SHC Clemsfold Group Limited

Orchard Lodge

Inspection report

Tylden House Dorking Road
Warnham
Horsham
West Sussex
RH12 3RZ

Tel: 01403242278
Website: www.sussexhealthcare.co.uk

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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

Summary of findings

Overall summary

The inspection took place on 1 and 2 November 2016 and was unannounced.

At our last inspection, in September 2015, we found breaches of the regulations in relation to good governance and how the provider had responded to feedback as well as the provider's failure to display their rating from our inspection in 2014. At this inspection, we found that there had been a great improvement in how the service was managed and delivered. The breaches in regulation had been addressed.

Orchard Lodge provides personal and nursing care for up to 33 people with learning and physical disabilities, including respite places. Most people have complex mobility and communication needs. Orchard Lodge is made up of two purpose built bungalows, Orchard Lodge which consists of two units and Boldings Lodge. At the time of inspection, there were 29 people living at the service.

The service has a registered manager. 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.

People spoke highly of the home. Relatives had confidence in the care provided and said that staff were welcoming.

People had developed good relationships with staff and had confidence in their skills and abilities. They told us that staff were kind and that they treated them respectfully. Staff had received training and were supported by the management through supervision and appraisal. Staff were able to pursue additional training which helped them to improve the care they provided to people.

Staff responded quickly to changes in people's needs and adapted care and support to suit them. Were appropriate, referrals were made to healthcare professionals, such as the GP or Dietician, and advice followed.

People were involved in planning their care and in making suggestions on how the service was run. Since our last inspection, action had been taken to improve how people were supported with the use of communication systems and aids. Communication passports had also been devised and were available to staff and visitors to enable better communication with people. A new Speech and Language Therapist (SALT) had been employed on full-time hours by the provider. They told us that their initial focus would be on further improving communication support and guidelines.

Staff understood how people's capacity should be considered and had taken steps to ensure that people's rights were protected in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards

(DoLS).

People felt safe at the service and there were enough staff to respond to their needs. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Risks to people's safety were assessed and reviewed. People received their medicines safely.

People enjoyed the meals at the service and were offered choice and flexibility in the menu. The chef had a good understanding of people's likes and dislikes and took great care to provide specific dishes or supplies to meet people's requests. A variety of activities were provided and a driver had been employed which helped to facilitate more regular outings. The premises were purpose built and provided space for people to move around freely, to relax and to enjoy outdoor spaces.

There was strong leadership within the home. The registered manager monitored the delivery of care and the provider had a system to monitor and review the quality of the service. Suggestions on improvements to the service were welcomed and people's feedback encouraged. One care assistant said, "(Registered manager) is willing to change things, she'll think about anything you suggest. Our ideas are more valued and I know that I can go to her".

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were enough staff to meet people's needs and keep them safe.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had received training to carry out their roles and received regular supervision and appraisal.

Staff understood how consent should be considered and supported people's rights under the Mental Capacity Act.

People were offered a choice of food and drink and supported to maintain a healthy diet.

People had access to healthcare professionals to maintain good health.

The premises were purpose built to cater for people's mobility and support needs.

Is the service caring?

Good

The service was caring.

People received individualised care from staff who cared and who knew them well.

People were involved in making decisions relating to their care and were supported to maintain contact with family and friends.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

The service sought and listened to feedback. People knew how to make a complaint if necessary and were confident any issue would be addressed.

People's care was planned and monitored to promote good health.

Staff understood how to support people and responded quickly to any changes in their health.

People enjoyed a variety of activities, including outings in the local community.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and inclusive. People and staff felt able to share ideas or concerns with the management.

People and staff spoke highly of the registered manager and leadership team. Staff were clear on their responsibilities and told us they were listened to and valued.

The registered manager used a series of audits to monitor the delivery of care that people received and ensure that it was consistently of a good standard.

Orchard Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 1 and 2 November 2016 and was unannounced.

