Acer Healthcare Operations Limited

Highfield 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

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

Highfield Care Home is a 53-bed residential and nursing care service providing care, treatment and support, including end of life care and support for people living with dementia. On the days of our unannounced inspection on 25 and 26 June 2018 there were 49 people living at the service. Saffron suite was a specific part of the service which catered for people with a diagnosis of dementia.

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

The last inspection of the service was conducted in July 2017 and we rated the service as, 'Requires Improvement' overall, and we found two breaches of the legal requirements. Equipment was not always maintained at the correct setting or regularly checked to make sure that it was working effectively. Care staff were not familiar with people's needs and the care plans did not provide sufficient direction to staff.

At this inspection, we found that improvements had been made. We found that there were clearer systems in place to check on equipment and ensure that it was safe to use when needed. Risk assessments were in place to manage risks and reduce the likelihood of harm, however further work was needed to ensure consistency of practice in relation to some of the documentation and moving and handling.

The care plans were more detailed and informative, and provided clearer guidance to staff on people's needs and their care preferences. Staff knew people well and there were effective handover systems in place to ensure that key information was communicated to those who were supporting individuals.

There were systems in place to review any accidents or incidents and to identify any learning or improvements needed. Staff received training on how to recognise abuse and we saw that concerns about individual's wellbeing had been appropriately escalated to the relevant authorities.

There was enough staff available to meet people's needs. Staffing numbers had been calculated based on the needs of the people using the service. There were clear processes in place to check on staff suitability prior to them starting work at the service which included references and disclosure and barring checks.

New staff received training to ensure that they had the skills and knowledge they needed to meet people's needs. Additional training opportunities were made available to staff to update their knowledge and

maintain their skills and competency.

People were supported to eat and drink and maintain a balanced diet. There were clear systems in place to monitor those individuals at risk of malnourishment.

People had good access to health care support which included access to the GP, optician, specialist nurses and dietician. The service worked with other organisations in a collaborative way.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People's ability to make decisions was assessed in line with the requirements of the Mental Capacity Act (MCA) 2005. Where appropriate Deprivation of Liberty Safeguard (DoLS) authorisations were in place to lawfully deprive people of their liberty for their own safety.

The environment was well maintained and comfortable. We have made a recommendation that further advice is sought on creating an environment that would further support people with dementia.

People looked well-groomed and were wearing communication aids such as spectacles and hearing aids. People told us that they were treated with dignity and their independence was promoted. There were systems in place to support people and their relatives to express their views about the quality of the service and suggestions were welcomed.

People had access to a range of interesting and stimulating activities which promoted their wellbeing.

There were systems in place to respond to people's concerns and investigate them. We have made a recommendation about the management of complaints.

The registered manager was supported by a deputy manager and a clinical lead. Staff supervisions, appraisals and team meetings were used to reflect on practice and explore what could be done differently. The registered manager worked with other agencies including the local authority quality team to drive improvement at the service.

Quality assurance processes were in place, which provided the registered manager and provider with oversight of the service. Information was collated on a range of areas and analysis undertaken to identify patterns and manage risks. The providers representative visited the service on a regular basis and completed a report on the quality of care which set out actions and timescales for delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were systems in place to manage risk and reduce the likelihood of harm however further work was needed to ensure consistency of practice in relation to documentation and moving and handling.

People were supported by sufficient numbers of suitable staff and the levels of staff were regularly reviewed to help people to stay safe.

Recruitment processes were in place to check on the suitability of staff and offer protection to people.

The provider had systems in place to oversee and ensure the safe use of medicines.

Infection control and prevention processes were in place and implemented by staff to reduce the likelihood of harm.

Incidents were reviewed and improvements were made when things went wrong.

Is the service effective?

Good

The service was effective.

Peoples care and support was delivered in line with current standards and guidance.

Staff received training to support them deliver effective care and support.

People were supported to eat and drink and maintain a balanced diet.

People had good access to health care support when they needed it.

The registered manager understood their responsibilities to protect people's rights and ensure that they were consulted

about their care.

The premises was well maintained but we have made a recommendation about creating an environment which supports people with a diagnosis of dementia.

Is the service caring?

Good

The service was caring

Staff knew people well and supported people in a kind and compassionate way.

People were treated with dignity and respect.

People were encouraged and supported to be as independent as they could be.

Staff supported people and their relatives to be involved in their care and its delivery.

Is the service responsive?

