Nellsar Limited

The Old Downs Dementia Residential Care Home

Inspection report

Castle Hill
Hartley
Dartford
Kent
DA3 7BH

Tel: 01474702146
Website: www.nellsar.com

Date of inspection visit:
08 August 2017

Date of publication:
18 September 2017

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 08 August 2017 and was unannounced.

The Old Downs Residential Care Home provides accommodation and support for up to 41 people living with dementia. It is set within its own grounds in the village of Hartley, close to Dartford, Kent. At the time of our visit, there were 35 people who lived in the service.

There was a new registered manager at the service. The new registered manager started in May 2017. 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.

At our previous inspection on 08 June 2016, we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People's medicines were not always managed safely. Appropriate procedures were not followed in managing covert medicines and medicine risk assessments were not carried out. Malnutrition Universal Screening Tool (MUST) records were not always completed to identify adults who are malnourished, at risk of malnutrition (under nutrition) or obese. We asked the provider to submit an action plan by 07 September 2016. However, due to the registered manager leaving her position, we did not receive an action plan.

At this inspection, we found that the provider had met the breach of the regulation.

Medicines were stored and administered safely. Clear and accurate medicines records were maintained. Staff knew each person well and had a good knowledge of the needs of people who lived at the service. Malnutrition Universal Screening Tool (MUST) records for five people we looked at were fully completed.

There were effective systems in place to monitor and improve the quality of the service provided. We saw that various audits had been undertaken.

The registered manager had systems in place to manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. All of the people who were able to converse with us said that they felt safe in the service; and said that if they had any concerns they were confident these would be quickly addressed by the registered manager. Relatives felt their people were safe in the service.

The service had risk assessments in place to identify risks that may be involved when meeting people's needs. The risk assessments showed ways that these risks could be reduced. Staff were aware of people's individual risks and were able to tell us about the arrangements in place to manage these safely.

There were sufficient numbers of qualified, skilled and experienced staff to meet people's needs. Staff were

not hurried or rushed and when people requested care or support, this was delivered quickly. The provider operated safe recruitment procedures.

Training records showed that all staff had completed training in a range of areas that reflected their job role, such as essential training they needed to ensure they understood how to provide effective care, and support for people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The registered manager understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and the service complied with these requirements.

The food menus offered variety and choice. They provided people with a nutritious and well-balanced diet. The cook prepared meals to meet people's specialist dietary needs. Both people and relatives told us they were happy with the food in the service.

People were involved in their care planning, and staff supported people with health care appointments and visits from health care professionals. Care plans were amended immediately to show any changes, and care plans were routinely reviewed every month to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed. Staff encouraged people to make their own choices and promoted their independence.

People knew who to talk to if they had a complaint. Complaints were managed in accordance with the provider's complaints policy.

People's needs were fully assessed with them before they moved to the service to make sure that the service could meet their needs. Assessments were reviewed with the person and their relatives. People were encouraged to take part in activities and leisure pursuits of their choice.

People spoke positively about the way the service was run. The management team and staff understood their respective roles and responsibilities. Staff told us that the registered manager was very approachable and understanding.

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.

There were appropriate safeguarding adults procedures in place and staff had a clear understanding of these. Risks to people's safety and welfare were assessed and managed effectively.

There were enough staff employed to ensure people received the care they needed and in a safe way.

There were effective recruitment procedures and practices in place and being followed.

Medicines were safely stored and administered to people.

Is the service effective?

Good

The service was effective.

Staff had received regular supervision from their line manager to ensure they had the support to meet people's needs.

People's rights were protected under the Mental Capacity Act 2005 (MCA) and best interest decision made under the Deprivation of Liberty Safeguards (DoLS).

People were supported effectively with their health care needs.

People were provided with a choice of nutritious food.

Is the service caring?

Good

The service was caring.

The registered manager and staff demonstrated caring, kind and compassionate attitudes towards people.

People's privacy was valued and staff ensured their dignity.

People and relatives were included in making decisions about their care. The staff in the service were knowledgeable about the support people required and about how they wanted their care

to be provided.

Is the service responsive?

Good

The service was responsive.

People's needs were fully assessed with them before they moved to the service to make sure that the staff could meet their needs.