Two inspectors, a specialist advisor in learning disability nursing and an expert by experience undertook this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in caring for a young person with learning disabilities.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications received from the registered manager. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We 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. We looked at care records for six people, medication administration records (MAR), monitoring records, accident and activity records. We also looked at five staff files, staff training and supervision records, staff rotas, quality feedback surveys, audits and minutes of meetings.

During our inspection, we spoke with two people using the service, two relatives, the registered manager, deputy manager, three registered nurses, one team leader, three care assistants, one agency care assistant, the physio assistant, the chef and the driver. We also spoke with the clinical nurse tutor from the provider's training academy, the Speech and Language Therapist (SALT) employed by the provider and three representatives of the provider. During the inspection we met with a GP who was visiting. Following the inspection, we contacted a SALT who used to provide services to the home, a second GP, a Reflexologist, a

senior social worker and a contracts officer from the local authority to seek their views and experiences. We have shared the views of those professionals who consented to their feedback being included in this report.

Good

Is the service safe?

Our findings

People appeared relaxed in the company of staff. Relatives had confidence that the home provided a safe environment. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Staff told us that they felt able to approach the registered manager if they had concerns. One care assistant told us, "(Registered manager) would deal with it". They also knew where to access up-to-date contact information for the local authority safeguarding team. The registered manager had completed training with the local authority on how to conduct a safeguarding enquiry and had a clear understanding of her responsibilities in this area.

Before a person moved to the service, an assessment was completed. This looked at their support needs and any risks to their health, safety or welfare. Where risks had been identified, such as in moving and handling, from falling or pressure areas, these had been assessed. Risk assessments detailed what reasonable measures and steps should be taken to minimise the risk to the person. For example, when people were at risk of pressure injury, prescribed creams were applied to their skin to reduce the risk of breakdown and pressure reliving equipment such as mattresses and cushions were used. Risk assessments were also in place for specific activities such as for accessing the community and using the hydrotherapy pool. The guidance was detailed and staff told us they had confidence in the measures in place and understood how to keep people safe.

Staff kept clear records to ensure that risks were managed safely. We looked at examples of repositioning records, fluid charts, bowel charts and night checks for those known to have seizures. These were completed in full and had been used to monitor people's health and seek further guidance and support when required. Where accidents or incidents occurred, these were logged and reviewed. This helped to identify any patterns or trends and to reduce the risk of future injury.

There were enough staff to keep people safe. A nurse worked in each unit, supported by a team of care assistants. One person had one to one support throughout the day and night and this was reflected in the staffing rotas. The rotas demonstrated that the planned staffing numbers had been maintained, though on occasions one nurse rather than two supported both units of Orchard Lodge. To maintain the staffing numbers, some temporary staff from agencies were used. Staff told us that this was manageable, although it did take time to explain things to staff who hadn't worked in the service before. An agency staff member told us, "I've been coming here for three or four weeks. I'm always in this building. I know the residents. I feel it is good here. I've requested to come here". Wherever possible, the registered manager requested the same agency staff, to improve continuity for people. The service was recruiting. The registered manager advised that two new care assistants were due to start in post once pre-employment checks were completed and that further interviews were scheduled.

Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references

were obtained from current and past employers. For nurses, their registration with their professional body was checked to ensure they were fit to practice. These measures helped to ensure that new staff were safe to work with adults at risk.

We noted that the references for two staff did not appear to have been verified by the provider. The registered manager advised that, although staff had provided these references, she had spoken with the referees to verify the details. These checks were not recorded. Following our inspection, the registered manager advised that a new form had been developed to record conversations relating to reference checks. Furthermore, she confirmed that all reference requests were to be sent by the home, rather than accepting pre-written references provided by staff.

People received their medicines safely. Medicines were administered by registered nurses whose competency had been verified by the registered manager. Medicines were stored safely, including those which required refrigeration. Guidance was in place for staff to describe how people preferred to receive their medicines, for example one person liked to take their tablets with food and this had been agreed with the GP. Medicines prescribed on as 'as needed' (PRN) basis included detailed protocols to describe to staff how the person would present if the medicine was needed, how much should be given, the gap between doses and the anticipated effect. We observed staff as they administered medicines to people. Each person was supported to take their medicines either orally or via their gastrostomy (PEG – this is a tube which delivers fluid and nutrition directly to the stomach). Staff ensured that medicines had been taken before signing the Medication Administration Record (MAR). MAR demonstrated that people had received their medicines as prescribed.