Good

The service was responsive

Care plans were in place to inform staff and the delivery of care. There were systems in place to ensure that staff were updated on changes to people's needs.

Staff supported people and families with end of life care.

People had access to a range of activities and to maintain their interests.

There were systems in place to address complaints but we have recommended that these are reviewed.

Is the service well-led?

Good

The service was well led.

There were systems in place to engage with staff, people who use the service and their relatives about the quality of care.

The registered manager worked with other agencies including the local authority quality team to drive improvement at the service.

Quality assurance processes were in place, which provided the

registered manager and provider with oversight of the service. Responsibilities were clear and risks understood.

Highfield 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 the 25 and 26 June 2018. We subsequently followed up information on the 25 July 2018. The inspection team consisted of an inspector, a bank inspector, a professional advisor and an Expert–by-Experience. The professional advisor was a registered nurse and focused on the provision of nursing care within the service. An expert by experience is a person who has personal experience of care services and caring for an older person.

The provider had completed a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give key information about the service, what it does well and the improvements they plan to make. Prior to the inspection we reviewed the information we held about the service including notifications of incidents that the provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law.
Prior to our inspection we spoke with stakeholders including commissioners of services. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

As part of the inspection we undertook a SOFI (Short observational framework for inspection.) This is a tool we use to capture the experiences of people who use services who may not be able to talk with us and involves observing care and interactions between staff and people who use the service.

There were 49 people living in the service and we spoke with eighteen of them, 10 visitors and 12 staff. We spoke with the registered manager, the deputy manager and the area manager. We looked at three staff records, people's care records and records relating to how the safety and quality of the service was being monitored. We observed care practice and medication administration.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in July 2017, we identified a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the oversight of equipment and the management of risk was not effective. Equipment was not always maintained at the correct setting or regularly checked to make sure that it was working effectively. At this inspection, we found that improvements had been made and there were clearer systems in place to check on equipment such as, pressure relieving mattresses and the suction machine to make sure that they were in working order and safe to use when needed. We also checked the dates on dressing packs and saw that they were within date and checked regularly.

The service used a range of risk assessment tools to anticipate and manage risks to people using the service. For example, those who had been identified as being at risk of pressure damage had pressure relieving mattresses in place and cushions to maintain their skin integrity. We observed that, staff ensured that the equipment was available to people when they needed it, and we observed staff moving a person's pressure relieving cushion from their wheelchair to their armchair when they assisted them to move. Similarly, people who had been identified as being at risk of malnourishment were being monitored and weighed more regularly to enable staff to see if the risk management plan was working effectively.

We saw that, where people were identified as at high risk of falls, particularly at night, the service made use of pressure mats beside people's beds to alert staff to people moving around who might be at risk of injury through falls. For one person, we saw that their care records highlighted the need for this equipment and specified how often staff should check on their welfare during the night. For the same person, their records showed they would forget to use their walking aid and that staff needed to remind them about this to help keep them safe. We observed that the person left the dining table and started to walk towards a corridor without using their walking frame. Staff intervened quickly to get this for them to promote their safety. We saw that where people had repeat falls, referrals were made to the falls service for further advice.

While we found evidence of good practice, there were issues of consistency and some omissions in the risk management systems. Some risks did not have a detailed assessment in place to record the actions which staff needed to take to reduce the likelihood of an incident occurring. One person for example had a diagnosis of epilepsy and we did not find clear guidance in place as to how this should be managed. Another person had been identified as being at risk of self-harm but we could not see that their mood was subject to ongoing monitoring and oversight. Staff spoken with were clear about the actions that they needed to take to monitor these individual's wellbeing but the documentation did not always reflect this. The registered manager subsequently confirmed that the documentation had been updated. There were risk assessments in place to guide staff on how to support people to mobilise which identified the equipment, size and type of sling that should be used. While we observed best practice in moving and handling, we also saw one person being transferred using another individual's sling. We raised this issues with the registered manager who agreed to investigate. They subsequently told us that they changed how information about moving and handling was recorded to ensure that staff were clearer on slings and had provided reminders to staff on safe moving and handling procedures.

There were systems in place to ensure that environmental risks were identified and managed. For example, we saw that checks were undertaken on fire safety equipment to ensure that it was working effectively, checks on equipment such as window restrictors and on water temperatures to make sure that the controls in place to manage the risks associated with scalding and legionella were being managed.

