

Pondsmead (Shepton Mallet) Limited

Pondsmead Care Home

Inspection report

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Tel: 01749841111

Date of inspection visit:
07 August 2018
08 August 2018

Date of publication:
08 November 2018

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 inspection took place on 7 and 8 August 2018 and was unannounced.

Pondsmead Care Home was last inspected in July 2017 and was rated requires improvement. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009.

At the last inspection we found there were insufficient staff to meet people's needs in a safe and timely manner. We also found that following an independent review of fire precautions some work needed to bring the fire precautions to the recommended standard had been completed. However, there remained areas, including one which had been identified by the review as "significant", which had not been completed. We also found records had not always been completed accurately to reflect how and when care had been provided to people in the home. The systems in place to monitor the quality of the service provided had not identified the shortfalls found in the inspection. The provider sent us an action plan setting out how and when they would be compliant.

At this inspection we found there had been an improvement in all areas of care and support provided in the home. However, there was still work needed to maintain the improvements consistently. We found that there was an inconsistency with the recording in care plans between the residential unit and the nursing unit. The residential unit care plans were person centred with sufficient guidance for staff to follow. However, the care plans on the nursing unit were more generalised and less person centred. Staff on the nursing unit had failed to record interventions in the correct forms. These shortfalls had been identified by the registered manager and training and one to one supervision had been put into place. This meant the systems in place to identify shortfalls and drive improvement were more robust and had been used effectively.

There were sufficient staff to support people in a safe and timely manner a reorganisation of the home so that people with non-nursing needs were cared for on one floor meant staff were deployed more effectively. Staff spoken to said they had more time to spend with people and less "running up and down stairs."

The first day of the inspection was carried out by one adult social care inspector, a specialist nurse advisor (this is a person who provides specialist advice during the inspection on general nursing) and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector and a specialist nurse advisor and two assistant inspectors and was announced.

Pondsmead 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.

All the work required to bring the fire precautions up to the recommended standard had been completed and fire precautions in place in the home were found to be safe.

The administration of medicines was managed safely however it was noted that one person's pain management care plans had not been developed following their initial assessment. The registered manager had identified that staff were recording pain management in daily records and not the specific form. training had been arranged for all staff in the correct way to use the electronic system.

People said the standard of food in the home was good, one relative said they were happy to see their loved one eating a healthy well-balanced diet. There were choices available on a seasonal menu and people could request an alternative if they did not like the food on the menu for the day. The dining experience for people was relaxed and a social occasion. However, we saw the dining room was laid up to a high standard during the morning but when meals were served people did not have the benefit of the tablecloths and cotton napkins which were removed. We discussed this with the registered manager who told us this did not usually happen and people usually had the benefit of a napkin and tablecloth. We saw the routine had changed on the second day of the inspection with the tablecloths remaining on the table and condiments provided. One person spoken with said, "The new owner likes it to look like that during the day."

People told us they felt safe living in the home. One person said, "I feel very safe living here." A relative said, "I am happy [the person] is safe. They were falling over at home and they haven't fallen once since they have been here."

There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. All staff spoken with were confident action would be taken by the registered manager and provider to address any issues they may raise.

People received effective care from staff who were well trained and understood their needs, likes and dislikes. People told us they felt staff were well trained and that they knew their care needs, likes and dislikes.

People said they received care and support from caring and kind staff. Comments included, "They [the staff] are all really nice and friendly." And, "They [the staff] are all lovely." And "There is always a cheerful and happy group of staff."

People told us they could talk with staff and the manager if they wished to raise a concern. One person said, "He [the registered manager] is always about the home and takes the time to listen to you."

People were supported at the end of their life to have a comfortable pain free death. Care plans showed people's advance decisions were taken into consideration and acted upon. The staff also supported the bereaved with compassion understanding.

There was a clear drive to improve the service and the quality of care provided. This could be seen at all levels of staff who told us they were proud of the changes they had made and the plans for the future development of the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

People were supported by staff who had been recruited to make sure they were safe to work with vulnerable people.

There were sufficient staff to maintain people's safety and meet their needs.

