had access to emergency maintenance information to ensure emergency repairs were arranged promptly.

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

Care plans and individual risk assessments were sufficiently detailed, to inform and guide staff to provide people with safe care. Plans to be used in emergency situations were readily available. The employers recruitment process ensured people were safe to work in the home.

Potential risks to people were managed and concerns about people's safety and lifestyle choices were discussed with them or their relatives to ensure their views were supported. Staff were employed in numbers to protect people, and understood their responsibility to report any observed or suspected abuse. Medicines were ordered, stored and administered safely.

Is the service effective?

Good

People felt staff were trained and supported to enable them to care for people safely and to an appropriate standard. Staff offered people choices and obtained people's consent before offering personal care. Staff had a good understanding of Deprivation of Liberty Safeguards and the requirements of the Mental Capacity Act 2005. People received appropriate food choices that provided a well-balanced diet and met their cultural and nutritional needs.

Is the service caring?

Good

People told us staff were caring and kind and recognised their privacy and dignity. People and when appropriate, their relatives, were encouraged to make choices and were involved in decisions about their care and staff gave people reassurance when they needed it.

Is the service responsive?

Good

People received personalised care that met their needs, and staff had access to care plan information that supported this. People received a service that reflected their cultural heritage, though it was unclear people were engaged in individual and meaningful activities.

People told us they would have no hesitation in raising concerns

or making a formal complaint if or when necessary.

Is the service well-led?

Good

The home had an open and friendly culture. The provider used audits to check people were being provided with good care and made sure records were in place to demonstrate this.

People using the service and relatives had opportunities to share their views on the service. People had high praise for the management team told us they were approachable and helpful.

Stoneygate Ashlands

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 14 and 24 June 2017, by two inspectors and an expert by experience on the first day and one inspector on the second day. Both days were unannounced.

Before the inspection visit, we looked at our information systems to see if we had received any concerns or compliments about Stoneygate Ashlands. We analysed information on statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We considered this information when planning our inspection of the service.

Before the inspection, we asked the provider 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. Due to technical problems a PIR was not available and we took this into account when we inspected the service and made the judgements in this report.

Many of the people living at the service were not able to tell us, in detail, about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help assess whether people's needs were appropriately met and identify if they experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

During the inspection we spent time observing the care being provided throughout the service. We observed people being supported at lunch time and at other times in the service. On the first day we spoke with nine people using the service, and three relatives, the registered manager, the deputy manager, administrator, one senior carer, four care staff, catering staff and cleaner. On the second day we spoke with two people using the service, and four relatives, the registered manager senior carer, one care staff and catering staff.

Over the two days we looked at four people's care plan records to see how they were cared for and supported. We looked at other records related to people's care such as medicine records, daily logs and risk assessments. We also looked at quality audits, records of complaints, incidents and accidents at the service and health and safety records. We also looked at records relating to aspects of the recruitment and staffing, as well as policies and procedures.

Good

Is the service safe?

Our findings

People told us they felt staff cared for them safely. One person told us, "I feel safe living here, it's much safer than living alone, though I miss my flat." A relative told us that their family member was safe and well cared for. They stated, "[Named] is safe here because the staff look after them well."

At our inspection of April 2016 we found the provider had failed to ensure the safe care and treatment of people in ensuring people were protected from access to the food servery and hotplate. At this inspection we saw this had improved. A risk assessment was now in place which included information for staff to keep the dining room doors locked to ensure people remained safe when the hot plate was turned on. We noted on both days of our inspection the dining room doors were locked until a member of staff was available to observe the people and so ensured their safety. There were signs near the hot plate area, warning people of the danger of hot surfaces. We also noted at our last inspection there were no fly screens to two of the kitchen windows. This was also raised by a recent environmental health inspection. When we visited this time the windows were now locked and notices to staff to keep them locked. The registered manager told us the fly screens were on order, and would be fitted by the company maintenance team on delivery.