There were systems and processes in place to safeguard people from abuse. Staff had undertaken training on how to recognise signs of abuse and safeguarding. We saw from the records in the service that incidents had been recognised as safeguarding and appropriate referrals had been made. Visitors to the service told us that they felt staff treated people well. One person told us that, "They had never seen anything or heard anything that raised concerns about the way staff supported their relative or others." Staff told us that if they identified any abuse they would report to the senior management and expressed confidence that their concerns would be taken seriously.

People were supported by sufficient numbers of suitable staff and the levels of staff were regularly reviewed to help people to stay safe. A visitor told us, "They [staff] are as quick as they can be if people call out." They explained that sometimes a staff member might need to have additional assistance to ensure that others were supported while they attended to an individual and that this might mean people waiting for a short time. However, they did not consider this was a problem and felt people's needs were attended to promptly.

People told us that they felt safe and were happy living in the service as staff were helpful and attentive. However, others told us that they sometimes had to wait for staff when they rang the bell. One person said, "If a need the toilet I sometimes wait a bit but other times they come quickly." Our observations were that call bells were responded to within three to four minutes and staff were visible, with people in the communal areas able to attract staff easily. In the lounge in Saffron suite we noticed a staff member present at all times. Care staff spoken with told us that they felt staffing levels were about right and enabled them to meet people's needs safely. They also said that, if there were problems or issues, nursing staff or team leaders would help them out so that people's needs were met safely.

The registered manager told us that they kept staffing levels under review and that they used the organisations dependency tool on a monthly basis. This tool included oversight of people's needs in the setting of staffing levels.

Recruitment processes were in place to check on staff suitability and protect people. Staff told us that they had attended an interview and references had been obtained before they could start work. Examination of three staff files confirmed that all relevant checks, including ID checks, criminal records check and appropriate references had been obtained on newly appointed staff. Checks on staff's nursing qualifications were undertaken on nursing staff before they commenced employment. Where agency staff were used the service requested from the agency details of the training completed and details of their criminal records check.

The provider had a system in place to oversee and ensure the safe use of medicines. Medicines were appropriately stored and the room temperatures were monitored. There was a clear process for ordering, receiving and disposal of medications. The service operates an electronic system and staff confirmed they had training to use the system and were confident that it had reduced the risk of errors. One member of staff explained how it prevented staff from giving doses too close together, if a previous dose had been given late for some reason. They told us that they had their competence assessed to use the system and to administer medicines safely. There were clear systems in place for PRN or as and when medicines such as pain relief and staff recorded the amount of medicine administered. We observed people being administered their medicines and this was undertaken in line with recommended guidance. Controlled medicines were

securely stored and additional checks completed on a weekly basis to ensure that the amounts tallied with the records. Regular audits were undertaken to check on medicine administration and identify any shortfalls.

Infection prevention and control policies were in place. The service was clean and there were no offensive odours. One person told us, "It always smells nice here." A visitor to the service told us that, "Sometimes there was food debris on the chairs in their [family member's] room, but generally, standards of cleanliness were good." They were satisfied with the way staff supported their family member with their personal hygiene.

Staff told us that their training included the prevention and control of infection. We observed that they used gloves and aprons when they needed to assist people with personal care and that these were available in bathrooms. We observed a small number of areas where improvements could be made such as the replacement of toilet brushes and some damage to grouting. The registered manger immediately addressed these areas following the inspection.

Improvements were made when things went wrong. Staff spoken with understood their responsibilities to raise concerns or safety incidents. Investigations were undertaken into near misses to identify learning and we saw that changes were made to processes to improve safety. For example, we saw that following a review of an incident all team leaders had received additional first aid training to enable them to support nursing staff.

Good

Is the service effective?

Our findings

People's care and support was delivered in line with current standards and guidance. The registered manager was involved with the prosper scheme which is a scheme run by Essex County Council and works with services to improve safety by working to reduce the number of falls, pressure ulcers and urinary tract infections. The registered manager said that they worked with the prosper team to monitor these areas and had targeted training to develop staff skills and knowledge.

Staff received training to develop their skills to enable them to deliver effective care and support.
Care staff spoken with confirmed that they had access to training which included a combination of on line and face to face training. This included areas such as infection control, moving and handling and dementia care. Additional training was accessed in line with the needs of the people resident for example on areas such as stoma care. The registered manager told us that they were speaking with the specialist nursing team about providing training on a specific health condition as a new resident had recently been admitted with this condition.

