Tamaris (Templemoyle) Limited

Ormesby Grange Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 inspection took place on 26 April 2016 and was unannounced. This meant the registered provider did not know we would be visiting. A second day of inspection took place on 27 April 2016, and was announced.

The service was last inspected in January 2016. At that inspection we found that medicines were not always managed safely, risk to people were not always assessed and remedial action taken to minimise them and pre-employment checks of staff were not always carried out to ensure they were suitable to work with vulnerable adults. We took enforcement action as a result, issuing warning notices requiring the services to be compliant with our regulations by 25 February 2016. When we returned for this inspection we found the issues identified had been addressed.

At that inspection we also found staffing levels were insufficient to support people safely and staff were not supported through a regular system of supervision and appraisal. We did not take enforcement action but required the registered provider to send us a report of the actions they would take to address this. When we returned for this inspection we found the issues identified had been addressed.

Ormesby Grange Care Home is situated in Middlesbrough and provides care and accommodation for up to 116 older people, some of whom are living with dementia. It is a purpose built, three storey home. Each floor housed a different unit; 'Daisy' unit on the ground floor, 'Tulip' unit on the first floor and 'Rose' unit on the second floor. Rose unit was used to provide nursing care. At the time of the inspection 59 people were using the service.

There was a registered manager in place. 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.

Medicines were managed safely, though the recording of topical medicine use required improvement. Risks to people were assessed, and steps were taken to minimise them. Risk assessments were regularly reviewed to ensure they matched people's current needs. The safety of the premises was regularly monitored and required maintenance certificates were in place. Plans were in place to support people in emergency situations.

Staffing levels were sufficient to support people safely, and changed in accordance with people's assessed levels of dependency. Staff understood safeguarding issues and were knowledgeable about the types of abuse that can occur in care settings. Pre-employment checks to ensure staff suitability to work with vulnerable people were carried out to minimise the risk of unsuitable staff being employed.

Staff received the training they needed to support people effectively, and said training had improved since our inspection in January 2016. Staff received a regular system of supervision and appraisal to support them

in their role.

Policies were in place to ensure that people's rights under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards were protected. Appropriate assessments took place where people lacked capacity.

People were supported to maintain their health through access to food and drinks. Meals were appealing and the dining experience was pleasant and encouraged people to maintain good nutrition.

The service worked closely with professionals to maintain and promote people's health and wellbeing.

People were treated with dignity and respect and people and their relatives spoke positively about the care they received. We observed positive and caring interactions between people and staff.

Procedures were in place to arrange advocates and end of life care should they be needed. The service worked closely with other professionals to plan end of life care that reflect the wishes of people and the relatives.

People received care and support that was responsive to their needs and reflected their preferences. Staff were effective at ensuring that changes to people's preferences or needs were passed on to colleagues.

People had access to activities that reflected their interests and preferences, though there were no specific activities for people living with a dementia.

There was a clear complaints procedure in place and this was advertised in the reception area of the service. There had been three complaints since our last inspection and these had been investigated and the outcomes sent to those involved.

Staff felt supported by the registered manager and deputy manager in the changes that had taken place since our inspection in January 2016. People and their relatives spoke positively about the registered manager and deputy manager.

Quality assurance checks were undertaken on a regular basis and were used by the registered manager to monitor and improve standards at the service.

Feedback was sought from people, relatives, staff and external professionals on how to improve the service.

The registered manager said the registered provider had supported them in making changes and improvements to the service. The registered manager was able to explain their responsibilities and described 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?

Requires Improvement

The service was safe.

Medicines were managed safely, though the recording of topical medicine use required improvement.

Risks to people were assessed, and steps taken to minimise them.

Staffing levels were sufficient to support people safely, and pre-employment checks were carried out to ensure staff suitability to work with vulnerable people.

Is the service effective?

Good

The service was effective.

Staff were supported through a regular system of supervision and appraisal and received the training they needed to support people effectively.

Staff understood and applied the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People received support with food and nutrition and were able to maintain a balanced diet.

The service worked with external professionals to support and maintain people's health.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

People and their relatives spoke positively about the care they received. We observed positive and caring interactions between people and staff.

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.

People received care that reflected their personal needs and preferences.

Most people had access to a range of activities that reflected their preferences. People who were living with a dementia did not always have access to relevant activities.

The complaints procedure was clear and applied when issues arose.

Is the service well-led?