The management team responded to people's needs quickly and appropriately whenever there were changes in people's need.

The provider had a complaints procedure and people told us they felt able to complain if they needed to.

Is the service well-led?

Good

The service was well led.

The service had an open and approachable management team. Staff were supported to work in a transparent and supportive culture.

The provider had a clear set of vision and values, which were used in practice when caring for people.

There was a robust staffing structure in the service. Both management and staff understood their roles and responsibilities.

There were effective systems in place to monitor and improve the quality of the service provided.

The Old Downs Dementia Residential 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.

This inspection took place on 08 August 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor who was a mental health trained nurse, with significant experience in elderly care and an expert by experience. Our expert by experience had knowledge and understanding of older people residential services and dementia care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications about important events that had taken place in the service, which the provider is required to tell us by law. We used all this information to help us plan our inspection.

Not everyone was able to verbally share with us their experiences of life at the service. This was because of their complex needs. We therefore spent time observing people and how care was delivered and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

However, we were able to speak with seven people, four relatives, a visiting friend, four members of staff, a senior care staff, cook, business support officer and the registered manager. We also spoke with the visiting operations manager and two healthcare professionals. We contacted health and social care professionals including the local authorities' care managers, and GP to obtain feedback about their experience of the

service.

We looked at the provider's records. These included five people's records, which were care plans, health care notes, risk assessments and daily records. We looked at five staff files, a sample of audits, satisfaction surveys and policies and procedures. We also looked around the care service and the outside spaces available to people.

We asked the registered manager to send additional information after the inspection visit, including training records, staff rotas, business plan and some contact telephone numbers. The information we requested was sent to us in a timely manner.

Good

Is the service safe?

Our findings

At our last inspection on 08 June 2016, we identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 'Safe care and treatment'. People's medicines were not always managed safely. Appropriate procedures were not followed in managing covert medicines and medicine risk assessments were not carried out. Malnutrition Universal Screening Tool (MUST) records were not always completed to identify adults who are malnourished, at risk of malnutrition (under nutrition) or obese. At this inspection, we found improvements had been made to medicine administration, medication risk assessments and the Malnutrition Universal Screening Tool (MUST) records for people living in the service. The provider was now meeting the requirements of the regulations.

Our observation showed that people were safe at the service. One person said, "I feel very safe here. No problems with staff".

Relatives felt their family members were safe in the service. One relative said, "My mother has a mat under her bed. Staff do check on her every two hours at night to keep her safe". Another relative said, "Yes, staff keep her safe when supporting her. This wasn't easy as she was very anxious at the beginning but staff were attentive and spent time with my mother. When I go home, I am never worried and staff keep me informed".

A healthcare professional commented, "I have been coming to this service for about 15 years. During these visits, I have never had any concerns regarding the care received and feel it is safe".

People were protected from the risks associated with the management of medicines. Any identified risks had been considered and medication risk assessments recorded how to manage these risks to promote people's safety and well-being. Risk assessments were scored and gave an overall level of risk, which was then addressed appropriately. Pre-admission assessment documentation also formed part of how risk was assessed with previous needs and requirements noted from the point of admission and staff were able to speak with knowledge on people's needs and the possible risks posed to them. A member of staff said, "If I have any concerns about someone's medicines, I will seek advice from the GP". There were guidance for staff on the handling of medicines on the notice board in the medication room.

We saw that there was a policy in place for the management of covert medicines if and when required in the service. The policy clearly stated steps to be taken if and when covert medicine administration would be needed. The policy referred to an assessment of mental capacity as specified in the Mental Capacity Act 2005 (MCA 2005). The Act stated that a mental capacity assessment should always be completed before the use of covert medication is considered and the National Medical Council (NMC) guidelines should be followed when deciding whether it is appropriate to administer medicines covertly. The registered manager told us that there was no one currently being given medicines covertly in the service.

People were given their medicines in private to ensure confidentiality and appropriate administration. The medicines were given at the appropriate times and people were fully aware of what they were taking as staff explained this to them. We observed a senior care staff administering people's medicines during the

service's lunchtime medicine round. The senior care staff checked each person's medication administration record (MAR) prior to administering their medicines. The MAR is an individual record of which medicines are prescribed for the person, when they must be given, what the dose is, and any special information. People were encouraged to be as independent as possible with their medicines. Medicines were given safely.