We noted that in the East Wing of Orchard Lodge, PRN medicine prescribed for seizures included a time for administration. We discussed this with the registered manager since a PRN medicine should be given when required, in this case if the person was having a seizure. The registered manager agreed to update the MAR to avoid any confusion.

Good

Is the service effective?

Our findings

People and relatives spoke highly of the care and support received from staff. One relative had written to the provider saying, 'We would like to thank all staff for their wonderful care and support for (name of person). We could not have wished for better care for our son'.

Staff received training to enable them to provide effective care and support to people. New staff attended a five day induction course held at the provider's training academy. They then completed a period of shadowing experienced staff as they got to know people and understand their support preferences. The provider was developing their training offer, to ensure that it equipped staff with the skills to support people who lived at the service. Additional training in learning disability awareness, autism and in Makaton had been sourced and scheduled as part of the induction programme.

Staff spoke positively about the training available. One care assistant said, "There are lots of training opportunities available via the Academy". Each year, staff attended refresher training in areas made mandatory by the provider. This included moving and handling, safeguarding, infection control and the Mental Capacity Act 2005 (MCA). Records showed that staff were up to date with this training. We saw that additional courses completed by staff included challenging behaviour, tracheostomy care, wound care and epilepsy. Physiotherapy staff had attended a respiratory course, which the assistant physio told us had already proved useful in practice.

Staff were encouraged to undertake training and were supported to pursue further qualifications such as diplomas in health and social care. We spoke with one staff member who was completing their nurse training, supported by the provider. They said, "The Company has been so supportive and they've been very flexible. I wouldn't have done the course if it wasn't for Sussex Healthcare". The registered manager told us, "Everything is possible, they just need to ask". Staff told us that the registered manager was supportive with their training needs. One registered nurse said, "(Registered manager) came in on a Saturday and covered my shift so I could go on a course. She chases everyone for training. Staff are very conscious of it now". The registered manager told us, "I'm doing my best to make the staff more confident and to promote training. When I work alongside them it helps to identify any gaps".

We noted that the records for some courses such as food hygiene and first aid, which were scheduled for bi-annual or three yearly updates had not been clearly recorded. We identified one registered nurse who had not attended first aid training within the last three years. Following our inspection, the registered manager advised us that where necessary staff had been booked on refresher training before the end of 2016 and that the records had been updated.

Staff felt supported. A new registered nurse said, "I like it. I have support from my manager. She explains everything to me". Another registered nurse told us, "There has been a lot of improvement since you were last here in terms of the support for staff. (Registered manager) has given each of the staff the support they need and encouraged everybody to do what they need to do. Before, no one corrected them, now (registered manager) will say do it this way, it is better for the service users". They added, "She (registered

manager) recognises us. She is open and straightforward. She appreciates people". Staff received regular supervision. Supervision meetings gave staff an opportunity to discuss their achievements, training needs and any concerns. One care assistant told us, "It can be useful; it's a chance to air any problems". Staff performance was reviewed annually during an appraisal meeting.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. We observed that staff involved people in decisions relating to their care and respected their wishes. A registered nurse told us "Sometimes (name of person) doesn't want their medication in the morning. I will try later. If he refuses, I respect that". A care assistant said, "If (name of person) doesn't want her hair washed, we can do it the next day. We give them as much choice as possible". Another care assistant told us, "It's (the MCA) about how they are able to make decisions and it is to keep them safe". We found that staff understood the requirements of the MCA and put this into practice.

