West Berkshire Council

Walnut Close

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

We inspected Walnut Close on 24 and 25 November 2014. This was an unannounced inspection. The service provides personal care and support for up to 35 older people. The service has a unit specialising in the care of up to 11 people living with dementia and four smaller units providing care for up to 24 people with needs relating to old age.

Thirty two people were supported in the service at the time of this inspection. The service has a registered manager who had been in post since 2013. 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.

Staff understood how to keep people safe and how to report any concerns about care or safety. People in the service and their relatives felt people were safe and well cared for. The care staffing levels helped to ensure that people's needs were met and their safety maintained. Potential risks to people were identified and assessed

Summary of findings

and appropriate steps taken to reduce the risk of harm. This included seeking advice from external health specialists where necessary. Risks from accidents were managed and monitored and steps taken to reduce their recurrence. People living in the dementia unit were assessed to identify whether they were at risk of pressure damage and provided with suitable equipment to minimise this risk.

Staff were subject to an appropriate recruitment process and required checks on their suitability were made. The required records of this process were maintained. Staff received training in aspects of their role relating to people's safety and their knowledge and competency were also assessed.

People's medicines were managed safely on their behalf where they could not manage these themselves. Appropriate procedures were in place around medicines management and administration, which reflected people's rights around consent.

Where people's behaviour could impact upon the safety of themselves or others, advice was sought from appropriate professionals in devising plans to manage the behaviour consistently to keep them safe. Staff had been trained on managing such behaviours effectively. The service was effective because staff received appropriate training and support. Staff were good at supporting people to maintain independence and seeking their consent to care. Appropriate decision making systems were in place where people were unable to consent for themselves.

Advice was sought from external health professionals when necessary to address health issues and staff communicated well as a team to maintain continuity of care. Although the service did not have a dedicated activities co-ordinator, care staff worked hard to provide a programme of activities for people which were supplemented by activities brought in from outside.

A new catering company had been contracted to provide meals in the service and feedback from people suggested the meals and the level of choice offered had improved. Nutritional risk assessments were used to identify those at risk with regard to food or fluid intake. Appropriate care plans and intake monitoring were in place.

People told us that the staff usually worked in a very caring way and respected their dignity. Staff offered people choices and supported them to make decisions and treated them with respect. Staff and the registered manager gave people time to express their views and people had a relaxed relationship with the staff. People were supported or encouraged where necessary to eat their lunch and their preferences were provided for.

Advice had been sought from recognised experts regarding the design of the dementia unit in order to meet people's needs. The building had other adaptations and equipment provided to meet people's needs.The environment supported people's dignity with all individual bedrooms and people could choose from a range of communal areas. A bedroom was prepared in advance of admission with familiar items to try to make the person's transition less stressful. People or their representatives were involved in decision making and care planning.

People's needs around identity and spirituality were provided for and staff promoted a positive self-image and identity. Relatives told us and records showed, that end of life planning and care was good. The staff provided care according to people's individual needs, which they knew well. They engaged with people effectively so they were able to recognise when someone was not themselves. People's social and emotional needs were met through a range of social activities and some outings within the limitations of staff availability. Some activities were led by external providers to broaden the range available. Staff had supported some activities in their own time to enable them to take place. The registered manager had applied to the provider to fund a dedicated activities co-ordinator post to take the lead on activities provision. A series of dementia focused reminiscence activities had been obtained to help address the needs of people living with dementia.

Although comprehensive surveys of people's views had not been carried out recently, a food satisfaction survey had been done. People also had opportunities to give feedback and raise any concerns through resident's meetings, the complaints procedure and informal contact with management. Any issues raised by people or their relatives had been responded to and addressed by management. The service was well led by an established management team who sought the views of people, staff and relatives in various ways to inform their management. People were positive about the

Summary of findings

management of the service, felt they had opportunities to give their views and were listened to. People's records were kept securely but were made available to staff to inform their care.

Staff were managed and supported effectively through regular supervision, appraisals and meetings as well as on a daily basis by a visible and accessible management team. With one exception, appropriate and timely notifications of events were made to the Care Quality Commission as required. The registered manager used a variety of systems to monitor the day-to-day operation of the service and people's health, safety and welfare. The registered manager and provider took appropriate action in response where any concerns were raised. The provider also monitored the effective operation of the service through regular audit visits and reporting systems.