People's medicines were safely administered by staff who had received appropriate training to carry out the task. However, some training around recording pain relief was required.

Is the service effective?

Good 

The service was effective.

People's health and well-being was monitored by staff and advice and guidance was sought from healthcare professionals to meet some specific needs.

People had access to a nutritional diet and food was provided which met their specific needs and wishes.

People received care with their consent or in their best interests if they were unable to give full consent.

Is the service caring?

Good 

The service was caring.

People were cared for by staff who were kind and patient.

People's privacy and dignity were respected and they received support in a way that respected their choices.

Is the service responsive?

Good 

The service was responsive.

People could take part in organised activities or choose to occupy their time in their preferred way.

Most care plans were person centred and informative. However, at the time of the inspection the electronic care plan system was not being used to its full potential.

People could make choices about their day to day lives.

People said they would be comfortable to speak with a member of staff if they had any complaints about their care or support.

Is the service well-led?

Good ●

The service was well led.

The management team promoted inclusion and encouraged an open working environment.

Quality monitoring systems were in place which ensured the management had a good oversight of service delivery

The home was led by a management team that was approachable and respected by the people, relatives and staff.

The home was continuously working to learn, improve and measure the delivery of care to people.

Pondsmead 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 checked 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.

Pondsmead Care Home was last inspected in July 2017 and was rated requires improvement. We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The provider sent us an action plan setting out how and when they would meet the breach.

This inspection took place on 7 and 8 August 2018. The first day of the inspection was carried out by one adult social care inspector, a specialist nurse advisor (this is a person who provides specialist advice during the inspection on general nursing) and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by one adult social care inspector, a specialist nurse advisor and two assistant inspectors and was announced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit including the providers action plan following the last inspection.

During this inspection we spoke with nine people living at the home, ten members of staff and three visiting relatives. We also spoke with the registered manager and the regional manager. We spent time observing care practices in communal areas of the home.

We looked at a number of records relating to individual care and the running of the home. These included seven care and support plans, three staff personnel files, training and supervision records and minutes of meetings held at the home and the organisations policies and procedures.

Is the service safe?

Our findings

At the last inspection in July 2017 we identified that people were not safe living at the home. This was because there were concerns around insufficient staff to meet people's needs in a safe and timely manner and progress with work to comply with findings from an independent review of fire precautions. Following the inspection, the service provider sent us an action plan to show how and by when they would carry out improvements in these areas.

At this inspection we found people received care that was safe and protected them from harm. People told us they felt safe living in Pondsmead Care Home. One person said, "I am safe and happy. No worries." Another person said, "I feel safe, everything is secure." A relative said, "I have no worries on that score I know [the person] is safe and well cared for."

We found there had been an improvement in staffing levels in the home. The registered manager completed a dependency tool to decide safe staffing levels. However, there were conflicting comments on staffing in the home. One staff member said, "There are enough staff here yes." Another staff member said, "It is a good team here. We now have enough staff. We had problems last year but I feel we now have enough. The call bell response times are quick. It is really important to answer bells as soon as you can." In contrast, another staff member said, "We could do with more staff especially on Woodlands but the call bell response times are good and even if I am on a break I will go and answer it." When asked about staffing levels people said, "I think there are enough staff. They never rush me and if I say hang on a minute they do." Whilst other people said, "Sometimes there are enough and sometimes not." And, "Now and again a bit thin on the ground." One relative said, "I am happy with staffing levels. If I want something doing, they come straight away, all mum's needs are being met." We observed there were sufficient staff in the home on both days of the inspection. During lunch time on both days there were sufficient staff assisting people. This meant the meal time was unrushed and people were supported in a timely manner.

We found all work required to bring the fire precautions up to the recommended standard had been completed and fire precautions in place in the home were found to be safe.

Systems were in place to identify and reduce the risks to people living in the home. People's care plans included risk assessments. However, some care plans lacked clear guidelines to inform staff how to mitigate risks. For example, one person at risk of pressure ulcers did not have a record for the correct setting of their pressure mattress or a record of checks to ensure the mattress was at the correct pressure. The registered manager had already identified this shortfall as staff had been making the records in the wrong place in the electronic system. Training and one to one supervision had been arranged to address the shortfall. Staff had contacted appropriate professionals to make sure people at risk of developing pressure ulcers had suitable pressure relieving equipment in place.