The care records for each person recorded whether they were able to communicate decisions relating to their care and treatment. The majority of people lacked capacity to make significant decisions regarding their health and care. In order to determine whether the person could understand the decision, staff had carried out capacity assessments. A new form was in place, which prompted staff to detail how the decision had been presented to the person. We discussed with the registered manager, how these forms could be more fully completed in order to demonstrate that all possible ways to maximise the person's decision making ability had been pursued. Where the assessment found that the person lacked capacity, best interest decisions had been made. These decisions had involved people close to the person, such as relatives, staff and other healthcare professionals. Examples of best interest decisions included the use of restraints such as lap belts or bed rails, support with medicines and the use of listening devices in people's bedrooms to monitor them for seizures.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, staff had made an application on behalf of each person living at the service, of which six had been assessed and authorised by the local authority.

People appeared to enjoy their meals. We observed the lunchtime in each of the three units. Staff engaged with people and offered support where required. One person told us that the food was, "Very, very lovely". The Chef knew people well and understood their preferences with regard to food and drink. A care assistant said, "(Name of person) has pork as she doesn't like fish. If I see they don't like something I tell the kitchen and get an alternative. The chef is wonderful, he really is". A relative told us, "The chefs over here are so brilliant, if (name of person) doesn't like certain things the chef knows". Each day there were two main dishes available, with a regular selection of alternatives such as soup, sausage and mash or omelette. There was flexibility over when people ate their meals, for example one person had an early lunch to accommodate an activity and a second person had their main meal saved for the evening which they preferred. Specific snacks or dishes were prepared for individuals, including a nut-free chocolate cake and ordering in a specific brand of fruit juice. The chef listened to people's feedback, which was gathered through regular surveys. There was also a book to record changes or requests used by staff to share information with the kitchen.

Where people had specific needs, this information was clearly recorded. We saw that some people had allergies and that others required their food prepared to a particular texture in order to minimise their risk of choking. Guidance on how to support people at mealtimes, written by the Speech and Language Therapist (SALT), was available to staff in each of the units. Staff also received training on how to support people at mealtimes, with a further course on dysphagia planned at the provider's training academy. Some people did not receive their nutrition orally and were supported by registered nurses to deliver nutrition via a PEG feed. The type and volume of nutritional fluid was determined by the dietician and guidance was followed by staff. Staff monitored people's weight and took action if any concerns were identified. This included additional support with eating meals, fortifying food or providing low-calorie options and referrals to healthcare professionals such as the GP or Dietician.

People had access to healthcare professionals and the service worked in collaboration to ensure that people's needs were met. The provider employed a physiotherapist and physio assistant to work in the home and physio support was available each weekday. We observed people being supported to walk using frames or to cycle in the grounds. The physio assistant told us how one person had made good progress and had moved from needing a hoist to managing standing transfers. Another person's incidence of chest infections had reduced, in part we were told due to regular chest physio. Records demonstrated that people had been supported to see healthcare professionals including the GP, Chiropodist and Dietician. A registered nurse told us, "Appointments are booked at the right time". A GP who was visiting told us, "I think it is fantastic. The staff are very knowledgeable and caring". A second GP who provided feedback wrote, "I always noted that our instructions were strictly followed and patients received the care we wanted them to receive".

The premises were purpose-built and provided space for people to manoeuvre safely and easily in wheelchairs. Each bedroom was equipped with an overhead tracking hoist. The home had a two hydrotherapy pools, sensory rooms and a sensory garden. The sensory garden included a fountain and mobiles, which caught the sunlight. Pathways around the grounds enabled people to move easily between different parts of the service and gardens.

Good

Is the service caring?

Our findings

People appeared to be happy in the company of staff and it was clear that staff knew people well. Each person had a keyworker who took a lead role in coordinating their support. One person was able to tell us about their keyworker and how they helped them. A relative told us, "The carers are very good they go over-board, they really are super". Another relative had written a note of thanks saying, 'Thank you for all your patience and kindness towards (name of person) we appreciate your work immensely'. The reflexologist who visited the home told us, 'I have always found the staff to be very kind, attentive and caring whilst also treating the residents with respect and dignity. The residents are all viewed and treated as individuals'.