Medicines were kept safe and secure at all times. Unwanted medicines were disposed of in a timely and safe manner. A lockable cupboard was used to store medicines that were no longer required. Accurate records were kept of their disposal with a local pharmacist and signatures obtained when they were removed. We saw records of medicines disposed of and this included individual doses wasted, as they were refused by the person they were prescribed for. Fluid thickener, which was used to thicken drinks to help people who have difficulty swallowing, was kept locked away in the cupboard in another locked storage room for safety. This demonstrated that the provider ensured medicines were kept safe.

There was a system of regular audit checks of medication administration records and regular checks of stock. The registered manager and deputy manager conducted a monthly audit of the medicine used. This indicated that the provider had an effective governance system in place to ensure medicines were managed and handled safely.

We looked at Malnutrition Universal Screening Tool (MUST) records for five people. A MUST record identifies adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. We found in people's care plans that these were fully completed. For example, information such as BMI or percentage of weight loss were completed in order for the assessment to determine risk likelihood. The registered manager had a meeting with the nutrition therapist in July 2017 in order to further reduce the likelihood of risk of malnutrition in the service. We found that four out of five people's records showed constant weight. The MUST record enabled the registered manager to refer one person to the dietician, which resulted into the introduction of fortified drink for the person. Fortifying is the addition of high calorie and high protein ingredients into drink or food. This led to weight gain for the person. The registered manager had also created a new staff position of nutrition champion in the service to oversee people's nutritional needs. This meant that people's nutritional needs were being met and advice was sought around eating and drinking.

The provider had taken reasonable steps to protect people from abuse. There were systems in place to make sure that safeguarding alerts were raised with other agencies, such as the local authority safeguarding team, in a timely manner. Care staff told us they would tell the manager or deputy manager of any safeguarding issues. A member of staff said, "I know my residents, and I would have no problem reporting or even whistleblowing if I saw something wrong".

Staff told us that they had received safeguarding training at induction and we saw from the training records that all staff had completed safeguarding training in April 2017. Staff were aware of the different types of abuse, what would constitute poor practice and what actions needed to be taken to report any suspicions of abuse that may occur. A member of staff said, "Safeguarding is about keeping people safe from abuse. I will report any suspicion to the manager and I can whistle blow if nothing was being done about it". Staff told us the registered manager would respond appropriately to any concerns. Staff knew who to report to outside of the organisation and gave the example of CQC. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. Staff told us that they felt confident in whistleblowing (telling someone) if they had any worries. The service had up to date whistleblowing policies in place. These policies clearly detailed the information and action staff should take, which was in line with expectations. This showed that the provider had systems and processes in place that ensured the protection of people from abuse.

People had individual care plans that contained risk assessments which identified risk to people's health, well-being and safety. Risk assessments were specific to each person. Staff told us they were aware of people's risk assessments and guidelines in place to support people with identified needs that could put them at risk, such as advanced dementia. For example, people who had been assessed as requiring support with dementia had a risk assessment in place which gave instructions to the staff as to how to manage this. Risk assessments were regularly reviewed and updated in line with people's changing circumstances. For example, where people were identified as at risk of falls, specialist equipment such as shower chairs had been obtained. Guidance was provided to staff on how to manage identified risks. This ensured staff had all the information they needed to help people to remain safe.

We spoke with a member of staff and the registered manager about how risks to people's safety and well-being were managed. They both were able to tell us how they put plans in place when a risk was identified. The member of staff described the action they had taken to minimise the risk of falling for one person who had had a number of falls. They told us they had contacted healthcare professionals for advice and also made a referral to the 'falls clinic'. A falls clinic is a medical clinic whose specialist staff assess people who have been falling. The staff at the clinic advise what measures to put in place to minimise the risks to people and help to prevent falls. There was a clear plan in place which staff were aware of and used. A relative confirmed this and said, "My father had no falls since moving in here".