The main meal was cooked in a commercial kitchen and transported to the service on a daily basis. We spoke with the catering staff on both days of the inspection who ensured the food was at a safe temperature before it was served. We saw records of this and of the fridge and freezers temperatures that were regularly monitored. Food stored in fridges included a date when it was opened, which meant staff could ensure it remained within date and was safe to serve to people.

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remained within date and was safe to serve to people.

Records showed equipment needed to support people such as hoists were maintained and regularly serviced. We spoke with staff who told us they were trained in moving and handling techniques, which we confirmed with the training matrix.

Care staff were aware of the safeguarding and whistleblowing policies and those spoken with said that they felt enabled to raise concerns with the registered manager or the service's deputy. Staff also told us a company director of visited regularly, and they felt they could raise any concerns with them. There was whistleblowing information available for staff in the service. That included the company's own whistleblowing telephone number as well as external contact details of the local authority and Care Quality Commission. Safeguarding information was available to people who lived in the service and their visitors, and was situated throughout the service.
The provider had policies and procedures to back up the training care staff received on safeguarding and whistleblowing. Records showed that care staff had completed training on how to keep people safe and staff spoken with confirmed they had been provided with relevant training and guidance. This meant that staff could alert outside agencies if they suspected people were being abused and their concerns were not being dealt with by the services' management.

Staff were aware of the reporting procedures for accidents and incidents that affect the health and wellbeing of people. Records showed that staff documented incidents including any injury, signs of pain and the actions taken. Records confirmed that staff had sought medical advice where a person had a fall or expressed pain. We saw that staff continued to monitor people's wellbeing following any such incident or accident.

Information on people's mobility in the event of an emergency was available and was updated regularly. Personal emergency evacuation plans (PEEPs) reflected people's mobility needs. PEEP's were placed near the main entrance to the service, and were kept securely to protect any sensitive or confidential information. Assessments for people who were at risk of falls, mobility, nutrition, developing pressure damage and choking, had been undertaken and were updated regularly. When we spoke with care staff about the risk to people they knew about and were able to explain individual identified risks. Care staff were able to explain how they kept people safe. This included detail discussions about individuals and more generalised discussions at staff meetings. For example, staff were warned about moving people in wheelchairs with one or no foot rests, which would result in disciplinary action against the staff. We later confirmed this with the minutes of the meetings.

On the first day of the inspection one person raised concerns with us about the number of staff on duty at the weekend. This also mirrored a complaint that was forwarded to the inspector prior to the inspection. On the first day of the inspection we confirmed the staffing rostered on duty were consistent throughout the week. When we visited on the second day of the inspection staff were well organised, all medicines had been administered and some people were being assisted with activities. A member of staff said, "We have five staff on a day, I have not been asked to cover a shift since March - we are not short staffed."

A person raised concerns and told us, "When [I am] on the toilet I often have to wait [for the call bell to be answered], sometimes I wait an hour after using the buzzer." We spoke with the registered manager who was able to monitor the time it takes for staff to answer call bells. He sent us a computer breakdown for the 4 week period for June 2017. There were over 2200 calls, and there was a very small number that had taken 10-15 minutes or longer to answered by staff. We saw that these were mostly at 'peak' times when meals were being served. The registered manager had taken action and had arranged a delegated member of staff

to answer these calls. One relative stated, "Staffing seems to be stable," and went on to explain that previously their relation had to wait longer for their call bell to be answered.

Care staff told us they felt there were sufficient numbers of staff on duty for people to stay safe and be supported with their daily needs. The registered manager told us that they regularly assessed the staffing levels in the service and that staffing numbers could be increased when people's needs changed. They gave us an example of an occasion when staff numbers were increased when a higher level of intervention was required when an increased number of people were unwell.

The registered manager told us they planned the level of staff in line with the needs of people and the staff skills. It showed that the staffing levels were maintained with five care staff in the day with the support of the senior carer and registered manager or their deputy. There are three care staff and senior carer at night with the management team providing on-call support.