The registered manager maintained a training matrix which showed which staff had completed which training and when refresher training was needed.

Staff received supervision to support them in their role and identify any learning needs and opportunities for professional development. Care staff we spoke with told us they felt well supported and had regular planned supervision sessions and appraisals. Staff told us that they could access additional qualifications such as Qualification and Credit Framework. Newly appointed staff who were new to the care sector completed the care certificate which is a national initiative to develop the abilities of staff and demonstrate they have key skills, knowledge and behaviour. In addition, staff completed an in-house induction to ensure they were familiar with the environment and specific values of the service. Alongside this they completed shadow shifts where they observed more experienced colleagues before working independently. Staff described the process as flexible and taking into account the confidence and previous skills of staff members new to the service.

People were supported to eat and drink and maintain a balanced diet. We observed through the morning people being given drinks from a trolley when they requested them. People were encouraged to drink as it was a hot day. A member of staff told us, "In this weather we offer people drinks constantly. Some people like a Baileys or a sherry."

Information was available in the kitchen about people who needed specialist diets, staff were clear about who required specialist support such as thickener added to aid swallowing.

People who did not like a meal were offered alternatives and people were well supported to eat their meal with staff being attentive and giving one to one time. Where one person had stopped eating their meal, a staff member sat alongside them to engage them in conversation and assist them with the occasional mouthful until they again started to eat independently. Another individual left the table however, a staff

member encouraged them to return, sat alongside them and chatted to them. This, and the occasional assistance to put food on their fork, encouraged them to eat.

One individual had been assessed as requiring a soft diet and we observed that items were separately pureed and the meal looked appetising. Staff supported the individual by sitting alongside them and the assistance given was appropriately paced.

People were supported to access healthcare services in a timely way. People told us that that staff worked well with health professionals to ensure that they received the care that they needed. One person told us, "This home is more professional than the last, the GP is here every Friday and if anything is wrong with health the home responds very well."

During the inspection one person's health deteriorated and they needed urgent medical intervention. Staff responded in a calm way and ensured that the individual received the support they needed.

People's weights were monitored and where individuals were identified as being at risk additional monitoring was undertaken and where necessary supplements were given. Referrals were made to the dietician as necessary. We saw in care plans details of visits from professionals, such as GPs and chiropodists.

The service operated in line with the legislation of the Mental Capacity Act 2005 and staff sought consent before providing care. Some people who lived in the service were not able to make important decisions about their care and how they lived their daily lives. The registered manager understood their responsibilities under the Mental Capacity Act 2005, (MCA) and around protecting people's rights. The MCA provides a legal framework for making 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 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 are called the Deprivation of Liberty Safeguards (DoLS) and the manager told us that they had assessed people's needs and made applications as required to the local authority.

Staff confirmed to us that they had training in the MCA. They explained to us how they supported and encouraged people to make decisions about their care. They told us how they would prompt and encourage people and act to deliver essential care if this was in people's best interests. Two staff members identified to us which people had authorisations under DoLS because of restrictions on their freedom and to deliver essential care

We observed that staff asked people for consent before commencing support and offered people choices as they interacted with them throughout the day.

The premises were well maintained and people had good access to appropriate spaces where they were able to spend time and access the gardens.

On the day of our inspection visit, the weather was very hot. We noted that a large roof light, providing daylight to a seating area in the Saffron lounge, was neither screened with blinds for use in very hot and sunny weather, nor able to be opened to let out the heat. We saw that three people sitting in that area were red in the face, two agreeing that it was very hot, and all of them later fell asleep. There was only one fan in

front of the seats that was not oscillating from side to side to provide a breeze. We spoke with the registered manager about this and they agreed to review this. They also told us about proposals to improve access to an outside space that was secure and safe for people who were living with dementia. This would enhance people's opportunities to enjoy the fresh air. A staff member we spoke with in passing was aware how much one person liked to be outside. They told us how they had ensured the person was provided with sunblock and had supported them to move into the shade.

There was level access through the home so that people with impaired mobility could move around it. There were handrails in the corridors so that people could gain support. A staff member told us how they felt the environment was better for people living with dementia than it had been. They explained that they were aware some types and colours of flooring could make it difficult for people and felt the replacement of some darker carpet with lighter laminate type flooring had improved things.