Summary of findings

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 because staff knew how to keep people safe.

Care staffing numbers were sufficient to meet people's needs safely and potential risks to their wellbeing were identified and acted upon.

Potential staff were subject to a rigorous recruitment and selection process and were equipped with the necessary skills. Staff competency in key areas was assessed. Staff managed people's medicines safely.

Is the service effective?

Good

The service was effective because staff had been trained and people were supported wherever possible to maintain their independence.

Advice was sought from external health professionals where necessary. Care staff provided a range of activities as well as supporting people's physical care needs.

A suitable choice of food was offered and people's nutritional needs were assessed and monitored to maintain their wellbeing.

Appropriate advice had been sought regarding the design of the building and appropriate equipment had been provided to meet people's needs.

The home complied with legislation around people's mental capacity and consent.

Is the service caring?

Good

The service was caring because staff treated people with respect and maximised their dignity, by offering choices and enabling people to make decisions about their care.

Staff and management had a relaxed and informal relationship with people which supported them to express their views.

People's wishes and preferences were provided for. Staff knew when to seek the advice and support of external health professionals for support with managing people's behaviour.

People's needs around identity, self-image and spirituality were provided for.

Is the service responsive?

Good

The service was responsive and provided care according to individual's needs.

Care staff provided a variety of activities, supported by external providers to meet people's social needs.

Specific reminiscence activities had been obtained to help meet the needs of people living with dementia.

People had a variety of opportunities to give feedback about the service and issues raised had been addressed.

Summary of findings

Is the service well-led?

Good

The service was well led by an established management team who obtained people's views about its effectiveness in various ways.

People felt the service was well managed and their views were listened to.

Staff were effectively managed, monitored and supported to do their job. Staff morale and team spirit was good.

The registered manager and provider had appropriate systems to monitor the operation of the service and identified issues were addressed.

Walnut Close

Detailed findings

Background to this inspection

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

We inspected Walnut Close on 24 and 25 November 2014. This was an unannounced inspection, which meant the staff and provider did not know when we would be visiting. The inspection was carried out by an Adult Social Care inspector.

Prior to the inspection we reviewed the records we held about the service, including the details of any safeguarding events and any notifications about reportable incidents sent by the service to the CQC.

We contacted a sample of external care and health professionals with recent experience of the service, to obtain their views. During the inspection we spoke with six people using the service, two relatives, the service manager, the registered manager, four staff and a student on a training placement at the service.

We examined five people's care records, reviewed other records regarding the operation of the service and carried out a SOFI observation of care practice over the lunchtime period. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed part of a medication round, a staff handover meeting and informally observed staff care practice during the two days of the inspection.

Good

Is the service safe?

Our findings

Relatives and people felt they were safe and well looked after. They told us staff seemed well trained and knowledgeable. One person told us: "I feel safe, there's always someone about. I have a call bell and the response is good". Another person said: "It's comfortable here and safe".

The staffing levels provided in the service helped to keep people safe. The regular staffing was a senior and six care staff throughout the day and four care staff on waking duty nightly. The registered manager said additional staff were authorised if people's needs required higher levels of support. Authorisation for an additional staff member was in place at the time of inspection, if the registered manager felt this was necessary, because several people had recently been unwell. At the time of this inspection all care staff vacancies had been recruited to although some new staff were awaiting start dates. The team would then be fully staffed, meaning that current high levels of agency use would be reduced. The service had three domestic staff vacancies which were covered by a mix of agency and in-house 'bank' relief staff. These vacancies were about to be advertised to seek permanent replacements promptly.

Risks to people were assessed individually to identify the best way to minimise the potential for harm. For example, where people used bed rails at night to prevent falls from bed, their use had been appropriately risk-assessed to establish whether they were the most appropriate means to safeguard the person. In some cases the risk assessment identified that the bed rails might present a hazard in their own right and the less restrictive option of "crash mats" had been used instead. Crash mats placed beside the bed at night, reduce the risk of injury should a person fall out of bed, by cushioning their fall.