Staff were subject to a planned recruitment process to ensure people were cared for safely. Staff went through a specified recruitment process which was controlled by the company's head office. We noted one person had gaps in their employment, which had been identified and asked about at their interview. However another person had concerns raised about their conduct by their previous employer. There was no evidence this had been followed up in the recruitment process. The registered manager later said this person, as all new staff were, employed on a probationary period and would only be employed if this was completed successfully.

People we spoke with said care staff supported them with their medicines. One person told us, "They (staff) give me my tablets, I just don't want the bother. If I have a pain they give me pain killers when I need them."

We saw care staff administered medicines in a safe and ordered way. Staff followed written guidance and ensured that they administered medicines to the right people. Staff were trained and regularly had their competency assessed by a senior manager.

Medication Administration Records (MARs) were in place for each person and detailed with a photograph and any allergy information which ensured staff were provided with information to ensure people were cared for safely. People who received 'as required' medicines (PRN) had clear instruction when, or under what circumstances staff should offer these medicines. There were separate charts for the application of prescribed topical creams, which ensured staff applied this consistently.

Storage of medicines was secure, and staff monitored the storage temperatures to ensure they remained potent and effective. The registered manager confirmed there were daily checks on the medicines system to ensure there was a sufficient supply of medicines in stock and people were given their correct medicines.

Good

Is the service effective?

Our findings

People told us they were happy with the staff that supported them and felt staff understood their needs and how they liked to be cared for. One person said, "The staff look after us all very well. A visiting relative said, "The staff are well trained, the senior on today is always friendly and chatty."

Staff confirmed they commenced their training with an induction training programme and then had a planned programme of courses which related to their role. Two staff confirmed they had induction training. One carer said, "I had an induction, which included following people around. And they showed me what to do. I was given time to sit with residents and talk to them. A second member of staff said, "I had an induction. It was not as good as it is now as it lasts 13 weeks. They have an induction file, training and shadowing.

We confirmed the induction programme by speaking with and looking at the records of a recently recruited member of staff. The registered manager confirmed the staff induction training and on-going training were linked to the care certificate, which is a nationally recognised training course.

Staff continued to attend specialist dementia training which was a 'virtual' experience where staff were placed in a situation that simulated what people experienced when living with dementia. Staff confirmed the training highlighted the difficulties that people living with dementia experienced. Staff gave us examples how they approached people directly and not from the side so they did not startle them. This was one example of staff putting into practice the knowledge of the restricted vision people can experience when living with dementia. We confirmed the staff training with the training matrix supplied by the registered manager.

One staff member said, "I have done safeguarding training. Signs (of abuse) include people being agitated, emotional and marks. I would talk to a senior. If she didn't do something I would go to a manager. I could go to head office." A second member of staff said, "We have quite a lot of supervision. The 60 second learning and hoist bingo [special training method]. We do that regularly. It is good as it refreshes my memory."

Staff had regular staff meetings the regularity of which depended on which member of senior care staff organised these. The staffing compliment was split into two separate 'teams'. They worked opposite each other to ensure all the shifts were covered and worked alternate weekends. There was no set agenda, but staff appeared to be given similar information. The frequency of staff supervision also altered between the two teams. Staff supervision can be used to advance staff knowledge, training and development by regular meetings between the supervisor and staff group. Supervision can benefit people who used the service as it helped to ensure staff were more knowledgeable and able to care and support people effectively.

Staff felt communication and support amongst the staff team was good. Daily handover meetings provided staff with detailed information about people's health and wellbeing and were provided for staff before they began their shift. Staff also told us they felt supported through the regular staff meetings and supervision meetings with their line manager.

The registered manager and care staff had been trained in the Mental Capacity Act (MCA) 2005. The Mental Capacity Act 2005 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 home are called the Deprivation of Liberty Safeguards.

Staff showed a good awareness of the Mental Capacity Act. One staff member said, "I have done training in MCA, I am learning to do capacity assessments. We [staff] have to make sure things are done in people's best interests. We have people who can't get out of bed, and have to consider if that is a deprivation of their liberty." A second member of staff said, "I never assume someone lacks capacity. I try and encourage them if they refuse something but you can't force them."