Good

The service was well-led.

People and their relatives spoke positively about the registered manager and deputy manager.

Quality assurance checks were undertaken on a regular basis to monitor and improve standards.

Feedback was sought from people, relatives, staff and external professionals on how to improve the service.

Ormesby Grange Care Home

Detailed findings

Background to this inspection

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

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

The inspection team consisted of one adult social care inspector, two specialist advisors nurses and one specialist advisor pharmacist.

The registered provider completed a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

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

We contacted the commissioners of the relevant local authorities, the local authority safeguarding team and health and social care professionals to gain their views of the service provided at this home.

During the inspection we spoke with five people who lived at the service and six relatives. We looked at 10 care plans, and handover sheets. We looked at 40 people's medicine administration records (MARs). We spoke with 19 members of staff, including the registered manager, the deputy manager, senior carers, carers and members of the domestic and kitchen staff. We looked at four staff files, which included recruitment

records. We also completed observations around the service, in communal areas and in people's rooms with their permission.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe. One person said, "I feel safe here. Safer than I did at home." Another person said, "I definitely feel safe here." A third said, "I feel safe living here."

At our inspection in January 2016 we found that medicines were not always managed safely. We took enforcement action requiring the service to be compliant with our regulations by 25 February 2016. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in January 2016.

Medicines were now properly recorded when received into the service. Stock left at the end of one month was counted and carried forward onto the next month's chart. For medicines with a choice of dose the actual dose administered was clearly recorded on the back of people's MAR chart. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

People's MARs had been consistently and accurately filled in which created a clear record of the medicines they had used. However, MARs for topical medicines were not always consistently completed. For example, one person was prescribed cream to be used on a daily basis and there were six gaps in their March 2016 MAR where it was not clear whether this had been administered. The registered manager said they were aware of the need to improve the topical MARs, and that this work was on going.

Medicine stocks were properly recorded as they were administered, though we did find a discrepancy in relation to two medicines which were short by one tablet. We spoke with administering staff about this and they said the medicines would be further audited. Medicines were safely and securely stored, and checks made to ensure they were kept at the appropriate temperature. At the time of the inspection no one at the service was using controlled drugs. Controlled drugs are medicines that are liable to misuse. We saw that procedures were in place to safely and appropriately store and record controlled drugs.

Improvements had been made to information available about people's 'when required' medicines since the last inspection. Information on these was now detailed and appropriate so that staff had the information they needed to manage people's medicines safely. We also saw that a system was now in place to obtain information from the supplying pharmacy on supporting people with covert medicines. Where covert medicines were used we saw evidence of best interest decisions made in discussion with people's GPs and families.

Audits of medicines were now carried out by the registered manager. We reviewed the most recent audit and saw that an action plan had been generated to address some issues the audit had identified.

At our inspection in January 2016 we found that risks to people were not always assessed, and steps not always taken to minimise them. We took enforcement action requiring the service to be compliant with our regulations by 25 February 2016. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in January 2016.

The registered manager said each senior carer had been allocated a batch of risk assessments to review following the last inspection. The registered manager had then worked through each file themselves to review the risk assessments.

We saw that risks to people had now been assessed and plans were in place to minimise them. Risks to people in areas such as mobility, nutrition, continence and skin integrity were assessed and care plans developed reduce the chances of them occurring. Where people had specific risks to their health these were also risk assessed so that preventative action could be taken. For example, people living with a dementia who were at risk of depression were risk assessed and had care plans developed as a result. The service used recognised tools such as MUST, Waterlow and the Cornell Scale for Depression in Dementia when carrying out risk assessments. 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 met people's current support needs.

At our inspection in January 2016 we found that not all staff had completed a current Disclosure and Barring Service checks to confirm that they were suitable to work with vulnerable adults. We took enforcement action requiring the service to be compliant with our regulations by 25 February 2016. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in January 2016.

All staff now had a completed Disclosure and Barring Service check in place. 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. One member of staff had been recruited since our last inspection. Their staff file contained a completed application form setting out their employment history, proof of address and identity, two written references (including from their most recent employer), confirmation of their professional registration with the Nursing and Midwifery Council (NMC) and a DBS check.

At our inspection in January 2016 we found that staffing levels were not always sufficient to support people safely. We required the registered provider to tell us how they were going to improve this. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in January 2016.