During our inspection we looked at the systems in place to manage medicines. People told us they were happy with the way their medicines were managed. One person said, "They [the staff] are always on time, and if I need any painkillers they get them for me. They are really good." We saw systems were in place to

ensure people's medicines were managed consistently and safely by staff. Medicines, including controlled drugs were obtained, stored, administered and disposed of appropriately. Controlled drugs are medicines which have special requirements about storage and recording.

Where people had been prescribed medicines on an 'as required' basis, such as pain killers, plans were in place for pain management. However, we did see one care plan which had failed to identify the need for as required pain relief immediately after the person was admitted. The need had been identified in the person's initial assessment but not carried over into their care plan. We discussed this with the registered manager who said they had already identified the lack of a pain relief record. We saw the registered manager had discussed this with staff and new measures were in place to ensure these details would not be missed in future. The registered manager explained the person did have capacity to request pain relief and they found staff had been recording pain relief in the daily records rather than a pain relief form.

Medicine competency records of individual staff who were responsible for administration of medicines were thorough and detailed. The provider recorded when staff last had a competency assessment and this meant people could be confident staff who administered medicines were competent and up to date in their practice.

The provider had systems and processes which helped to minimise risks of abuse to people. These included a robust recruitment process and ensuring staff understood how to recognise and report concerns.

Before commencing work all new staff were thoroughly checked to make sure they were suitable to work for the organisation. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. One staff member confirmed they had not started work until all the relevant checks had been carried out.

All staff spoken with had a good understanding of safeguarding and recognising abuse. they had all completed training about how to recognise and report abuse and all were confident that anything reported within the home would be dealt with to make sure people were safe. One staff member said, "I would talk to my manager, then manager would take it up. I have every confidence it would be dealt with properly. Staff were also aware of who they could talk with outside of their organisation. One staff member said, "I would talk to a nurse or take it to a senior manager. They would deal with it from there, but I know I can talk to the police, social services or ring CQC."

Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. We saw evidence of other risk assessments relating to, nutrition and hydration and the risk of falls. When people needed transferring, there were clear guidelines about which type of sling and hoist should be used. During the inspection we observed people being assisted to transfer appropriately.

People were protected against the risks of the spread of infection because all areas of the home were kept clean. There were handwashing facilities throughout the home and alcohol gel was available for staff and visitors to use. There was clear guidance in toilets on hand washing and staff had received infection control training. Staff had access to personal protective equipment [PPE] such as disposable gloves and aprons which also helped to minimise risks to people. One staff member said, "I am really hot on PPE so always talking about aprons and gloves. Everyone works as a team here right from cleaners to management."

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and

safety and fire safety.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

There was a system in place to record any accidents or incidents that occurred. These would be reported directly to the registered manager so appropriate action could be taken. The time and place of any accident/incident was analysed to establish any trends or patterns and monitor if changes to practice needed to be made.

Is the service effective?

Our findings

People received care and support from staff who had the skills and knowledge to meet their needs. People said that staff knew their needs and preferences. One person said, "They know what they're doing and if I don't know what I am doing they show me." Another person said, "Yes, they all get training, they know how to hoist."

All new staff worked a probationary period and carried out a full induction including the providers mandatory training. The induction included information relating to the Care Certificate and gave new staff the chance to shadow more experienced staff. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. Staff confirmed they had spent time in induction training and shadowing other staff before working unsupervised. One staff member said, "I worked alongside experienced staff on Woodlands [the residential unit] and got to know people before I started working alone. It was really good the staff were all very supportive and didn't worry about me asking questions."