At this inspection we found evidence of mental capacity assessments for individuals and best interest assessments. Where people were unable to make informed decisions themselves, the correct procedure had been followed to protect their rights under the Act. There was a form in place for assessing people's mental capacity. We found that the registered manager had ensured that people were protected by the DoLS. Records showed that they had applied for the necessary authorisation from the relevant local authority.

The appropriate deprivation of liberty safeguards (DoLS) had been applied for, to ensure people were lawfully restricted from leaving the service. Where DoLS had been authorised they were current and conditions were being adhered to. There was also a care plan supporting each authorisation.

We found people had mixed opinions about the meals. Staff offered people choices and sought consent before they helped them. We looked at the service's meal provision and how staff assessed that people received a nutritious and healthy diet and maintained their weight. The meal came ready prepared from a central kitchen, and was delivered in time for the main meal to be served at 12.30pm, staff told us it was always served around this time. Most people told us they were happy with the meals provided.

One person said, "I like the lunches because we get vegetables, Brussels (sprouts) and runner beans which is good." Another person said, "Meals are adequate." However one person who was not happy with the meals said, "[The food is] terrible not cooked properly." Another person stated they did not like the way the meals were sent in from the central kitchen, and preferred to eat alternatives which they sometimes prepared them self. They told us they enjoyed the breakfast and evening meals and the meals on a Saturday which were prepared by home's kitchen staff. We found the meals offered by the provider allowed people a nutritious and balanced diet. However people told us the range of choice of potatoes could be expanded, as one member of staff said, "I think there could be an improvement in the meals to give variety. Sometimes they have the same potatoes every day. They need to mix it." People confirmed that boiled potatoes were served most days the previous week with no alternative.

We saw people were provided with food choices but drinks were pre-chosen by carers. We saw different options were placed on different tables mostly fresh fruit juice or squash with a good selection of choice overall. Staff we spoke with indicated they were aware of people's preferences which were recorded in care plans, and we saw staff provided the choices of drink that met the person's choice. Three people needed one to one assistance with their meal at lunch time. Staff were placed appropriately to assist people with good eye contact, and maintained a pleasant conversation with those being assisted and in the surrounding area.

Menu preference questionnaires were completed when people were admitted to the service and included people's likes and dislikes, and this included people's individual dietary information. People were offered a choice of meals but these were plated with the potatoes vegetables and when appropriate gravy added. We discussed this with the registered manager who agreed to look again at how to promote people's independence by offering vegetables in dishes, which they agreed following the last inspection.

People living with dementia were not directly supported to choose a meal to suit their taste. We saw that some people were presented with a plated meal, later staff told us that the meal was based on people's individual preferences. Monitoring charts were in place for people where they had a weight loss or special dietary requirements. The registered manager said if he had concerns about anyone monitored this way, he would seek further medical advice if concerned about the person's health. The registered manager was able to demonstrate where people had been referred to a dietician to assist with the prevention of weight loss.

Staff were encouraged to discuss ideas at staff meetings to encourage good practice. We viewed the minutes of the staff meetings and noted discussions around people's individual needs. For example, how to encourage one person to drink fluids and if people wanted their meals in their bedroom, to inform senior staff so meals can be taken to them.

Catering staff were aware of people's individual dietary needs, and had information relevant to each person. We saw that risks had been assessed to ensure staff prepared food and fluids safely for people. Where required, people were referred to their GP, speech and language therapist (SALT) and the dietician. That ensured any meal supplements or changes were managed in line with professional guidelines. Staff described how they supported one person which showed that they followed the advice recommended by a SALT.