Other risks to people such as from accidents or incidents were documented, monitored and reported to the provider for monitoring. The records noted where action had been taken to address changes in people's needs and keep them safe. The registered manager maintained a monitoring spread-sheet to record people's needs regarding bed types and whether bed-sides had been assessed as appropriate for use.

People in the dementia unit were supported to reduce the risk of pressure injuries by the provision of pressure relieving cushions on all seating. The registered manager said and records showed, the level of pressure relief required was individually assessed to maximise effectiveness. A new device to aid people's transfers from place to place had recently been obtained. Staff had immediately been provided with training so they knew how to use it safely. The Speech and Language Therapy team confirmed that their advice had been appropriately sought in one case where staff had concerns about possible swallowing issues.

New staff were subject to appropriate recruitment checks to ensure they were suitable to provide care and support to vulnerable people. We saw evidence of these checks, which met the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People were safeguarded because new staff did not commence work until all of the required checks were complete. The registered manager had obtained staff profiles for the agency staff used by the service in order to verify they had been subject to the required checks by the employing agency and had attended the necessary training.

People were cared for by staff who had been provided with training on aspects of care relating to safety such as safeguarding, manual handling and medicines administration. Staff had been assessed with regards to medicines management and manual handling through both written test and practice observation, to ensure they were sufficiently competent. The manual handling training and competencies had recently been updated for all staff.

Staff were aware of their responsibilities with regard to safeguarding people and whistle-blowing and knew to whom they should report any concerns. They told us they would report any concerns to the senior person on duty or contact the head office and would record what had been said to them. Staff had recently reported examples of inappropriate practice by one of the team and the provider had taken appropriate investigative and disciplinary action to safeguard people.

Staff demonstrated during the handover between shifts, that they understood the need to pass on key information relating to people's wellbeing to keep them safe and well. For example changes in people's care needs such as food or fluids intake, changes in wellbeing or medication were handed over to the incoming shift.

Good

Is the service safe?

None of the current people had been assessed as being able to manage their own medicines, although a risk assessment format was available should this be thought appropriate. Locked cabinets were provided in each bedroom which would provide secure storage if a person was managing their own medicines. People did sometimes refuse their medicines. The provider had a medication procedure which addressed this appropriately.

The registered manager described an instance where a person had refused to take their medicine, which could have had serious consequences for their wellbeing. The person was assessed as not having the capacity to make an informed decision about the impact of this so it was referred to the local authority. A 'best interests' discussion took place involving the appropriate people, to consider whether to provide the medicine covertly. It was decided this would not be in their best interests and an alternative plan was devised in case of subsequent refusal. The registered manager said that had covert medication been agreed, guidance would have been sought from the GP about the appropriate method. We saw the format used to record the details of the covert administration process if required.

Medicines records complied with requirements. However, PRN (as required) medication stock quantities were not always brought forward on the record sheets to make stock checks easier. One medicines error had occurred since the last inspection. Appropriate action was taken by the staff at the time, who contacted the GP and mental health team for advice. The staff member was subsequently retrained on medicines management and their competency re-assessed. The service's medicines management was inspected by the pharmacist in March 2014. The registered manager had compiled an action plan to address the points raised, which had been resolved or were in the process of being addressed.

Where people's behaviour potentially impacted on the safety of others the behaviours were logged to identify their frequency and any possible triggers. Incident reports had also been completed and referred to the provider. The support of GP's and the community psychiatric team had been sought to risk assess and devise a plan to manage these behaviours to keep people safe. Additional staffing had also been provided to support this and medicines had been changed in some cases. The health trust 'in-reach' team had also provided support and guidance to staff. Staff had all received training on managing "Stress-related behaviours". Staff demonstrated they understood ways to defuse challenges and support people to a more positive frame of mind. Staff did not use physical intervention. To check the attitude of job applicants to the use of restraint, a scenario question was asked in the recruitment process.

The registered manager said and records showed that potential risks from the environment or equipment were managed through regular servicing and inspection by staff as part of health and safety monitoring. The registered manager also made a point of spending time around the service observing practice and talking with the people in the service so that people had opportunities to report any concerns.