However, on occasion, inspectors found it difficult to orientate themselves around the home. The colours of walls were similar and some people had no means of identifying their individual bedrooms. In some cases, these had names and numbers, in others there were photographs of people as they were at the time of our inspection. There were no "memory boxes" or photographs of people as they used to be and how those living with dementia might perceive and recognise themselves, to help them identify their rooms independently. We also found that there were locations with mirrors that could pick up a reflection and startle people living with dementia, for whom this could be distressing. We have recommended that the registered manager seek advice from a reputable source on creating environments for people with a diagnosis of dementia.

Good

Is the service caring?

Our findings

People spoke positively about the staff and the care they received. One person told us, "I think the staff are all marvellous." Another said, "There is always banter with the staff here." A relative told us, "On the whole [my relative] is looked after very well, some of the staff are better than others. Some do it as a job but some really care."

Staff knew people well and supported people in a kind and compassionate way. Staff knew about people's histories, so that they could engage and communicate with them in a meaningful way about things that were important to people. Our discussions with staff showed that they understood people's backgrounds and histories. One staff member gave us an example of something they had found out about a person's history, which enabled them to engage with the person in a meaningful way. They said it had also resulted in the person engaging in an activity they had not done since moving into the service and which had been an important part of their life prior to their admission to the service. Staff told us about another person for whom their garden and flowers had been important.

During our formal observations, we saw good quality interactions between staff and people using the service. We observed that staff took action promptly when people became anxious or distressed. Throughout our inspection visit, staff intervened promptly and cheerfully to offer reassurance and support.

We saw that one person, who had been restless during their meal, was encouraged to come back to the table. A staff member said, "We are having lunch now. It would be nice if you came and joined us." The person took comfort from the presence of staff after they had been encouraged back to the table. They sat with one hand resting on the staff member's back while they were chatting. They smiled and engaged with the staff member while the staff offered quiet encouragement with their meal.

People were treated with dignity and respect. One person told us, "I am treated with dignity and respect the staff are nice, they are kind and very gentle." We observed a staff member supporting a person at their own pace and assisting them to walk across to the dining table. We noted them saying to the person, "In your own time, take a step forward for me." They assisted the person gently and encouraged them. They introduced the person to others who were using the table and made efforts to engage all of them in conversation while they ate their meal. We did however observe one person being transferred to their bedroom on a commode chair which was not dignified however we saw that the senior member of staff on duty had also identified this and addressed the issue directly with the staff member.

People were encouraged with their independence. For example, staff asked whether they needed assistance or could manage for themselves. One person prepared their own drink. Another person, who could manage a teapot, had this on their breakfast tray so they could pour their own drinks.

We saw that staff intervened promptly when another person asked twice in 25 minutes to use the toilet. Staff responding quickly and discreetly, supporting the person to leave, describing the direction they needed to go in, and offering support.

During our inspection, we observed that staff closed people's bedroom doors when they assisted people with personal care. We also observed staff knocking on doors before entering rooms. We did note however, that a shower room did not have a suitable privacy bolt fitted so that staff could close it securely when they assisted people and prevent others from walking in. The registered manager agreed to address this.

Staff supported people and their relatives to be involved in their care and its delivery. People told us that their views were respected. One person told us, that they liked to stay in their room and staff observed this but did offer gentle encouragement to join in sometimes. However, they said, "I only do what I want to do. "A visitor to the service told us that they felt involved in their family member's care and said they could not think of anything staff were not doing that would improve the person's life.

A team leader gave us two examples of how they involved people and their families at six monthly reviews, taking the electronic care plan on the laptop so they could go through it. They showed us the record they completed to confirm who was involved in those reviews and decisions about care.

People told us that resident and relative meetings were held and we saw a poster in the entrance to the service entitled, 'You say we did' which set out what steps the service had taken in response to suggestions from people living in the service and their relatives. The changes included making coffee and tea freely available in reception and having a chef available until later in the day.

Good

Is the service responsive?

Our findings

At the last inspection in July 2017, we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because staff were not familiar with people's needs and the care plans in place did not provide sufficient direction to staff. At this inspection we found that improvements had been made and care plans were more detailed and informative. For example, we saw that information was provided on catheter care and how support should be provided to reduce the likelihood of infection. Guidance was provided to staff on how best to support people and included information on the protected characteristics under the Equality Act, and included any communication aids that people needed. Information was included on people's interests, aspirations and how to enable them to have as much control as possible. For example, one plan stated, '[Individual will often refuse staff's assistance with personal care, at these times they need encouragement and a gentle approach…. another member of staff can often be successful…. best cared for by staff they are familiar with.'