Staff received the training they required to safely fulfil their roles and effectively support people. All staff said the provision of training was good. They felt supported to obtain further training relevant to the needs of the people they supported. One staff member said, "I had an induction with [staff members name] for two weeks. As soon as I came in I did moving and handling practical training. I am now up to date with all my training." Another staff member said, "The training here is good. I have done manual handling training and that was delivered immediately. The training is updated frequently and we are offered opportunities to go on more training". The staff member continued to say they were undertaking specialist health and social care training. Records showed that staff had attended and received updates in the areas the provider considered mandatory training as well as training relating to people's specific needs such as dementia, diabetes and catheter care.

The provider also supported registered nurses to maintain their registration through continued personal development. Trained staff confirmed the provider supported them to keep up to date with their skills and personal development.

Staff confirmed they received support from the registered manager to discuss people's care needs and their training needs. Staff attended regular one to one supervision with senior staff and an annual appraisal. They also attended team meetings when wider issues could be discussed. One staff member said, "I have a supervision meeting with my senior regularly usually every month. If you have any concerns you can go to them anytime though." Another staff member said, "We have regular opportunities to talk with a senior in a one to one meeting and we have floor and full staff meetings."

Staff worked with other professionals to make sure people received the care and treatment they needed. A registered nurse was always on duty with care staff to ensure people's nursing needs were monitored and

met. People told us they had good access to healthcare professionals according to their individual needs. Care records showed people had access to a range of professionals to promote their health and well-being such as GPs, nurses, opticians and dieticians. Outside the kitchen, was a board which identified people's likes and dislikes, allergies or special dietary needs. The cook said when a new resident came in they went and asked them and their family what they liked and disliked. They also confirmed staff kept them up to date with people's changing needs.

People had their nutritional needs assessed and were supported to have a good diet. The staff sought appropriate advice regarding people's food and fluid needs and put recommendations into practice. Everybody spoken with was complimentary about the food served in the home. One person said, "I enjoy the food I have. There is always a choice." Another person said, "I am a fussy eater. But there is always a choice, if there is nothing I like on the menu they ask me what I would like instead and get it for me." A relative said, "I have observed [the person] enjoying a well-balanced meal. I have just had a meal with her and it was very tasty. Like a restaurant."

At the beginning of the inspection we saw the tables in the dining room were laid with tablecloths, napkins and wine glasses. We commented on this to people living in the home. One person said, "It's the way the new owner likes it to look, like a hotel." However, just before lunch was served we observed a member of staff take the tablecloths, napkins and glasses off the table and lay them with white napkins no tablecloth, no condiments and no wine glasses. The staff member said, "We do this every day, we have the special cloths and napkins for show." During the meal nobody was offered a glass of wine or beer. We spoke with the registered manager who told us, "The linen napkins are folded in a decorative way for display purposes during the day. These are removed prior to a mealtime and are replaced with plain folded napkins for residents to use. The only reason that the ornately displayed napkins are removed and then replaced with plain folded ones is so that, after a mealtime, the tables are easily and quickly dressed using the decorative napkins, that are always folded, without the need for staff to spend time folding them, leaving a nicely displayed dining room for our residents to enjoy at all times". They also confirmed tables were usually laid with tablecloths and condiments during mealtimes. One staff member on the second day of the inspection said, "They, [management] need to remember it is the resident's home and it should look more homely." On the second day of the inspection the tables were laid with a tablecloth and condiments were in place.

We observed mealtimes in the home and saw people were supported with dignity and respect. The lunchtime experience was relaxed and a social occasion with background music and some people's relatives joining them. People made their menu choices earlier in the day so a menu was not available on the table. Some people were asked if they would like salt or pepper and on the second day condiments were on the table. Everybody was offered a choice of water or squash with the meal. Some people chose not to go to the dining room for lunch. We saw they were supported in a timely manner to receive their food whilst still hot. One person said, "I prefer my own company and the lunch is always on time and well cooked." Some people also chose to use the dining area in the residential unit and we saw one person had forgotten their meal choice. The staff member explained what they had ordered but showed them what the alternative was as well so they could change their mind if they wanted to. One person said, "I didn't fancy anything on the menu. I just wanted a jacket potato which we saw them eating."