People had been involved in planning their care and support insofar as they were able. Records indicated that wherever possible, people had been involved in reviewing their plans of care. Where people had been unable to contribute directly to discussions, their family members or people who knew them well had been asked about their likes, dislikes and preferences. Each person's care plan included information on how they liked to spend their time, the people who were important to them and their preferred daily routine. People were supported to maintain relationships with their family and friends. One relative told us that they had been able to stay at the service on occasions, for example if their daughter was unwell.

At the time of our inspection, bedrooms were being redecorated. People had been involved in choosing the colour schemes for their rooms. In the East Wing of Orchard Lodge, where work had begun, there were a number of brightly coloured bedrooms. One person showed us their room and said that they had chosen the colour pink. The maintenance staff member told us, "(Name of person) wanted blue but she chose two shades so we did two walls of each". People told us that they liked the home and their bedrooms.

People were asked for their views and ideas during regular 'service-user meetings'. These meetings were chaired by activity staff. In the minutes we saw that activities, outings, the menu and plans for future events such as the Halloween party had been discussed. People had been asked for their feedback on visiting entertainers and on where they would like to go.

At our last inspection, we made a recommendation that the service explored the use of communication systems to promote people's ability to communicate their views. At this visit, we found that the registered manager had taken action to make improvements. Each person had a communication passport, which detailed how they communicated and how staff or visitors could best interact with them. These passports were attached to people's wheelchairs. One staff member had attended a course on communication run by the local authority and had subsequently been designated the home's 'Communication Champion'. The course ran over five months and a further three staff were booked to attend. The provider had also increased their in-house Speech and Language Therapy (SALT) provision, from a day a week to a full-time position. The new SALT told us that they hoped to focus on people's communication needs, as assessments for eating and drinking needs had recently been completed. They told us, "I feel the staff know people really well, they interpret their gestures and vocalisations. They are really good at offering choices and going with what people want. I will introduce more guidelines and give training".

There was clear guidance in people's care plan regarding their methods of communication. This helped staff understand how best to communicate with people and what their gestures could mean. Further information was included in a DisDAT assessment for each person. This detailed the person's appearance, vocal signs, mannerisms and posture when content and when distressed. For example we read, '(Name of person) makes sounds and grimaces and moves his hands when he is not comfortable or in pain' or, 'I will turn my head away when I have had enough to eat or I do not like what is being offered'. Staff were using a 'Touch Cue' system for one person. This involved using consistent gestures before carrying out daily tasks so that the person would know what to expect and understand through non-verbal means. For example, prior to assisting the person to the toilet, staff were to, 'Use two downward strokes on the outside of his right thigh'. Staff maintained daily records of when they had used the system. A second person used an iPad to aid their communication and staff supported them in this.

We observed staff as they communicated with people and saw that they supported people to be as involved as possible in decisions affecting them. One staff member held up their hands, asking the person to look to the left hand for 'tea' and the right hand of 'coffee'. The person was able to make their choice. Another staff member used a 'hand on hand' approach to support one person to participate in a sensory cooking session.

People told us that staff treated them respectfully. We observed that staff called people by their preferred names, informed them of what they intended to do, asked permission before moving them in their wheelchairs and ensured that care and support was carried out discreetly or in a private space. A relative told us that they were, "Perfectly satisfied", adding, "We would say her privacy is second to none". A GP said, "People are looked after well and with dignity". A senior staff member had been appointed as a dignity champion. They told us that the role was about, "Respecting people" and said, "It's the little things, asking people what they'd like. It's the people's home and staff come here to work".

Good

Is the service responsive?

Our findings

At our inspection in September 2015, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not taken sufficient action in response to feedback on the services provided. At this visit, we found that feedback had been sought and responded to appropriately. The breach in regulation was met.