Staffing levels were based on people's assessed levels of dependency, and this was reviewed on a monthly basis. Morning staffing (8am to 2pm) levels were two senior carers and three carers on Daisy unit, two senior carers and three carers on Tulip unit and one nurse and two carers on Rose unit (in addition, one additional carer was deployed on Rose unit at all times to support a person requiring 1:1 care). Afternoon staffing (2pm to 8pm) levels were one senior carer and three carers on Daisy unit, two senior carers and three carers on Tulip unit and one nurse and two carers on Rose unit. Night staffing (8pm to 8am) levels were one senior carers and two carers on Daisy unit, one senior carers and two carers on Tulip unit and one nurse and one carers on Rose unit.

The registered manager said, "Since the last inspection we have had staffing increases, for example if someone (using the service) is not well and needs more support, or if they are at hospital on appointments. If we need more staff we ask if staff can come in. If we need to we will use agency (staff)." Staff told us there were enough staff employed to support people safely. One member of staff told us, "I think we have enough staff." Another said, "Staffing is okay at night." A third told us, "There are enough staff." Another said, "I think

we have enough staff. People do have sick days but management phones around to replace." A person who used the service told us, "(Staff) are here straight away when I buzz. There are enough staff." Another person said, "If I buzz them they're here within seconds." Throughout the inspection we saw that staff attended to people promptly when they signalled they needed support. Staff also spent time checking communal areas and making conversation with people as they moved around the building.

Staff had knowledge of safeguarding issues and procedures were in place to deal with safeguarding incidents. Staff felt confident to raise any concerns they had. One member of staff told us, "If I had any concerns I would see management straight away." The service had a safeguarding policy which contained guidance to staff on the types of abuse that can occur and advice on how to identify them. There was a framework for reporting and investigating incidents. Where issues had been raised we saw evidence of investigations and reporting to the appropriate authorities. There was a whistleblowing policy in place. Whistleblowing is when a person tells someone they have concerns about the service they work for. One member of staff told us, "We have a whistleblowing policy. I would whistle blowing to protect people. We're their carers and we need to do that."

Plans were in place to support people safely in emergency situations. Each person had a personal emergency evacuation plan ('PEEP'), containing information on their mobility and support needs in case of an emergency. 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 regularly reviewed to ensure they were up-to-date. The PEEPs were stored in an emergency 'grab bag' stored near reception for easy access in an emergency evacuation. The grab bag also contained a first aid kit, blankets and identification tags to support people who had been evacuated. There was a business contingency plan, which contained information to assist staff in providing a continuity of care in emergency situations.

Regular safety checks of the building were carried out to minimise the risks to people living there. Records showed that fire alarms, emergency lights and fire doors were checked on a monthly basis. Maintenance checks were also carried out on the nurse call system, window restrictors, mobility equipment and contaminated waste storage on a regular basis. Required certificates in areas such as PAT electricity testing, hoist tests and gas safety were up to date.

Accidents and incidents were investigated and recorded, and the registered manager reviewed these for any trends emerging that required remedial action. For example, the registered manager told us about a specific person they had noticed was having a high number of falls, which triggered a referral to the falls team and Parkinson's nurse. This reduced the number of falls the person was having.

The service was clean and tidy, with communal areas and people's rooms cleaned on a regular basis. Throughout the day, we saw staff using personal protective equipment (PPE) such as aprons and gloves where appropriate to assist with infection control. We saw staff tidying and clearing away trip hazards as they moved around the building.

Good

Is the service effective?

Our findings

At our inspection in January 2016 we found that staff were not supported through a regular system of supervision and appraisal. We required the registered provider to tell us how they were going to improve this. During this latest inspection we found the service had made a number of improvements and had addressed the issues we identified in January 2016.

The registered manager told us that they had reorganised the supervision system following our last inspection. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. They said they had allocated a number of supervisions to senior members of staff, and would be rotating these as, "I wanted everyone to meet everyone. I also thought it would be easier for staff to raise issues with people if they weren't working for them." As an example, the registered manager said the cook would not always be conducting supervisions for kitchen staff. The registered manager said they had also reviewed records from recent supervisions to see if any trends had emerged in feedback.

Records showed that all staff had received at least one supervision in 2016, and 29 members of staff had received two. Records of supervisions showed that staff were free to raise issues, and where they did there was evidence that action had been taken. For example, one member of staff had asked for additional guidance on calculating people's daily fluid targets and records confirmed that this had been given. Supervision meetings were also used to ensure staff were aware of the service's policies and procedures, for example in safeguarding and whistleblowing. The registered manager also carried out spot competency checks on staff, especially those administering medicines.