People only received care and support with their consent or in their best interests if they were unable to give consent. We heard staff asking people if they wished to be helped and staff respected their decisions. Care plans we looked at showed people's ability to make specific decisions had been assessed. Records showed how the staff had tried to involve people as far as possible in decision making. People told us they felt they maintained control over their care, one person said, "They [staff] always knock and wait for me to reply before coming in." Another person said, "I feel like I am involved in my care. They always respect my wishes

and ask me if things are ok." Another person said, "They [staff] are very good at understanding how you feel and get consent for everything, you have to nowadays you know."

Staff had received training about the Mental Capacity Act 2005 (MCA). 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff spoken with were aware of the need to assess people's capacity to make specific decisions. Where appropriate they had involved family and professional representatives to ensure decisions made were in people's best interests. Care plans contained assessments of people's capacity to make certain decisions and where necessary, a best interest meeting was held with appropriate people involved in their care and decision making.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made when necessary and the registered manager had followed up decisions with the local authority. When a DoLS application was accepted the registered manager completed the necessary notification to CQC.

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the day we saw staff spoke to people respectfully and showed kindness and patience when supporting them. Staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

People spoke positively about their relationships with staff. One person said, "They [staff] are all very kind and friendly, never too much trouble to do anything." Another person said, "I have always got on with them [staff]. They are kind and caring. I can't find anything wrong with them." One relative said, "I have no concerns at all. Very friendly and helpful all the time. I am really pleased with how [the person] is getting on." Another relative told us how they felt they had been supported throughout the admission process by the registered manager. They said, "He was there for us right from the start went over and above what we thought would happen and he is still helping us now with assessments, nothing is too much."

People's privacy and dignity were respected and their independence was promoted where possible. One person said, "They [the staff] always seem to respect me, they knock on the door and they never make me feel embarrassed when I am having a shower." Another person said, "They [the staff] really care and you can see that. They aren't in it for the money as there is not much of that in care. They come in and always ask me how I am and make me feel relaxed and comfortable."

We observed doors remained closed during care giving and witnessed staff knocking on doors before entering. People were able to choose who supported them with personal care. This was clearly recorded in people's care plans. Staff told us of people who preferred female care workers and they all knew to ensure this was respected.

Some people we spoke with were not sure about being involved in creating their care plans. One person said they had been involved in, "Something. I think we talked about what I would like the staff to do for me, but I don't bother with all that, as long as I am well cared for and fed and watered." Another person told us how they had been involved and consulted. They said, "I know what has been written and I have agreed it with the staff. They are good at keeping you involved." Relatives spoken with told us they had been involved and had been given the chance to comment on the way care was provided. One visiting relative said, "We were involved from the assessment at the start and we are still involved now. They are very good at keeping us informed. Communication is very good."

Is the service responsive?

Our findings

At the last inspection we found records had not always been completed accurately to reflect how and when care had been provided to people in the home.

At this inspection we found there had been an improvement in the way people's care plans were recorded and managed. Although some improvements were still required, the registered manager had identified this and had a plan of action to resolve it.

At this inspection we found staff were responsive to people's needs and wishes. They had a clear understanding of people's needs and how to meet them. People told us they were happy with the care and support they received. One person said,

People's care plans were entered onto an electronic system and staff could record interactions in real time. This meant that there were clear records of when people had eaten and how much, and when people had been repositioned. However, the system was not being used to its full potential. There were some inconsistencies in the recording of the care provided and omissions relating to equipment checking and detailing the changes to resident's care.

We sampled care plans from both the residential and nursing units. We found inconsistencies in the way the electronic system was being used. The care plans on the residential unit contained clear guidance for staff and supported a person-centred approach to providing care and support. For example, one person's care plan was clear about the way they had been involved in looking at a healthy diet to reduce further weight gain. Information was written in a way that ensured staff were aware of people's changing needs. However, the care plans on the nursing units lacked some details and were not always written in a person-centred way. For example, some care plans read as general actions and interventions which appeared to be set up by the electronic system. One care plan indicated the person experienced low moods but did not expand on what triggered this or how staff could support that person when feeling low. The registered manager had already identified that some staff were not using the electronic system to its full potential. This was being addressed through additional training, one to one supervision and staff meetings.