Relatives were asked for their feedback through surveys sent out by the provider. We looked at a selection of survey responses received in 2016. The majority of respondents were satisfied with the service and found much of it to be 'good' or 'excellent'. Actions in response to other feedback were on going, such as through the redecoration programme that was underway to upgrade people's bedrooms and furnishings. A suggestions box was available in reception for people, relatives or staff to provide comments or ideas. A reflexologist who visited the service told us, 'On the occasions when I feel it necessary to provide feedback or query something regarding a resident, it is always listened to and acted upon quickly'.

People and their relatives felt confident to raise any concerns or complaints. How to make a complaint was a discussed during service user meetings, along with information on how to access advocacy services if they wished. The complaints procedure was displayed in the home, including in a pictorial format to aid understanding. We looked at the record of complaints received. The complaints dated back to the first quarter of the year. These had been responded to appropriately and in line with the provider's policy. The registered manager completed a quarterly review of complaints to check for trends and to ensure that any learning had been taken on board.

People, or their relatives, had been asked how they would wish to be cared for and about what was important to them. This information was included in a care plan which provided information to staff about the person and their support needs. The care plans were personalised and demonstrated that staff had taken time to get to know people and understand their wishes. There was information about people's lives, important events and their interests.

People's care needs were clearly documented. Each person's care plan contained an assessment of their needs and detail on how to support them. There were sections including physical health needs, personal care and social activities. Where appropriate specific care plans had been completed such as for suctioning or the use of a tailored sleeping system. Monitoring records were in place to ensure that care had been delivered in accordance with the care plan. Staff had also prepared hospital passports for each person. These documents provided a summary of people's care needs which would go with them to hospital. The hospital passport should help hospital staff to provide support in line with the person's needs and preferences, especially when they are unable to communicate their views directly.

We observed that staff followed the guidance in people's care plans, for example by using a personalised communication system, providing adapted crockery or cutlery at mealtimes and in responding when a person was distressed. In one person's care plan we read that they did not like noise. When they appeared disinterested in their meal, staff turned off the television which appeared to calm the person and enable

them to enjoy their food.

Staff attended handover meetings, which helped them keep up-to-date with any changes in people's care and support needs. Staff told us that these meetings were useful and that they felt confident they understood people's support needs and wishes. A GP told us, 'We are always contacted at the surgery if there is any issue with health of a patient at an early stage, a demonstration of the responsiveness of staff to their patients' needs'.

People were involved in a variety of activities. One person told us, "We had a Halloween party on Monday, it was so lovely. I was (dressed) in all black". Photos of other events were displayed on the walls within the home. This included photos of the summer garden party to which people invited their relatives and friends. The home employed an activity coordinator and activity assistant who provided daily activities within the home. Records showed that people had been involved in sensory cooking, music therapy, arts and crafts and outings. There were also performances from visiting entertainers and a regular church service. A registered nurse told us, "(Name of registered manager) is arranging more activities. (Name of person) is supposed to go out twice a week, now that is happening. They're all going out a lot more". Since our last inspection, a new driver had been employed by the home, which made it easier for staff to facilitate off-site activities. We saw that people had been shopping, out for coffee and to visit day centres. In December, several outings to a local pantomime were planned. We observed a variety of activities during our visit and saw that people were engaged and interested.

Good

Is the service well-led?

Our findings

At our inspection in September 2015, we found the provider was in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not displayed their rating received following our inspection in November 2014. At this visit the rating from our September 2015 inspection was prominently displayed in both Orchard and Boldings Lodges. The breach in regulation was met.

There was a positive and open culture at the service. Staff spoke of great improvements, including in how the management listened, responded to suggestions and supported staff to work as a team. One care assistant said, "Now you don't feel stressed, you are able to speak up". Another told us, "We've improved a lot since then (the last inspection). We are more focused on the service users. Now we are organised, we work as a team. I can feel the difference for the people living here". A third said, "It's a good atmosphere. She's a bubbly manager, very easy to talk to. If you've got any concerns she will listen and is proactive about sorting it out". A reflexologist who visited the service told us, The overall atmosphere is friendly and there is always time for laughter, compliments and praise for the residents as well as firm yet positive encouragement when needed (e.g. during physio)'. Throughout our visit, we observed that people were greeted and supported in a positive way. Relatives were warmly welcomed. One relative told us, "We would definitely recommend the home. We have done. We are very happy with how they look after (name of person)".