People were given a choice if they would like to eat in the dining room, lounge or their bedroom. Staff were prompted at staff meetings to inform the senior on duty so no one missed their meal. The atmosphere at lunchtime was relaxed and staff supported people to eat without rushing them. Fluids such as water and cordials were readily available in communal areas along with fresh fruit and snacks which was in addition to regular hot beverage rounds provided by care staff. Staff were observed to give choices to people, and we saw staff prompted people to maintain the ability to eat independently.

People and their relatives told us their health and medical needs were met. One visiting relative said, "Mums physical well-being is much better." A second relative said, "They told us staff would call the GP if their [relatives] health was of concern." People's care records showed that people received health care support from a range of health care professionals and attended routine medical appointments.

Records showed that people had access to a range of health care professionals including GPs, a specialist dementia team, SALT staff, district nurses, chiropodists, opticians, and dentists. If staff were concerned about people's health they referred them to the appropriate health care services and accompanied them to appointments. That meant that people were supported to maintain a healthy lifestyle.

Good

Is the service caring?

Our findings

People told us the staff were kind and caring. One person told us, "They [staff] got a nice manager." A second person said, "The carers are kind, doing their job." A visitor said, "They [staff] are kind and caring with my mum, the vast majority of staff seem to know my mum." A second relative said, [Named person], "Always seems happy when we visit." A third relative said, "the staff are kind and caring, and mum thinks they are lovely."

We observed staff interactions with people and noted these to be caring and warm. We saw staff guiding people out of lounges and into the dining room with their arms linked and overheard staff gently prompting people. We saw others adjusting people clothes to preserve their dignity, but engaging the person in conversation to ensure their inclusion and agreement. A member of staff said, "I think the staff are very loving and friendly. We are like one big family. You kind of adopt people as your own family. I like working with [people living with] Dementia."

Staff treated people with dignity and respect throughout our visit for example with personal care. We heard one member of staff call one of the people who lived at the service by the term they preferred. The person later confirmed this was the term they preferred to be addressed by. We also saw where people were provided with personal care, doors were closed whilst this was undertaken, and we observed staff knocked and waited for a response before entering peoples' rooms.

The registered manager and senior staff understood and promoted respectful and compassionate attitudes by the staff team. Staff told us this way of respectfully relating to people was regularly discussed at meetings and supervisions, and was an accepted part of caring for people.

Some people were unable to express their views and opinions. Records showed that family members had been contacted and some involved in care plan reviews. The registered manager confirmed some people's family relatives were involved in care planning and reviews. Some care records were not signed by the individuals or a family member, but staff told us care plans were read to people and their comments recorded. The registered manager said care plans reflected people's needs and were reviewed regularly. Staff said people were asked to take part in care plan reviews but only a few of them chose to do so. Staff added relatives were informed when people's health or wellbeing changed.

We observed that staff checked on people's well-being throughout the day. Individual choices, preferences and decisions made about peoples care and support needs were recorded. The daily records included the care and support people received, and demonstrated that staff supported people's decisions about how they were cared for. For example one person declined a bath early on the morning of our inspection, we later saw another member of staff attempt this, and the person agreed. We also saw where a person was wanted to remain in their bedroom. We saw staff checked on the person's wellbeing regularly offering them drinks and the choice of sitting out of bed.

People spoke to us about the staff and how they are respected. One person said, "They always knock on the

door before waiting for an answer to enter. I like that."

Staff understood the importance of respecting and promoting people's privacy and dignity, and took care to preserve this, when carrying out their duties. We observed staff sought consent where people required support with personal care and heard to knock on bedroom doors and identified themselves on entering the room. One member of staff said to us, "If something is wrong I will fix it. It is important to speak with people with respect."

We saw where one person was going out for the day. They were encouraged to change their shirt before they went out as they had food stains on it, which demonstrated staffs' commitment to promoting people's dignity.

Staff gave us examples of the steps taken to ensure people's privacy and dignity when people were supported with personal hygiene. One member of staff said, "I give people privacy by shutting the door and curtains and covering them up. I like people to do what they can for themselves." We also saw examples of this when staff used a hoist to transfer a person from a chair into a wheelchair.