Good

Is the service effective?

Our findings

Relatives and people told us the staff were very good at supporting people to maintain their independence and encouraging them to do whatever they could for themselves. Relatives also told us the staff sought the advice of external health professionals promptly when necessary and kept them informed about any concerns. A relative told us: “The staff manage well” and said they were good at defusing situations. The relatives were also happy with the way staff had managed a medicine refusal issue and involved them in the ‘best interests’ discussions. They said the person had been happier to take the medicine because staff had explained its purpose to them.

During the handover staff communicated people’s needs effectively to the incoming staff to maintain continuity of care and passed on details of health appointments and other needs. They also passed on and explained the need for completion of a monitoring chart for one person to support an assessment by an external health professional. The way information was handed over showed that staff understood and respected people’s rights. For example the need to wait for written instructions from the GP about an aspect of care, was explained to the incoming staff.

Training records showed staff had an appropriate programme of core training and additional specialist training in relevant areas to meet people’s needs. Training was updated on a planned basis and the records also showed upcoming booked courses. Staff had been provided with training on dementia care and dementia activities to enable them to support people with these needs. The additional training provided to key staff had helped enhance people’s experience in the service. This included training on nail care, arts and crafts and the effective use of a reminiscence system used by the service.

Staff told us their induction and training had been thorough and effective and that recording systems were effective in monitoring people’s wellbeing. They confirmed that training was updated regularly and that their competency was also checked.

Staff told us and records showed they had attended regular supervision meetings and had annual appraisals of their personal development. A range of staff meetings also took place and the minutes showed that they were used effectively to share information about changes in people’s welfare to maintain continuity of care.

At the time of inspection the service did not have a dedicated person with responsibility for providing people with suitable activities for their needs. However, the registered manager had made a business case to the provider to establish this post within the team to ensure that someone had the skills, knowledge and training to provide appropriate stimulation and occupation for people in the service. In the interim, care staff were responsible for providing activities alongside their other responsibilities.

During our observations people were supported to give their consent to day-to-day care and to make decisions where they were able. Where people did not have the capacity to make decisions, this had been clarified by means of ‘capacity’ assessments and the advice of either family or other advocates was sought. Capacity assessments are carried out under the Mental Capacity Act 2005. This Act protects the rights of people with regard to decision making about their lives where they do not have the ability to consent themselves. If ‘best interest’ decisions needed to be made about care or treatment, care managers and external health professionals were consulted. For example in one case where a decision was needed about whether to hoist a person out of bed, the views of family and two health professionals had been sought.

People told us the staff sought their consent when supporting them. One said: “They check our consent” and another told us their care was: “discussed with them”. Where people had been assessed not to have capacity to manage their finances and had no actively involved family, the local authority sought ‘Deputyship' to manage them on their behalf. One person was subject to 'Deputyship' when we inspected and a further two applications were pending to ensure that funds were managed in people’s best interests.

Where bed-rails were used at night, people had either consented to their use, where they had capacity, or a Deprivation of Liberty Safeguards (DoLS) application had been made to the local authority to authorise their use. DoLS applications are a way the provider obtains authorisation for any limitation on a person’s liberty deemed to be in their best interests. The registered

manager had also identified the people who might be subject to deprivation of their liberty through the provision of keypad locks on external doors. The local authority had requested a list of such people and the registered manager had provided this to the local authority DoLS team for them to carry out assessments.

The service had changed to a different specialist catering company recently to address previous problems and complaints. The new caterers provided a more varied menu with three options at each meal. We heard people being offered these choices and being given flexibility if they had changed their mind since making a choice previously. Additional special events had taken place involving other meal options. A Chinese meal had recently been provided for people in one of the units in response to their request to do this. People told us they had really enjoyed this and were looking forward to it happening again.

Following a trip to see the Christmas lights a fish and chip supper was bought in. Other feedback about the meals from the people in the service was mostly positive. People described the food as: "good and tasty" and: "pretty good" and said that the level of choice had improved. Another person said: "the food was still hot" when they got it and: "they could also ask for a salad". A person in another unit told us the food had improved although at times it wasn't as hot as it could be when it arrived. People's views about the meals were sought via a questionnaire ahead of their review meetings and also during resident's meetings. The new menu provided by the catering company had been shown to people at a resident's meeting for their views. Any issues raised by people about the food were recorded in a comments book for the caterers to address.