There were suitable numbers of staff to care for people safely and to meet their needs. The registered manager showed us the staff duty rotas and explained how staff were allocated to each shift. The rotas showed there were sufficient staff on shift at all times. As lunch time was a busy period in the service, the registered manager had also created a new position titled 'Dining room assistants', who had been newly recruited. This was to ensure that there were enough staff to safely cater for people's needs at lunch time. The registered manager said that if a member of staff telephones in sick, the business support officer or themselves would step in and provide direct support. This showed that arrangements were in place to ensure enough staff were made available at short notice. The registered manager told us that the rota is based on the needs of people. They said, "We look at the needs of people re allocation of staff and the number on each shift". Staffing levels were regularly assessed depending on people's needs and the occupancy levels in the home, and adjusted accordingly. This demonstrated that the registered manager had staffing levels based on people's needs in order to keep them safe.

Safe recruitment processes were in place. Staff files contained all of the information required under Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Appropriate checks were undertaken and enhanced Disclosure and Barring Service (DBS) checks had been completed. The DBS checks ensured that people barred from working with certain groups such as vulnerable adults would be identified. A minimum of two references were sought and staff did not start working alone before all relevant checks had been completed. Staff we spoke with and the staff files that we viewed confirmed this. This showed that the provider had followed a safe recruitment process.

Each care plan folder contained an individual Personal Emergency Evacuation Plan (PEEP) reviewed in 2017. A PEEP is for individuals who may not be able to reach a place of safety unaided or within a satisfactory period of time in the event of any emergency. The fire safety procedures had been reviewed and the fire log folder showed that the fire risk assessment was recently reviewed in 2017. Fire equipment was checked weekly and emergency lighting monthly. Fire drills took place monthly and staff recorded those people present. Staff had completed a fire competency assessment.

There was a plan for staff to use in the event of an emergency, for example, in the event of a fire. This included an out of hour's policy, including weekends and bank holidays and arrangements for people which

was clearly displayed in care folders. The staff we spoke with during the inspection confirmed that the training they had received provided them with the necessary skills and knowledge to deal with emergencies. We found that staff had the knowledge and skills to deal with foreseeable emergencies.

The design of the premises enhanced the levels of care that staff provided because it was spacious, well decorated and had been suitably maintained. Corridors had good lighting and were very clean and fresh.

Good

Is the service effective?

Our findings

Most people were unable to verbally describe their experiences. However, one person said, "Very good here. It is a nice atmosphere". We observed that people had the freedom to move around the service and spend time alone in their rooms as well as in communal areas. People appeared relaxed in the company of staff.

One relative said, "Staff are very good and very knowledgeable. I go to them if I have any concerns". Another said, "Yes, staff are dedicated to the people and we appreciate what they do here. Everybody has something different and the staff know them all".

A Healthcare professional commented as follows, "I have to communicate with the service with regards to appointments and changes of treatment and this has been most effective with no problems to identify. They cooperate with us".

All staff completed training as part of their probationary period. New staff had the provider's comprehensive induction records which they worked through during their probationary period. Staff told us that they were mentored by both the deputy manager and the registered manager to help them to complete their induction. Staff were confident that by the end of their induction period they had attained the skills and knowledge to be able to care for the people living in the service. These skills were built upon with further experience gained from working in the service, and through further training. Staff told us that their training had been planned and that they could request further specialist training if needed.

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people living in the service. Training records evidenced that staff had received training relevant to their roles. Some staff had completed vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. Staff received refresher training in a variety of topics, which included health and safety, fire safety, safeguarding and food hygiene. All trainings were up to date with refresher training planned for 2018. This showed that all staff had been trained to work towards expected standards of caring effectively for people.

Staff were supported through individual one to one supervision meetings. This was to provide opportunities for staff to discuss their performance, development and training needs, which the manager was monitoring. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. A member of staff said, "I am a lot happier than before. It is great coming to work now. This is due to the support I get from my manager". This showed that the registered manager adhered to the provider's policy in ensuring staff received adequate support.

Yearly appraisals were carried out and reviewed on all staff performance. For example, one member of staff was identified to benefit from additional training. This was actioned and planned for by the registered manager. This would enable staff to improve on their skills and knowledge which would ensure effective delivery of care to people. Records confirmed that supervision and annual appraisals had taken place.