Regular reviews of care plans were carried out however the computerised system did not appear to evaluate the care provided in a structured and clear way. Evidence of reviews was available however changes were not always reflected in the care plan. For example, generated electronic statements were evident in some care plans which were not followed up with an impact or action for the person. However, we also saw some care reviews that had been written in a person-centred way and took the person's opinions into account. For example, one care review included a discussion with the person who had said they were happy with their care plan and had asked for it to be sent to their relative so they could comment and have a say before it was finalised.

During the inspection we observed staff respond to people's needs, one person became upset and staff spoke with them quietly and asked how they could help them. Another person was observed sat in their

room with a staff member singing songs and having a good time laughing and interacting with the staff member.

The home had developed a good working relationship with the local GP practices. There was a weekly GP round when care needs and medicines reviews could be carried out. The home was working closely with the GP to introduce Treatment Escalation Plans which clearly document people's and when appropriate family wishes relating to resuscitation status.

People could be confident that at the end of their lives they would be treated with compassion and any discomfort would be effectively managed. People were supported to make choices about the care they received at the end of their life. The staff worked closely with local healthcare professionals to ensure people's comfort and dignity at the end of their lives was maintained.

The registered manager and staff also took into consideration the feelings and emotions of the bereaved. We met with two relatives during the inspection who had lost a loved one. One relative said, "[The person] was well cared for in the last days and appeared pain free and comfortable. The staff also looked after me and made sure I was kept informed and they were very compassionate." Another relative said they had been encouraged to spend time with their loved one. The registered manager was aware the person was very upset and had invited them back to the home for support from staff in managing their grief.

There was an activities program available for people to attend if they wished. A programme of activities was delivered to people's rooms so they were aware of what was happening and when. People told us activities had improved. One person said, "I know they happen, but I choose not to go. I stay in my room, they do try and encourage me to go." Another person said, "'She [the activities co-ordinator] comes and has a chat with me, she's lovely." Whilst another person said, "I like my computer and I go out with good companions twice weekly, and I sit in the garden." However, one person said, "I think activities have declined we used to go out in the minibus but we don't do that anymore." There were no posters visible promoting activities or any photos of recent events such as the summer fete. However, the activities co-ordinator had a record of activities carried out and who had attended.

During the inspection we saw people take part in one to one activities and group activities. One person sat in the garden. The team leader on the residential unit explained how they had purchased an electronic doorbell so people could sit in the garden and still call staff if needed. The activities co-ordinator said they now had a second staff member to help them so had plans for the future. They also said the registered manager was very supportive and approachable. They had readily funded anything they planned to organise. One relative told us how their loved one did not like to join in activities but staff took him to the office with them where he would, "hire and fire staff all day."

The home was building relationships with the local community. Children from a local school had visited the home. People had enjoyed this and there were plans for the visits to continue in the new school year. The home also had connections with the local church and a local singing group visited. The activities co-ordinator had plans to build further relationships with local groups.

The registered manager told us they had organised a resident and staff party. Which included a BBQ and a karaoke. One staff member said it had been a fun evening. One person told us, "I really enjoyed the party I got to know some of the staff better as fun people rather than people working here."

The home had a complaints procedure which was prominently displayed and was routinely given to people when they moved in. We looked at the complaints procedure and found it was written in large print so

people with a visual impairment would be able to access the policy.

People and visitors said they would be comfortable to make a complaint if they were unhappy with any aspect of their care. Most people said they would speak to the manager or senior staff. One person said, "I know how to complain and I would if there was anything to complain about." Another person said, "I complained about the light in my room and [the registered manager] sorted it out straight away." One relative said, "If I thought I needed to raise anything I would go straight to [the registered manager] he seems approachable and would listen."

We discussed with the staff how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff told us they used a variety of ways to communicate information depending on the person. We looked at the care plan for one person who could experience some difficulty in understanding. It was very clear about the way staff could ensure they made an informed choice. The care plan stated, "[The person] sometimes does not understand but if carers write notes it helps. Sometimes likes things written down." Other information could also be provided in either; easy read versions, large print or verbally recorded. At the time of the inspection everybody's first language was English. Translations of documents could be obtained for people whose first language was not English.