Nutritional risk assessments were completed for each person to identify any risk associated with food and fluid intake. The outcome of the risk assessment then determined whether they were weighed weekly, fortnightly or monthly to monitor their wellbeing. If the nutritional risk assessment identified a concern, or if people were being supported by the external dietician, their food and/or fluid intake was monitored and recorded. We saw examples of such records being maintained. If staff felt that someone had swallowing problems, they were referred to the speech and language therapy, (SALT) team. The SALT team had recently assessed one person for swallowing difficulties and provided a care plan for staff to follow to assist the person so their risk of choking was managed.

Where people had identified health concerns, they were referred to the GP or other external health specialists such as the occupational therapy team. People's need for support with maintaining or managing continence were assessed and where necessary, referred to the continence team or the district nursing team. Continence was managed effectively by the staff and there was no evidence of any unpleasant odours anywhere in the building.

The registered manager maintained an overall record of people's needs with regard to continence, health, nutrition, skin integrity, falls, manual handling. This provided an overview for discussion with staff, for management reporting and staffing level assessment. The support of the health trust 'In-reach' team was also available to the service to maximise their effectiveness. People confirmed that the GP was called promptly by staff if they were unwell. One person said that staff had asked them if they would like them to call the GP. Another told us the GP was: "called the same day". People's files showed that they had had access to relevant health professionals when necessary.

The service had signed up to the "Purple Angel" project to support developments in the area of dementia awareness. This included work with staff to develop their awareness and support the dementia training they had received. The focus was on seeing the person first and communicating effectively with them to minimise the impact of their dementia.

Advice on the design of the dementia unit had been sought from the King's Fund, who provide recognised guidance on dementia care. The circular layout of the dementia unit corridor was designed to avoid confusing 'dead-ends' for people living with dementia walking around the building. The use of individual colour coding of the walls around people's bedroom doors also supported people living with dementia by enhancing their ability to locate their own bedroom. Larger signage for toilets also helped people to locate these independently where they were able. The carpets in communal areas were muted in colour, in accordance with best practice guidance on the dementia environment.

The service had six bathrooms of which one was an adapted shower. Two of the bathrooms had been upgraded with height adjustable baths with integral hoists to enable easier access and safer use. Three other bathrooms, equipped with older style adapted facilities, were scheduled for upgrading after Christmas. One

Good

Is the service effective?

person's bedroom had been fitted with overhead hoist 'tracking' to meet their needs. A variety of mobile hoist equipment had been purchased to meet peoples' needs including a new style device to aid transfers. The garden had been fully enclosed and provided a secure space accessible by people independently if they did not require staff support. The use of the garden had been developed as part of a planting project by staff and work in this area was on-going. The environment had therefore been adapted well to meet people's needs. The registered manager planned to visit another specialist dementia service to seek ideas for the further development of their garden.

Good

Is the service caring?

Our findings

People described the staff in positive terms. One person told us: "the staff are marvellous, they can't do any more". Two people said of staff: "they are kind and gentle" and two said they got on well with them". Another person said that staff were: "very good, the manager and assistant manager are the best". The same person also said that at times some staff could be a bit gentler when giving a bed wash. People told us the staff offered them choices and responded promptly when they used the call system. One gave the example that they liked their bedroom door held open and the staff respected this. People said that when they were unwell, staff called in the GP promptly. Two told us staff were: "careful and respectful of their dignity", when hoisting them or providing care. People said staff respected their gender preferences with regard to staff supporting their personal care.

Staff compared the care provided at Walnut Close favourably with other services they had known. Staff referred to a warm atmosphere, consistency and a person-centred approach.

During the inspection we saw that staff treated people with dignity and respect, offered them choices and supported them to make day-to-day decisions. People knew the registered manager well and felt able to ask her about things and shared a joke with her about previous events. People were not rushed by staff and were given time to process information. Staff took the time to sit with people when they could and engaged them in conversation. On several occasions, staff greeted people as they passed, rather than passing by in silence. People's responses showed they valued these interactions.