There were procedures in place and guidance was clear in relation to the Mental Capacity Act 2005 (MCA 2005) that included the steps staff should take to comply with legal requirements. The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Guidance was included in the policy about how, when and by whom people's mental capacity should be assessed. Staff had attended MCA 2005 and Deprivation of Liberty Safeguards (DoLS) training. Staff evidenced that they had a good understanding of the MCA 2005 and DoLS. One staff member explained that every person has some capacity to make choices. They gave examples of how they supported people to make choices about what they wear, ate and how they spent their time. The registered manager was able to describe how capacity was tested and how a person's capacity impacted on decisions. They could all describe how and why capacity was assessed. The registered manager said, "We carried out an MCA 2005 assessment of less complex needs. For example, when we felt one person required a bed side rail, we carried out an MCA 2005 assessment, which showed that the person was unable to provide consent. Then we carried out a best interest meeting. After this it was decided that we should put a bed rail in place in the best interest of the person. We also applied for DoLS because it was a restriction". This showed that the registered manager understood the MCA 2005 processes and its implementation.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. People in the service were currently subject to a DoLS. There were good systems in place to monitor and check the DoLS approvals to ensure that conditions were reviewed and met. The registered manager understood when an application should be made and how to submit one and was aware of a Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty as indicated above. We observed that staff sought and obtained people's consent before they helped them. For example, at lunch time, people were asked if they would like to have their lunch in the dining room or in their rooms. Some opted for the dining room, while some had their lunch in their rooms.

The risks to people from dehydration and malnutrition were assessed so they were supported to eat and drink enough to meet their needs. People who had been identified as at risk had their fluid and food intakes monitored and recorded. Records of allergies were kept in people's care plans. We saw this in the kitchen food plan adhered to by the kitchen staff. Staff responded to concerns about people's weight or fluid intake by seeking advice and additional support from people's general practitioner (GP), specialist nurses and dieticians. For example, one person was provided with a soft diet and staff helped them while eating to ensure risks of choking were reduced. Hot and cool beverages and snacks were offered to people by staff upon request.

Staff told us how they encouraged people to eat and drink. One said, "If someone did not eat their food I would always go back and offer them something different." Another said, "People get plenty of food and they are offered snacks at other times"; "People can get food and drink during the night if they want it, like tea and toast". We observed that people who were awake early in the morning were offered drinks and snacks.

Relatives were very positive about the quality of the food, choice and portions. One relative said, "A very good nutritional system. They take into consideration what residents want to eat and can eat". We observed lunch in the dining room where all the people were offered a choice. The food was served hot straight from the kitchen, looked and smelt appetising and the portions were generous. Staff worked with the cook as a team to ensure meals were delivered quickly and hot. Special requests and special dietary requirements were plated up separately. Other options were immediately available should anyone change their mind or

want something not on the menu. There was a pleasant atmosphere in the dining room and it was evident that people enjoyed the food. The cook was aware of the dietary requirements of people and was very actively involved in the delivery of the food and service. Diabetic desserts were available for those with diabetes. The cook told us that they provided a variety of food and special needs/requests such as a soft diet like pureed food and a diabetic diet for diabetic people were taken care of. The cook also confirmed that they fortified meal for the people who required this as advised by the Speech and Language Team (SALT). This showed that staff ensured people's specific nutritional needs were met.

The doctor visited when requested and people's treatment was reviewed and changed if necessary according to their medical condition. The community nurses and other healthcare professionals supported the service regularly. A relative said, "They call the doctor out whenever needed. They inform me at home. For example, they had the Speech and Language Therapy team came into assess her and recommended the fluid thickener, which is being used. Also, they called in an eye doctor because of a concern for spectacles".

Records confirmed that there were systems in place to monitor people's health care needs, and to make referrals within a suitable time frame. The health records were up to date and contained suitably detailed information. Staff implemented the recommendations made by health professionals to promote people's health and wellbeing. Staff described the actions they had taken when they had concerns about people's health. For example, they maintained soft diets for people with swallowing difficulties and repositioned people who were cared for in bed on a regular basis to minimise the risk of pressure ulcers developing. A member of staff said, "We take pressure sores seriously. Sometimes people come with them, but we work hard to ensure they are healed or stop them getting worse. We don't have any problems at the moment''.