Staff spoke positively about supervisions and appraisals. One member of staff said, "I had a supervision the other day with [named member of staff]. They're good as you know where you stand. You review what you're good at, and what needs improving." Another said, "I do my supervisions and appraisals with [named member of staff] and they're both up to date."

Staff received the training they needed to support people effectively. Mandatory training was provided in areas including medicines, the Mental Capacity Act 2005, safeguarding, first aid, fire safety and food hygiene. Mandatory training is training the provider thinks is necessary to support people safely. Training was refreshed annually to ensure it reflected current best practice. Records showed that staff completion rates for training in 2016 were all above 70%, and the registered manager said all staff would complete required training by the end of the year. The service had recently introduced the Care Certificate as the basis of staff training. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It sets out explicitly the learning outcomes, competences and standards of care that will be expected.

Most training was completed online, but some was classroom based and organised jointly with the local authority or local professionals. The deputy manager told us, "I've got links with [named community practice nurse]. We provide them with a venue and have other services come in. It gives us a chance to do more training." The deputy manager had also arranged for the local authority to provide workshops on

undernutrition at the service, and was arranging end of life care training at the local university. Upcoming training was displayed in the staff room for staff to check.

Staff spoke positively about the training they received. One said, "There has been a big increase in training, a lot on dementia awareness and challenging behaviour with in house trainer from the organisation. I love my role especially sharing my knowledge and skills with other colleagues. Training is a passion." Another said, "Training has been really good in the last couple of months. Each time I go into the staff room there is a signup sheet. I am due to have dementia awareness training and I have just done the nutrition books. People are coming in to do the training." Another member of staff told us, "Training is much improved, some e-learning but a lot of face to face now. Recently I did three days first aid with the Red Cross. We get dementia and challenging behaviour training too."

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. DoLS re-authorisation applications had been submitted for 42 people at the service, with 15 having been approved at the time of our inspection. The registered manager said the local authority had a backlog in processing applications, and that they (the local authority) were working through them.

Where relevant, capacity assessments had been undertaken and were reviewed on a monthly basis. People who lacked capacity to make decisions had decisions made in their best interests. Where this was the case there was evidence in their care records to show that discussions had taken place with their families and other professionals before a decision was made. For example, for two people a decision had been made that it was in their best interests to use bedrails to keep them safe while sleeping. Where appropriate, Do Not Attempt CPR (DNACPR) decisions were completed, stating discussions with relevant parties had taken place. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.

People were supported to maintain a healthy diet. MUST was used to assess and monitor people who were at risk of malnutrition, and people were regularly weighed. 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. People's dietary needs and preferences were listed on the kitchen wall and the cook was able to describe how meals were tailored for people with diabetes, swallowing difficulties and other support needs. One person had speech and language therapist (SALT) recommendations displayed in the kitchen, including advice to staff on how they could best be supported. We observed a staff handover and saw that people's dietary intake and needs were discussed so that incoming staff had the latest information on people. For example, staff discussed how one person living with a dementia sometimes struggled with cutlery which led to one member of staff suggesting, "Try to use coloured cutlery."

People spoke positively about the food they received at the service. One person said, "They (staff) come

around with a menu every morning for you to choose, then are always around with a tea trolley. You can change what is on the menu." Another person told us, "The food is lovely." We observed a lunchtime sitting and saw that people looked relaxed, happy and were clearly enjoying their meal.

People were supported to accesses external professionals to maintain and promote their health. Care plans contained evidence of close working with professionals such as GPs, district nurses, mental health nurses, occupational therapist and the speech and language therapy team. For example, for one person the service had worked closely with the occupational therapist to arrange a new chair to improve the person's positioning and allow them to have more comfortable interaction with their family. This meant people were supported to access external services to improve their health.

Good

Is the service caring?