Is the service well-led?

Our findings

At the last inspection we found the systems in place to identify shortfalls and drive improvement was not robust in ensuring areas of weakness potentially impacting on the quality of care were addressed.

At this inspection we found people benefitted from a service that was well led. There was a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found the systems in place to monitor the quality of the service provided had improved. There were effective quality assurance systems operated by the registered manager, regional manager and a mentor from another home within the organisation who supported the registered manager. These included regular audits, surveys and meetings with people living in the home, their relatives and staff. The systems in place looked at areas to improve to ensure the care provided for people was consistent and met their needs. Senior management completed audits of topics including medicine administration, night care and care plan reviews. In addition, they completed weekly and daily checks, such as reviewing nutrition, hydration and re-positioning records, and ensured medical equipment was fully functioning.

We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, following the last inspection the registered manager had looked at why staff levels had appeared to have an adverse impact on the care and support provided. Following discussion with staff at all levels it was agreed that staff spent a lot of time, 'running between floors,' as there was a mix of residential and nursing care on all floors. It was agreed that one floor would be dedicated to residential care. This meant staff were better deployed throughout the home. Staff said they could concentrate on the area they were working in and they had more time to spend with people. This showed the registered manager listened to staff and acted to improve the provision of care in the home.

Systems in place were being used effectively to identify and drive improvements in the home. Issues raised had been managed through training for staff and team managers. For example, the registered manager had already identified the shortfalls in using the electronic system effectively and had arranged staff training and supervision to address this specific shortfall.

People told us they felt the home was well led. People, relatives and staff told us the registered manager had an open and transparent approach to managing the home. One person said, "I know the manager well. Always been ok with me. He walks around. I think the manager listens and would try and resolve a problem." One relative said, "We have seen [the registered manager] in all roles even as a nurse joining in and getting the work done. He was very open and there have been meetings about future plans."

Staff told us the registered manager was ready to listen and act on suggestions. One staff member said, "[The registered manager] is a good manager. He is lovely and approachable. If you have any problems you

can get to him." Another staff member said, "I am really happy with the management of the home. Since last year they have improved a lot making connections with staff. We feel somebody is supporting us. Any kind of problem and we can go to [the registered manager]." All the staff spoken with said they were proud to work at the home and felt the registered manager had instilled a team spirit. One staff member said, "I love it here. Good variety of work on all different floors. It's brilliant. Good staff and good bosses. [The registered manager] always listens and is approachable."

People and their relatives or people important to them were involved and engaged with by staff and the management team. One relative said, "I have been coming here for a number of years now and seen a lot of changes. The management is far better and communication has improved. We can come to resident and relative meetings if we want to and be involved in their plans for the future." Another relative said, "It has really changed we are involved more and I believe they listen. It seems better organised." One person however, said they had been to a residents meeting but didn't feel things had changed much. They then said they felt they could talk to staff and that the registered manager would listen.

The registered manager and provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the Duty of Candour. The Duty of Candour is a legal obligation to act in an open and transparent way in relation to care and treatment. A copy of the home's policy and procedure for the Duty of Candour was available for people, staff and visitors to read. This demonstrated the organisation's approach to being open and transparent.

Staff confirmed that a system of one to one supervision meant they could discuss training needs and any issues regarding the care and support they provided or the running of the home. This also gave the registered manager the opportunity to share best practice training and guidelines with staff either on a personal basis or in group supervision.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The management team attended local provider groups which enabled them to keep up to date with local initiatives and share good practice with their own staff and other providers. The management team also kept their skills and knowledge up to date, through research and training, and through manager meetings within the organisation when they could share what went well and what they did about things that did not go so well. The registered manager was also supported by a mentor who was a registered manager from another home within the organisation.

The registered provider ensured the home was run in line with current legislation and good practice guidelines. There were up to date policies that were available to all staff to make sure they had the information they required to provide safe and effective care.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.