Good

Is the service caring?

Our findings

One person told us that staff were caring. They said, "The staff are fine".

One relative said, "Absolutely, they (staff) treat my family member with kindness and compassion. They (staff) are so happy, always laughing and smiling. This puts the residents at ease, you don't want grumpy staff". Another said, "Staff always go to my mother and would ask if she is alright. They (staff) sit with her when I'm leaving for home. They (staff) are very supportive".

A healthcare professional commented, 'I have always found the staff very helpful and accommodating to people they cared for. They spend time with people now unlike before'.

We spent time and observed how people and staff interacted. Staff were seen to be kind and caring throughout our visit. The care that was provided was of a kind and sensitive nature. Staff responded positively and warmly to people. Staff checked on people's welfare when they preferred to remain in their bedroom or not to take part in the activities. Staff provided reassurance for a person who was anxious during mealtime. A member of staff sat next to them gently speaking and feeding the person, which provided comfort and reassurance. This showed that staff were knowledgeable about how to care for the person.

People were supported to make sure they were appropriately dressed and that their clothing was arranged to ensure their dignity. Staff were seen to support people with their personal care, taking them to their bedroom or the toilet/bathroom if chosen.

Staff provided clear explanations to people before they intervened, for example when people were helped to move from an armchair to their wheelchair using specialised equipment. Staff checked at each stage of the process that people were comfortable and knew what to expect next. People were presented with options, such as participating in a group or one to one activity, have a cup of tea, read their newspaper or walk with the staff. Staff checked with people if they wished to visit the toilets at regular intervals and offered to accompany them. We observed that staff were interested in what people had to say and were actively listening to them.

Staff promoted independence and encouraged people to do as much as possible for themselves. People were dressing, washing and undressing themselves when they were able to do so. They had choice about when to get up and go to bed, what to wear, what to eat, where to go and what to do according to their care plan. Their choices were respected. Staff were aware of people's history, preferences and individual needs and these were recorded in their care plans. Times relating to people's routine were recorded by staff in their daily notes. As daily notes were checked by senior staff any significant changes of routine were identified and monitored to ensure people's needs were met.

People were able to spend private time in quiet areas when they chose to. Some people preferred to remain in a quieter sitting area when activities took place in the main lounge. For example, one person came to sit

next to inspectors in the living room and chatted with us. This showed that people's choices were respected by staff.

Staff addressed people by their preferred names and displayed a polite and respectful attitude. They knocked on people's bedroom doors, announced themselves and waited before entering. People chose to have their door open or closed and their privacy was respected. People were assisted with their personal care needs in a way that respected their dignity. Staff covered people with blankets when necessary to preserve their dignity.

People were involved in their day to day care. One member of staff said, "We talk to people and try and see how to help them choose what they like to eat; we try and involve them as much as we can. You have to be patient as some people don't like to eat much". People's relatives or legal representatives were invited to participate each time a review of people's care was planned. People's care plans were reviewed monthly by senior staff or whenever needs changed.

The registered manager told us that advocacy information was available for people and their relatives if they needed to be supported with this type of service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. People told us they were aware of how to access advocacy support. Advocacy information was on the notice board for people in the service.

Good

Is the service responsive?

Our findings

One person said, "We have a good level of activities here every day. I enjoy gardening and we have a gardening club".

One relative said, "The service has the bus and take the residents out to garden centres and parks. Last year I bought a van and took (named relative) out". Another said, "My family member doesn't like participating much but will get up and dance occasionally. They like to sit back and watch and staff respect that".

People's individual assessments and care plans were reviewed with their participation or their representatives' involvement. A relative told us, "We are informed and involved every step of the way".

Each person's physical, medical and social needs had been assessed before they moved into the service and communicated to staff. Pre-admission assessment of needs included information about people's life history, likes, dislikes and preferences about how their care was to be provided. Care plans were developed and maintained about every aspect of people's care and were centred on individual needs and requirements. This ensured that the staff were knowledgeable about people's individual needs from the onset.