The interactions we saw were almost exclusively positive and people reacted warmly to the attentions of staff with smiles. On one occasion a staff member responded in a slightly critical way to one person and moved their meal around without explanation. However, the same person then offered positive care and support. Other staff made positive, affirming comments about such things as people's clothes and hair. One person was assisted to the dining table and offered a choice of where they wished to sit. During the handover between shifts, staff referred to people in respectful terms, recognising their individuality. The staff knew people's individual needs well and discussed these positively in a person-centred rather than task-centred way.

During lunch, staff offered assistance in a timely way when people were struggling to manage alone and others were offered appropriate encouragement to feed themselves. The meals were individually plated and the chef was familiar with people's preferences and dietary needs. He checked whether a newly admitted person was a vegetarian. We saw people's previous meal choices were respected. One person was provided with additional custard with their dessert, based on the chef's knowledge of their preferences. Staff checked periodically that people were managing with their meals. Where there were short delays in serving meals, staff acknowledged this, talked with people and offered additional top up drinks. One staff member saw that the sun was shining into one person's eyes and offered to draw a curtain to address this.

People's needs were supported in various ways by the physical environment and equipment provided. Individual bedrooms maximised people's privacy and dignity. The presence of five separate lounges allowed people a choice of where to sit and who to spend their time with. Some areas were designed to be quiet spaces and could be used to see visitors. People told us their relatives and friends could visit at any time without having to give prior notice.

One person was due to be admitted from hospital. Their bedroom had been personalised prior to admission by their family who had been asked to bring in items significant to the person to reduce anxiety and make them feel welcome. The service respected people's right to be involved wherever possible in decisions about their care and treatment. Where possible, people were involved in reviewing their care. Where people were unable to contribute, their representatives were involved.

The registered manager said and records showed that the GP usually involved people or their relatives in decisions about resuscitation in the event of heart failure. In two cases the forms about resuscitation did not include evidence of this consultation by the GP. The registered manager agreed to ask the GP to review these forms with people or their families. The decisions made about resuscitation were available to staff in people's care files and also in their hospital information packs. These

Good

Is the service caring?

information packs also included relevant information about people's care and support needs and their wishes and preferences to inform nursing staff of their needs if admitted to hospital.

People's dignity was enhanced by such things as displaying items of their art and craft work about the building. Information about people's individual histories, preferences, likes and dislikes, including end of life care, was sought from them and their families via the "All about me" format. This provided staff with the information they needed to support an individualised approach. Relevant information was incorporated within people's care plans.

A relative told us that another family member had previously lived at Walnut Close and their satisfaction with the care provided had led them to seek the current relative's admission. They told us the end-of-life care provided had been excellent including appropriate pain relief. They were kept properly informed so they and others important to the person were able to be with them when they died. A relative told us that: "Overall care was very good" and people were supported to maintain their independence. One person's file contained an advanced care plan detailing the palliative care required in the event of specific medical needs arising.

Good

Is the service responsive?

Our findings

People and their representatives had been involved in planning and reviewing care. Changes in people's needs were discussed informally and during reviews. Staff knew the people they supported well, and were aware of key information about their backgrounds and interests. Staff were good at communicating with people verbally whilst providing care and support. In this way the time spent providing care was used as a valuable opportunity to engage with people to monitor their mood and wellbeing. We saw staff engaging some people in specific activities on a one to one basis during the inspection, for example nail care. People and their relatives felt the staff responded well to people's individual needs and were quick to notice any changes in wellbeing and seek medical help. One relative told us: "I wouldn't have wanted [the person] to go anywhere else". Another relative felt that the level of activities had improved. They said they had been consulted properly and involved in decision-making and that staff had communicated well with them.

Where people could exhibit behaviours which could harm them or others the service had plans in place describing how staff should support them to minimise their distress. Advice on these had been sought from the community psychiatric nurse in one case, who had observed their care and helped rewrite the care plan. The person's risk assessments were also updated. The registered manager and deputy registered manager also supported personal care at times so they were aware of any particular concerns raised by the staff about individual's needs.