All bedrooms were en-suite, and additional toilets were situated near communal areas helped to maintain and promote people's privacy and dignity. Staff told us that people were offered a bath or shower and that staff respected their wishes. Care records reflected people's choices.

Good

Is the service responsive?

Our findings

Staff provided person centred care for people and this was reflected in their plans of care. We found one person wanted to do a sponsored event at the service. This was organised in conjunction with the person, and staff supported them throughout the activity. The person said, "The staff were very supportive, they kept checking me, and brought me cups of tea." One member of staff said, "We always give people options and choices. You can show people objects to give them a choice." A second member of staff said, "We get to know people and have a chat. Most people have a set routine so I adjust to it. I know when they will want something."

Care plans were personalised, for example we found one person chose to continue their cultural support with their community and continue to visit the day centre they had commenced before coming into the home. The person was provided with a choice of culturally appropriate meals or meals from the 'main' menu. People, and when appropriate, their relatives were involved in reviews of their care plan, which ensured that they had the opportunity to discuss and agree the care staff then offered. Care plan reviews took place most months or sooner when a person's circumstances changed. These were carried out by people's keyworkers and a senior carer or one of the managers'.

People had communication passports for use on transfer or admission to other services such as hospital. These were used to inform the other service of the individual needs the person had, for example how they communicated, what preferences likes and dislikes they had. Some of these had been produced from a document called, 'getting to know me' which was compiled when people were introduced to the service. This information was used consistently to personalise the care plans we reviewed.

Staff responded to people's health needs and promptly sought medical advice and ensured that preventative interventions were available. For example, the annual flu vaccination, opticians, chiropody and dental visits, and people were able to choose in house or community appointments. We saw one person having an optical test on the first day we inspected.

Visiting relatives gave us mixed comments about activities and stimulation in the service. One relative said, "We were very happy with the help we got from [named the registered manager], we knew that [named relative] was not being stimulated enough, that's all changed with his input." However a second relative commented, "Its thin on the ground with activities especially at weekends. They could do more including things like films. I don't think [named relative] is stimulated enough even things like music is lacking. Weekends are a concern due to lack of stimulation." A third relative commented, "[Named] is stimulated far more [since coming into the service] with the petting animals and activities." The fourth relative said, "[Named] seems very happy here when we visit, [named] doesn't join in activities normally." The relative pointed out this was the person's choice as they preferred to be watching rather than taking part. We also saw a garden party activity advertised for the weekend following our second day of the inspection.

In the morning we observed some people were engaged in a game of snakes and ladders with the assistance of two staff. The carer gave each person a special push button dice and carefully guided them to push the

button. One person told us, "I enjoyed the snakes and ladders and I like Ludo." A second person said, "They take me to the hairdressers, its good isn't it." Following lunch we saw some people remained in the dining room to play Bingo. This was led by one main carer and the assistance of four additional carers at different tables.

One member of staff told us, "The activities vary, some people say there are no activities, we ask them to join in and they don't want to participate." They added, "We do bus trips. The next one is to Skegness on 27 June (2017). We also do garden parties and BBQ's." Another member of staff added, "Every so often we do a fundraising evening. The summer one is coming up. We have wine, music, bingo and a raffle. The money goes into the social fund – we use it to for trips and activities. We have an animal party where different animals come in – it pays for that." The person went on to explain they involved as many people living in the service in the running of the event and invited people's relatives to take part. A third member of staff said, "I think we do activities well, people get to do something every day. We have pets [petting animals] coming in, Elvis, singers and lots of things."

There was some evidence of activities available for people who chose to remain in their bedroom, which reduced their social isolation. There was a programme of one to one activities for people who do not like group activities and people remaining in their bedroom. There were activities provided by the learning for the fourth age (L4A) staff which were available for people in the home. This is a voluntary group that encourages older people to follow up existing interests or develop new ones, using a multimedia range of resources. This group supported a number of people one day a week. They interviewed people in advance of compiling a detailed plan and agreed this in advance with the person or their family. Activities have previously included hat making as a short term activity and life story work which required more time for people complete.