People's care plans included risk assessments with clear recommendations to staff about how to reduce the risk that was identified. For example, a person who likes to leave the premises abruptly was provided with additional staff support when they stepped outside of the building so they could provide help and reassurance. We observed one person in the morning being supported by both the registered manager and staff outside the building in response to their behaviour, which could put them at risk. Care plans were reviewed monthly or as soon as people's needs changed and were updated to reflect these changes to ensure continuity of their care and support. For example, a care plan had been updated to reflect a change of medicines following a G.P.'s visit and a review of their care. This showed that management and staff responded to people's changing needs whenever required.

Staff ensured that people's social isolation was reduced. Relatives and visitors were welcome at any time and were invited to stay and have a meal with their family member. A relative said, "We are encouraged to keep in contact by phone, visits, meals and birthday celebrations. Another said, "I visit regularly and I am always welcomed".

We found that staff worked in a variety of ways to ensure people received support they needed. Equality and diversity was covered in people's care plans and it detailed people's preferences and individuality. For example one person liked to be called a certain name at certain times and other times, another name. One person said, "They call us by our Christian names, which is good". We observed that staff called them these preferred names. Religious and cultural needs were also taken into consideration. People attended services with a visiting vicar in the service when they wished. A relative said, "If the vicar comes in, they will do some singing, which is good".

People were able to express their individuality. Bedrooms reflected people's personality, preference and taste. For example, some rooms contained articles of furniture from their previous service, where they lived before and people were able to choose furnishings and bedding. This meant that people were surrounded by items they could relate with based on their choice.

Activities took place daily. The activities coordinator consulted people and took their preferences and suggestions into consideration before planning the activities programme. There were group activities and one to one sessions for people who preferred or who remained in their room. Activities included card games, identification of photographs and reminiscence, bowling, exercise, music, dancing and arts and craft. One to one sessions included arms and hands massages, pampering sessions for nail painting, reading aloud and sing-along. The activities coordinator organised activities for each month. During our visit, the activities coordinator carried out pampering sessions for people. The registered manager told us that this took place two days every week. There was a weekly activities timetable displayed on the notice board. Activities were person-centred. People were able to express their wishes, choices and interests.

The provider contacted other services that might be able to support them with meeting people's mental health needs. This included the Speech and Language Therapist (SaLT) teams. The provider had referral procedure in place which demonstrated the provider promoted people's health and well-being. Information from health and social care professionals about each person was also included in their care plans. There were records of contacts such as phone calls, reviews and planning meetings. The plans were updated and reviewed as required. Contact varied from every few weeks to months. This showed that each person had a professional's input into their care on a regular basis.

The provider used an annual questionnaire to gain feedback on the quality of the service. These were sent to people living in the service, staff, health and social care professionals and relatives. The registered manager told us that completed surveys were evaluated and the results were used to inform improvement plans for the development of the service. The relatives feedback received for 2017 were generally positive. Where needed action plans had been developed to provide for suggestions made. For example, a healthcare professional had commented, 'Waiting time is an issue'. The registered manager explained that this related to when a District Nurse had finished with one person, there may be a wait for them to be collected and the next person brought to them. We found that the registered manager had reviewed this and put action plan in place, which was 'To ensure that there is a member of staff available to be with the District Nurse or to leave a hands free phone from the administrative office with the District Nurse so they can call the senior staff on shift straight away when they have finished'. This showed that the registered manager was proactive in listening and putting required action/s in place to improve the service.

The complaints process was displayed in one of the communal areas so all people were aware of how to complain if they needed to. The information about how to make a complaint had also been given to people when they first started to receive the service. The information included contact details for the provider's head office, social services, local government ombudsman and the Care Quality Commission (CQC). One complaint was received in the last 12 months before this inspection. This was satisfactorily resolved by the registered manager.

Staff told us that they would try to resolve any complaints or comments locally, but were happy to forward any unresolved issues to the registered manager. People told us that they were very comfortable around raising concerns and found the registered manager and staff were always open to suggestions; would actively listen to them and resolved concerns to their satisfaction. A relative told us, "If I had reason to complain I would just talk with the manager and this will be sorted straight away". We saw complimentary messages sent to the registered manager and staff. These included comments such as, 'A great big thank

you. We will never forget how amazing you are!'