People's needs with respect to such things as gender identity, disability and religion were met. A range of hoists and other equipment had been purchased to meet people's physical support needs and specialist adjustable beds were available for those who required them. Staff provided support for people's identity through such things as hair and nail care and people could individualise their bedroom to reflect their personality. Staff commented positively on people's appearance in order to recognise and support their identity. People told us and records confirmed that their spiritual needs were identified and provided for by visiting clergy. One person's file noted visits from a Methodist minister.

Although the service did not have a dedicated person to lead on activities provision, there were group activities listed daily and projects like the dementia garden planting, involved people in the service. Various seasonal events were planned in the lead-up to Christmas. A car, shared with another service, was available to take small numbers of physically able people out. People had been taken to local places of interest including a farm shop and the canal. Some people had been on a recent trip out to see the Christmas lights and a further trip to a garden centre was planned.

A lot of group activities were carried out in the dementia unit to promote integration of people across the service. This enabled those with dementia to observe the activities taking place, which might encourage improvements in their participation. On occasions, staff had supported people's activities in their own time to enable them to take place. One staff member was planning to make Christmas cakes and puddings with people the day after the inspection, in their own time.

People told us they had taken part in various events and activities. The regular visits from the "Pets As Therapy" (PAT) dog were popular. One person said there had not been a lot of activities they wanted to join in with. They suggested they would like some more gentle exercise as was provided by the visiting "motivation" person. This external support was usually provided fortnightly as part of the activities programme and was well attended. The external provider supplied the service with records of people's participation and details of the activities provided. The records showed that up to a dozen people took part on most occasions.

The service had signed up to access a series of dementia-focused reminiscence packs. These included equipment and facilities to set up temporary reminiscence environments such as a 'period' kitchen, shop, sitting room, dance hall or cinema. To date they had used the cinema and projector equipment to show old movies, which had been very popular, and planned to obtain more of the equipment. Use of these reminiscence tools was intended to lead on to other related activities and discussions, although the current reliance on care staff to lead activities limited this aspect.

The recording of people's activities involvement was inconsistent and lacked sufficient detail to identify who was and was not benefitting from what was provided. The

Good

Is the service responsive?

registered manager had applied to the provider to obtain funding for a dedicated activities coordinator post to take a lead role on planning, providing and monitoring activities provision.

Some surveys had been carried out, most recently focused on catering, in July 2014. Any issues raised had been passed on to the caterers to be addressed. Resident's meetings had also provided opportunities for people to comment about the service. These had been held most recently in May and July 2014.

Complaints records and staff meeting minutes showed that concerns raised were recorded and investigated under the complaints procedure or referred to the caterers if they related to food. The registered manager told us she was devising a survey to seek people's views as this had not been done recently. A telephone survey of relatives was also being considered.

Resident's meetings had taken place. The minutes showed that attendance had been good with up to 17 people taking part in meetings. Additional contributions were also included from two people who were spoken to separately on one occasion. The minutes recorded regular discussion around activities and outings as well as referring to such things as catering and new staff. People also had opportunities to express their views through their day-to-day contact with staff and management.

The registered manager and deputy made a point of daily walk-arounds throughout the service. It was evident from people's responses and comments that they knew the registered manager well and were used to seeing her. People's comments and requests had been listened to and resulted in actions. For example, events such as the Chinese meal had been organised in response to a direct request. Changes to room layouts and the provision of some new curtains had also resulted from comments by people in the service.

The complaints procedure was given to people within the welcome pack and explained when people were shown around the service. People had access to blank complaints forms in the entrance hall without having to ask staff for a copy, which meant they could raise a concern anonymously if they wished. People said they knew how to complain although most said they had not had cause to do so. One person told us they had complained to the registered manager about an agency worker and were happy the agency worker had not been used again by the service.

Complaints that had been made were recorded and investigated and had been resolved to people's satisfaction. The complaints and compliments log contained three complaints since the last inspection. Each had been investigated and action had been taken to address them in a timely way. Six compliments about the service were recorded in the same period.

Good

Is the service well-led?