People living with a dementia often have communication barriers to engage in group based activity and often benefit from individual one-to-one sessions using personalised memory books or photographs about their life. Where people had participated in activities this was recorded in daily notes. Some activities included having a chat where people had not wanted to participate in group activities. We saw one person who was in their bedroom and completing puzzle books. They said, "I love my puzzle books." We spoke with other people who told us they enjoyed trips out in the bus. One person said, "We have been on a couple of bus trips, we watched some scuba diving on one and last year went to Skegness." Several people told us they had enjoyed outings and a favourite one mentioned was the trip to Skegness beach last year.

We spoke with the registered manager about this. He said that the activity planner had been changed to the summer timetable. That would include time for people in the garden and barbeques (weather permitting) The gardening club on a Friday had commenced and was supported by a volunteer relative , as well as the on-going pampering and entertainment that was currently on offer. The registered manager said he would look at what could be put in place for people who preferred one-to-one help.

An activity programme was displayed in the service which contained the suggested activities staff may like to offer. We observed people reading daily papers and listening to the television, though we did not see where these stimulated discussion between people or the staff group. Staff told us even though the activity planner was in place, they did adjust the activities to suit individual's requests on the day, however we did not see any examples of this on the days of our inspection visits.

One person said, "If something's bothering me I tell them, I don't like it here but it's something I have to accept." The person went on to explain they didn't like the thought of having to remain in residential care, but were unable to live on their own. A visiting relative expressed frustration at the registered manager's

response to concerns raised, "Mum points things out and I raise them for her, they are not 100 per cent responsive." However we looked in detail at the complaints that had been made to the registered manager, which had all been responded to appropriately.

People we spoke with told us they knew they could raise concerns with any of the staff in the service. The registered manager explained there was a weekly management 'surgery', which meant that he or his deputy manager were available to speak with people, should they wish to discuss any concerns or require a general discussion. The registered manager added he had an 'open door' policy, which meant people could approach him with any concerns, without an appointment. Relatives that we spoke with were aware of how they could speak with the registered manager.

The service had a complaints policy. People could make complaints verbally or in writing to the registered manger or directly to the provider's head office. The procedure explained how the complaints process was operated and the timescales involved when responding to a complaint. The procedure explained who people could take their complaint to if they were not satisfied with the response.

We saw fifteen complaints had been received in the last 12 months, and all included a response to the complainant to ensure they were satisfied with the outcome. Many of these complaints were about missing clothes, and the recorded outcomes included where the clothes were found or replaced. This was confirmed by one relative who said, "Clothes were going missing, that has been resolved and some replaced as they couldn't be found." The registered manager said a new laundry system had been introduced and the number of issues had now reduced.

Learning from complaints was fed back to staff through staff meetings, which was evidenced in staff meeting minutes, or individual staff supervision.

Good

Is the service well-led?

Our findings

At the last inspection on April 2016, we asked the provider to take action to make improvements about the quality audits and ensure people were cared for safely and this action has been completed. The provider sent us an action plan that the actions would be complete by October 2016.

At this inspection we saw the quality assurance system had improved. There was now a consistent audit system to assess risk around the ordering, storage, administration and disposal of medicines. The shortfalls we identified around the hot food trolley in the dining room, medication system and first aid kits had all been rectified and so protected people from unsafe practices.

We discussed the checks and audits the provider and the registered manager conducted in order to ensure people received the appropriate support and care. The registered manager told us there were regular audits undertaken by a director of the company and staff in order to ensure health and safety in the service was maintained. We saw records of these checks that had been completed to ensure the building was safe for people. These included weekly checks on the, care plans, accidents and incidents, people's weight loss or gain and their nutritional and people's dietary requirements. We saw where the regularity of nutritional audits had been increased and the outcome was that staff serving fortified drinks at meal times where people had declined to eat. Regular falls audits had resulted in increased referrals to physiotherapists and that had an overall effect of improving people's mobility.