Our findings

People spoke positively about the care they received. One person said, "They (staff) look after me brilliantly. I can't fault them. They're very nice people. I've never met anybody nicer" and "The night staff are good as well." Another person said, "I would never go to another home. I started here on respite care, then came in for good. I wouldn't swap it for anything. The [staff] can't do enough for you" and "I'd recommend this place to anyone." A third person told us, "I am happy living here, everything is lovely, the food is good and I get on with all the staff, they are very kind." A fourth person said, "Oh yes, I begged to come back after a fortnight respite. The staff are great, I just press the buzzer and they come. The food is lovely and my room clean and warm. It is having company that is great. At home I was alone, a few carers a day and microwave meals. Here I am treated so well, am so happy and want to stay the rest of my days." Another said, "They (staff) are very kind. They are there for me when I am down. The place is very, very nice."

One person using the service had written a poem about the care they received. This was entitled, 'Best Wishes to all you Wonderful staff at Ormesby Care Home' and was displayed in the reception area of the service. The poem thanked all staff for the care they delivered, stating, 'I wouldn't leave anyone out, that is not my intention. I have nothing but praise for every one of you. You're always pleasant no matter what you have to do.'

Relatives we spoke with described the service as caring. One relative said, "[Named person] is well cared for." Another relative said, "[Named person] is happy and gets all he needs. We have no complaints at all. Completely happy." Another relative said, "They (staff) are all smashing. [Named person] never has to want for anything."

Throughout the inspection we saw examples of staff treating people with respect and caring for them with dignity. When people indicated to staff that they needed support, staff approached them and asked them discretely how they could help. If staff wanted to discuss a particular person's support needs with another member of staff they left communal areas to do so. Staff knocked on people's doors and waited for a response before entering their rooms. One person told us, "(Staff) treat me with respect." Staff told us how they treated people with dignity and respect. One member of staff said, "We always respect people's wishes. We do what they want and always explain what we are doing."

We observed people being treated in a kind, caring way by staff that clearly knew them well. In one example, we saw a person joking that it would be nice to be offered a cup of tea to a member of staff who was in earshot with a drinks trolley. When they were being poured a cup of tea, they then joked it would be nicer still to be offered a biscuit. In another example, we saw a member of staff explaining to a person living with a dementia that they (the member of staff) was going to another area of the building and wanted to explain where they were going. The person thanked the staff member for telling them, and there was an appropriate hug before the staff member left. We saw another person living with a dementia asking staff if they would know where they were if they sat on a chair in the corridor. A member of staff offered the person reassurance in a kind and friendly manner by saying, "We'll know where you are, don't worry darling." The person was clearly reassured by this.

At the time of our inspection two people were using an advocate. Advocates help to ensure that people's views and preferences are heard. The registered manager described how the service had supported people to access advocacy services.

Two people were receiving end of life care at the time of our inspection. Their care plans contained detailed records of their wishes and preferences and evidence of close collaboration with GPs and specialist nurses in the planning of their care. The wishes of people's families had also been recorded, and these were reflected in the care plans produced.

Good

Is the service responsive?

Our findings

People's care was based on their assessed needs and preferences. People's needs in a number of different areas were assessed, including mobility, nutrition, personal hygiene, continence, cognition and tissue integrity. Care plans were then developed which reflected their personal preferences and how they wanted to be supported. Person-centred planning is a way of helping someone to plan their life and support, focusing on what's important to the person. For example, one person's care plan contained detailed instructions on how their end of life care should be managed based upon the wishes of the person and their family. Another person had a care plan covering a medical condition they had, which included their preferences for how the condition should be managed. Each person was assigned a key worker from among the care staff. This helped to ensure people received consistent support and care from the same member of who staff who would get to know them.

Care plans included a monthly dependency assessment that staff used to monitor changes in people's support needs. This was also used by the registered manager to ensure there were sufficient staff deployed to support people. Care plans were reviewed on a monthly basis to ensure that they contained information on people's current needs.

We observed a shift handover between night and day staff. This was used to update incoming staff on people's current support needs. The handover was detailed and included information on people's mood, how they had slept, what they had eaten and anything else relevant to their care and support. For example, there was a discussion about monitoring one person to see if a referral to the local community mental health team was needed. This meant staff had the latest information on how people could best be supported.

People and their relatives said care responded to their needs and that they were involved in planning it. One person told us, "I get a choice over what I want." Another person told us about a request they had made to change something in their care and how this was acted on quickly. A relative we spoke with said, "The family was involved in care planning." Relatives also said the service was good at updating them on any changes in people's support needs. One relative told us, "They are good at phoning us with any changes." Another said, "Communication is brilliant."