Our findings

Although a service wide survey had not been completed recently the views of people and their relatives had been sought in a variety of other ways. The registered manager and deputy manager's daily walk-around helped ensure that people in the service were familiar with them and felt able to raise any concerns they might have. People spoke with the registered manager in a relaxed and familiar way when we were shown around the service. The registered manager and deputy worked some shifts to maintain awareness of the issues faced by staff and also carried out unannounced spot checks at night to monitor practice. People spoke warmly about the registered manager and described her as being: "available", "accessible" and: "listening". People were aware that resident's meetings were held. Some people had taken part in these or had a relative who had done so on their behalf.

The provider demonstrated that its services were well led by revising the medication procedure in Walnut Close in response to an issue raised by CQC during the inspection of another of its services. This showed improvements were made across its services in a proactive way.

People's records were kept password-protected on computer or in locked cabinets or trolleys to safeguard their confidentiality. Copies of daily task plans and night care plans were also kept discretely in people's bedrooms so staff had ready access to the information they needed.

Minutes showed that regular staff team, keyworker and senior staff meetings took place to discuss care practice and monitor people's wellbeing. Staff were provided with regular individual support through supervision meetings and annual appraisals promoted staff development by setting goals and measuring progress.

Where care practice concerns had been identified, these were properly addressed. This had been demonstrated by the recent response to a whistle blowing alert from staff. The registered manager had notified relevant incidents and events to the Care Quality Commission throughout the year with the exception of one instance of whistle-blowing. The whistle blower had reported inappropriate behaviour by a staff member. This was fully investigated and appropriate action was taken at the time. The registered manager provided a retrospective notification immediately after it was raised during the inspection.

The staff were supported by the presence of management on site or available on call out of hours. Staff therefore had ready access to management for advice or to report any concerns. Where concerns were identified the management have taken appropriate action. For example in the case of the recent whistle-blowing and where moving and handling concerns had been identified. In the latter case, additional moving and handling training was provided. People were also safeguarded when a medicines handling error had been identified, by staff attending retraining and having their competency reassessed.

Staff felt supported day-to-day and through regular supervision and team meetings. One staff member said: "we all have a say" and another said: "I love my job". Staff said there was a sense of teamwork and common purpose although at times over the last year this had not been so easy due to the increased numbers of agency staff. This was now reducing as people were recruited to permanent positions. One staff member described the teamwork as: "good" and said they worked on developing this and openness within the team. Staff were supported, listened to and enabled to resolve issues. Staff knew the service manager who line managed the home's registered manager but one person commented that: "It would be nice to meet other senior staff". The previous year had been one of consolidation following the establishment of the dementia unit and additional dementia care training had been provided to staff to support this.

The provider had undertaken quarterly monitoring visits, resulting in reports which included action plans for the registered manager to address. Each was followed up at the subsequent meeting in order to monitor progress. Members of the management team also carried out monthly audits of the service's performance. These included talking to people in the service, relatives and staff to obtain their views. The reports also addressed the service's operation including recruitment, meals, activities, premises, staff support and reported on reviews of a sample of people's care plans.

The registered manager maintained an on-going risk monitoring system in relation to each person's wellbeing and areas of heightened risk. The format provided the

Good

Is the service well-led?

registered manager with a summary of people's needs with regard to key aspects of their care and record keeping. The form was used as a reference in staff supervisions and for team discussions regarding people's needs. People's weights were also monitored by the registered manager to maintain an overview and identify where external referrals might be necessary.

Health and safety was monitored by fortnightly monitoring "walk-arounds". Another management spread-sheet recorded the presence of risk assessments and DoLS applications, where required, for bed-rails use and also identified the type of bed provided. People's health and safety were maintained and monitored in various ways. The registered manager had a fire risk assessment for the service and weekly visual checks of equipment and fire doors were made.

Accidents and incidents records were monitored by the registered manager and also collated centrally on a computer record sent to the provider. The registered manager's record cross-referenced to the accident record form and noted the action taken following particular events, this enabled these actions to be monitored. The registered manager had produced an action plan following the pharmacist monitoring visit. This was discussed with senior staff and actions taken to address the points raised. Any health and safety issues were therefore monitored regularly and any issues were acted upon.