A relative told us that they felt staff responded quickly when people's needs changed, and tailored their support accordingly. They explained to us that, during a short period of illness, staff had provided extra time and support to encourage their family member with their meals.

Staff told us that they had handovers between shifts to ensure that they were up to date. They told us that handovers would "backtrack" sometimes for up to a week to ensure that all staff were aware of any recent changes to people's care.

We asked staff if there were enough of them to respect people's preferences for when they received support, such as what time they got up or went to bed. They told us that they felt there were. They explained how sometimes people did not respond well to a member of staff. They said that, if this happened, they would return later, or a colleague, that the person knew well would offer support. They gave us examples of how this worked for individuals, describing a flexible approach to meeting people's needs.

Staff supported people and families with end of life care. People had their end of life wishes recorded in their care plans and the preferred priorities of care (PPC) documentation was in place. The service had developed links with the local hospice and staff knew who to contact if they required additional advice or support. Systems were in place to ensure anticipatory medicines were sought where required when people were nearing the end of their life.

People were supported to follow their interests and take part in activities that were appropriate for them. An activity coordinator was employed within the service. They organised a variety of events in the communal area which people from all the units could attend. People spoke positively about the activities on offer and told us that they enjoyed them.

We saw that, in the Saffron unit, there was a "virtual reality" projector in use that gave people the opportunity to engage in table top activities. We saw people actively engaged in bursting the projected bubbles. On another occasion, the equipment was showing flowers that people could make bigger if they

wanted. A staff member supporting people told us that one person really liked their garden when they were at home and the person agreed. They were taking an interest in what was happening with the activity. During the afternoon, we saw three people using the same equipment to do a virtual jigsaw puzzle.

We saw that some people had enjoyed having their hair styled. There was a dedicated room for this, which, although small, was decorated like a hairdresser's salon, with pictures of film stars on the wall. During people's appointments, we heard the hairdresser chatting with people about their families.

There were systems in place to investigate concerns and we looked at the records of complaints and saw that investigations had been undertaken for written complaints. However, outcomes were not always clearly recorded. Some people expressed confidence in the processes but others did not and two complaints were raised with us during the course of the inspection. The area manager investigated these and provided us with a report and details of subsequent actions taken. We recommend that the complaints processes are reviewed to enable people to have full confidence in the processes and address peoples verbal complaints.

Good

Is the service well-led?

Our findings

At our previous inspection we identified that the governance process had not always identified where the service needed to improve. At this inspection, we found improvements had been made and the levels of oversight strengthened. The registered manager was supported by a deputy manager and a new clinical lead had been appointed to oversee clinical care at the service. We observed that they were visible throughout the service and known to people using the service and their relatives. There was a clear vision known by all staff which focused on the delivery of person centred care and the values of compassion, dignity and respect.

The registered manager had worked with the local authority quality improvement and the prosper project, which is a local quality initiative to implement change within the service. They were also involved in the 'My Home Life,' which is a UK-wide initiative that promotes quality of life and delivers positive change for people living in care homes. Staff told us that they received regular supervisions to reflect on their practice and yearly appraisals to support their career development. Staff meetings were held on a regular basis to discuss what was working well and agree how improvements at the service could be made. People and their relatives were encouraged to provide feedback on the quality of care and we saw that satisfaction surveys were undertaken and the results published. The registered manager told us that people were also able to nominate staff to the providers awards scheme to celebrate good practice. One member of staff had won nurse of the year at the company's annual award ceremony.

There was a governance framework with clear responsibilities and a focus on risk and quality of care. The registered manager and the management team collected information on a range of areas as well as completing monthly audits. For example, we saw that they collected information on accidents and analysis was undertaken on falls and near misses. Information was collated on residents who were identified as being at high risk to ensure that any deterioration in people's wellbeing was being identified and escalated if necessary. This looked at areas such as skin tears, weight loss, pressure ulcers and infections. Audits were undertaken on areas such as medication, catheter care, health and safety and care plans. Where shortfalls were identified actions were agreed.

The provider's quality and compliance representative visited the service on a regular basis and completed a report which looked at areas relating to the key lines of enquiry. We looked at these reports as part our inspection and saw that records were checked, on areas such as staff training, accidents, catheter care and complaints. Observations were undertaken and staff spoken with. The report reviewed actions already agreed and set out areas for improvement along with dates for completion.