People were supported to access activities by two activities co-ordinators. Activities available included bingo, sing-alongs, film nights in the service's cinema room and physical exercises. An external company had been booked to stage a pantomime at the service later in the month. Activities were advertised throughout the service, and people were given a planner for their rooms so they could see what was scheduled.

However, we did not see any activities specifically for people living with a dementia. Some staff told us activities could be improved by taking people out of the service more. One member of staff said, "I would improve things with a sensory room, more days out and a mini bus." Another said, "I would improve things by taking the residents out more and get a mini bus." A third member of staff told us, "I would improve

things with a mini bus to take residents out" and "cover for weekend activities."

People confirmed that activities took place and they were free to participate in them as and when they wishes. One person said, "They do activities but I haven't gotten around to doing them." Another person said, "There's something on every afternoon" and then pointed to an activities planner on their wall setting out what was taking place that week.

There was a complaints policy in place, which was publically displayed in the reception area of the service. The service had received three complaints since our inspection in January 2016. For each we saw evidence of the investigation that had taken place, a log of the actions taken and letters of update and apology to the parties involved. A relative we spoke with told us about a complaint they had made and how it had been dealt with appropriately.

Good

Is the service well-led?

Our findings

We asked staff to describe the culture and values of the service. One member of staff said, "Calm, happy place. I enjoy coming to work. It doesn't feel like a job. I really enjoy it." Another said, "To make sure all residents are cared for and are safe and comfortable."

The registered manager had been in post since January 2016. Staff described them as a supportive and stabilising presence in making changes following our January 2016 inspection. One member of staff said, "Management has been in flux but hopefully things will settle down now." Another said, "[The registered manager] is nice. I can talk to her." A third member of staff said, "Lots of changes (in management), always going on. [The registered manager] is nice, approachable. I would feel okay to go to her for advice."

Staff said they had been told about the findings of our January 2016 inspection, and that staff meetings had been used to discuss the changes needed. One member of staff said, "We have regular staff meetings to be given information and we can also raise any concerns." Another member of staff said, "We're well informed about changes. We have staff meetings all the time."

People and their relatives spoke positively about the registered manager. One person said, "[The registered manager] is a lovely person. I was waiting for a lift and she involved herself (to help). So pleasant." A relative told us, "The manager seems good. We see her at resident meetings."

People also spoke positively about the deputy manager. One person said, "[The deputy manager] is lovely." Staff said the deputy manager had supported them through recent changes at the service. One member of staff said, "Through the changes and problems [the deputy manager] has kept the ship afloat. [The deputy manager] is brilliant." Another member of staff said, "[The deputy manager] is superb and supportive, very good." The registered manager and deputy manager were visible presences at the service. Throughout the inspection we saw them interacting with staff, people and relatives and asking how they could help them.

In addition to staff meetings the registered manager also organised clinical governance meetings, health and safety meetings and resident and relative meetings. Records confirmed that these had all taken place in April 2016, with further meetings planned. The clinical governance and health and safety meetings were used to share best practice and discuss any specific issues arising at the service. Resident and relative meetings gave people and their families an opportunity to meet the registered manager and raise any concerns they had.

The registered manager carried out a number of quality assurance audits to monitor and improve 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 the dining experience, mattresses, bed rails, kitchens, infection control and health and safety. An action plan was generated to monitor any remedial action needed, and this was supervised by the registered manager. The registered manager also audited care plans. They said, "The standard is one (care plan) a week, but that doesn't mean I

only do one a week. Will see files fairly regularly and I have been focusing on nursing care."

Feedback was sought from people, relatives and visiting external professionals through an electronic questionnaire completed on a tablet computer in the entrance to the building. The tablet was also taken around the service to seek feedback from people who were less mobile. One person who had taken part in this told us, "They ask how things are to make sure we're happy." One person who had filled in a feedback survey in March 2016 had recorded, 'They listen if I feel I need someone to talk to', 'Sometimes I need another opinion and they help' and had said the service was a happy place to live. Another person who had filled in the questionnaire in March 2016 recorded, 'I love living here and the staff are so helpful. I've always said it is more like a hotel than a care home.' A visiting professional completed a questionnaire in April 2016 and described the service as 'very clean', said they were 'very happy' with the care provided to the person they were visiting and recorded, 'The staff are very kind.'

The registered manager said the registered provider had supported them in making changes and improvements to the service. The registered manager was able to explain their responsibilities and described the notifications they were required to make to the Commission.