The provider had also arranged 'sit and see' sessions which are a type of observation tool. This is where a senior manager or company director observes the interaction between people using the service and staff and observe for care and compassion. The 'sit and see' system has been introduced to oversee, record and where required improve the compassionate caring of people. Feedback is by way of a written report and we saw two such reports in the foyer of the service for people to view. One outcome from the first reports was a recognition that social stimulation for people required to be increased. Staff have done this by leaving 'prompts' around lounges and communal areas. For example staff then stimulate conversations about these items and join in to stimulate people's interest. This has resulted in more interaction and inclusion of the people in the home, at times where staff have less time to provide the regular activities.

Along with the sit and see visits a director of the company continues to monitor changes through supervision of the management team and introduces and monitors improvements in the home. This also provided people with an opportunity to make comments or raise concerns with them directly. One member of staff said, "I have opportunity to talk to my manager, he is very open and will listen. His door is always open." A second member of staff said, "We do get given feedback on what we have done. They tell you what you have done. If we are doing something wrong they tell us. At the end of each shift the [named staff] says thank you." A third member of staff said, "I can always talk to a senior or the manager. We have a staff meeting once a month. We can talk to [named manager]."

The registered manager showed us the outcome of the last annual questionnaire that was distributed to people in the service and their relatives in October 2016. There was criticism of the menus and staff smoking

area. A meeting was arranged in December 2016, and all the relatives' were invited to take part in suggesting changes to the menus. The staff smoking area was also fenced off to detract from view of people arriving in the car park. There were also positive comments from people in the home and their relatives in the report about the availability of the registered manager and the welcoming care staff.

The registered manager and deputy continued to work weekends and flexible hours to ensure they had an overview of how the service ran on different days and at different times. They also supported staff by providing an on-call system, so staff could contact them for support at any time.

Staff continued to have high praise for the senior carers and management team. Staff said they were supportive and would assist them with any issues that arose. They also confirmed there were regular team meetings.

There was a system in place for the maintenance of the building and equipment, with an on-going record of when items had been repaired or replaced. Staff were aware of the process for reporting faults and repairs. Records showed that essential services such as gas and electrical systems, appliances, fire systems and equipment such as hoists were serviced and regularly maintained. The management team also had access to external contractors for maintenance and emergency repairs. There were up to date copies of the fire manual, the Fire Risk Assessment and personal evacuation plans (PEEP's) kept securely in foyer. That ensured staff could access this vital information at any time, and ensure the continuing safety of those in the service.

We looked at the record of safety tests undertaken in the service. These were completed by the Prime Life's 'estates team' from the head office. The periodic testing of gas appliances and electricity supply were up to date and were performed by appropriately qualified engineers. There was a business continuity plan produced by the provider. This had information for staff in the event of a significant failure of part of the building, water, gas or electrical services. That meant staff had essential information they could use in the event of an emergency to immediately arrange any remedial action.

The service had a registered manager in post and there was a clear management structure within the service. The registered manager understood their responsibilities and displayed a commitment to providing quality care in line with the provider's vision and values. The registered manager notified the Care Quality Commission of events they were required to report. These included accidents and incidents that affected the people living in the service and staff group. They also had arrangements in place that ensured notifications would be forwarded when they were not in the service.

Staff demonstrated a good understanding of their roles and responsibilities and knew how to access support. Staff had access to people's plans of care and received updates about people's care needs at the daily staff handover meetings. There was a system to support staff, through regular staff meetings where staff had the opportunity to discuss their roles, training needs and they could discuss how the service was changing. Staff told us there was staff supervision in place, but some staff had not received recent sessions. We spoke with the registered manager about this who said he would ensure these were brought up to date, and sent us a plan following our inspection visit to confirm this.

Staff told us that their knowledge, skills and practice was kept up to date. We viewed the staff training matrix, which showed that staff had updated refresher training for their job role and training on conditions that affected people using the service such as dementia awareness and behaviours that challenge.