Good

Is the service well-led?

Our findings

At our last inspection on 08 June 2016, we identified there were processes in place to monitor the quality of the service. However, improvements were needed as these were not always effective. Records demonstrated regular audits were carried out at the service to identify any shortfalls in medicines but the provider was unable to identify the issues we found at our inspection including the safe management of medicines, medicine risk assessments and completion of MUST records.

At this inspection, we found improvements had been made to the quality assurance system of the service. There were effective systems in place to monitor and improve the quality of the service provided. Records were detailed, clear and risk assessments were in place.

We found that the registered manager understood the principles of good quality assurance and used these principles to critically review the service. The operations manager visited the service every month to carry out a monthly audit. The registered manager had effective systems in place for monitoring the service, which they fully implemented. They completed monthly audits of all aspects of the service, such as medicines, care plans, nutrition, health and safety and risk assessments for staff. They used these audits to review the service. Audits routinely identified areas that could be improved upon and the registered manager produced action plans, which clearly detailed what needed to be done and when action had been taken.

There were systems in place to manage and report accidents and incidents. Accident records were kept and audited monthly by the registered manager to look for trends. This enabled the staff to take immediate action to minimise or prevent accidents. These audits were shown to us as part of their quality assurance system. The registered manager said, "We record all incidents and I investigate and also feedback to my line manager during my supervision regularly".

Some people were unable to verbally tell us about their experiences. We observed that people knew staff including the head of care and the registered manager. Relatives told us the service was well led. One relative said, "The service is well run because there seems to be enough staff day and night. Members of staff are well organised. They (staff) seem to know people very well and their capabilities. They (staff) try to include us (the family). The manager seems very nice and proactive. She knows all the residents and wants to make good changes". Another said, "This is more like a homely home and the staff make it like that. It has a homely feel about it, it is nice and clean. I like the manager because they are out and about speaking to people and approachable".

The registered manager inspired the staff to maintain good standards of practice by setting examples for staff to follow. The staff told us, "She is approachable; I can go to her at any time", "We work as a team, we support each other" and "They give us information and guidance. We get support from them. I can walk into the manager's office at any time".

The provider had a clear set of values. This stated 'We believe every one of the individuals we support deserves dignity, choice and independence, as these values lay the foundations for a high quality of life'. Our

observations showed us that these values had been successfully cascaded to the staff who worked in the service. Staff demonstrated these values by meeting people's needs based on their assessed needs. People told us that it is a home from home for them.

The management team at the service included the registered manager and support was provided to the registered manager by the operations manager, in order to support the service and the staff. The registered manager oversaw the day to day management of the service. The registered manager knew each resident by name and people knew them and were comfortable talking with them. The registered manager told us they were well supported by the operations manager who provided all necessary resources necessary to ensure the effective operation of the service. The operations manager supported the registered manager with our inspection. The registered manager said, "The operations manager has been fantastic with providing support to me. Other managers from other services too for peer support are good. This made my last three months in post positive". We observed the presence of the operations manager in the service and found people chatting with them. This showed that the registered manager and staff were well supported by the provider.

Staff understood their roles and responsibilities and told us they worked well as a team. They were able to describe these well and were clear about their responsibilities to the people and to the management team. A member of staff said, "My responsibility is to meet the needs of the people we care for. If we are unable to for any reason, I will speak with my line manager". The staffing and management structure ensured that staff knew who they were accountable to.

Communication within the service was facilitated through weekly and monthly management meetings. This provided a forum where clinical, maintenance, catering, activities and administration lead staff shared information and reviewed events across the service. Staff told us there was good communication between staff and the management team.

The service worked well with other agencies and services to make sure people received their care in a cohesive way. Healthcare professionals we contacted told us that the service always liaised with them. A healthcare professional told us that staff worked well with them at all times. This showed that the management worked in a joined up way with external agencies in order to ensure that people's needs were met.

Staff had access to a range of policies and procedures to enable them to carry out their roles safely. The policies and procedures had been updated by the management team and cross referenced to new regulations.

The registered manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that required a notification. We used this information to monitor the service and to check how any events had been handled. This demonstrated the registered manager understood their legal obligations.