Since our last inspection, a new registered manager was in post. There was strong leadership within the home and we noted significant improvements in the care that people received and how the service was delivered. People told us that the registered manager was kind and easy to talk to. One person said, "She's very lovely". We observed that she was regularly available to people in the different parts of the home and was willing to assist staff. All of the staff we spoke with praised the registered manager. One care assistant said, "(Registered manager) is great. She's made a big difference. She's got a very good relationship with all of them (people who lived at the service) and the families too". Another told us, "The registered manager listens to our side, when we bring something up they make an action plan". A registered nurse said, "She'll chase things up and make sure it is done". Feedback from external professionals was equally positive. A reflexologist told us that the registered manager was, 'Always visible and approachable'. A GP said, 'I believe there has been noticeable improvement since October 2015 due to the arrival of a new enthusiastic manager. I see the service as efficient, safe, caring, responsive and certainly well led'. The registered manager told us, "I can see the staff trust me. They will come to me and say. That's a good feeling. They will come to me with any problems".

The registered manager was supported by a deputy manager who had been in post since June 2016 and a new area manager who had been in post for four months. Staff had confidence in the leadership of the home. One care assistant said, "There is none of the politics now. You can just go to the manager and discuss any problems. There is also discipline now. We used to just talk about problems with each other but now if we have problem they will look at it. Before I didn't know where to work or who you could trust". Other staff spoke of improvements, including in how sickness absence was managed, the fairness of how the

rota and annual leave was decided and in communication.

The registered manager held regular staff meetings. These provided an opportunity for staff to have their say and to provide relevant updates. We saw that safeguarding, wound care and the use of body maps had all been discussed. At the end of the minutes we read, '(Registered manager) asked staff individually about any issues, problems or comments'. A registered nurse said, "They (staff meetings) give people the opportunity to say what they need to say. (Registered manager) will listen to the suggestions. She is willing to try new things". One staff member told us how their suggestion to move the staff smoking shelter had been taken on board and the work completed.

The registered manager monitored the quality of the service to ensure that it was of a consistently good standard. Being a registered nurse, the registered manager would often cover shifts on the floor which she told us helped her to identify what was working well and where improvements could be made. This also enabled her to support staff and identify any areas of practice that needed attention. The registered manager told us, "I really like to check everything. I check folders at random, such as MAR or the carer and nurse notes. I address any findings to staff and/or raise it at staff meetings. I usually walk around every day. They do know that I am going to check". A care assistant confirmed this when they told us, "Before we had papers to fill but no one was checking. Now there is accountability and that's a good thing. You feel proud of your job now. Before there was no motivation, nobody appreciated what you were doing". Staff told us that the registered manager often attended handover meetings and that she had carried out unannounced spot checks, including during the night.

The registered manager and provider used a variety of internal and external audits to monitor the performance of the service. Internal audits included checks on infection control practices completed by a registered nurse with lead responsibility in this area, monthly audits of hoist slings were carried out by the physio and checks on the medicines in each unit completed by the registered nurses. The registered manager reviewed accidents, incidents, hospital admissions and ambulance calls outs to identify any possible trends or patterns. On a monthly basis, a representative of the provider, known as the area manager, completed a detailed check of the service. A larger internal audit had been carried out by representatives of the provider and the feedback received in September 2016. We saw that actions identified by these audits had been addressed and signed off when completed. This included an order for new dining room chairs, updating portable electric appliance (PAT) testing and installing a sensor mat to reduce one person's risk of falling.

External audits had been commissioned by the provider to look at the service's compliance with the regulations and to ensure that health and safety requirements were met. In addition, the pharmacy had reviewed the home's medicines practice and the local authority contracts and commissioning team had completed a visit in May 2016. In each case, the registered manager had responded to feedback from the audits to deliver improvements in the service. Between January and June 2016, the score on the health and safety audit had increased from 91 to 94 percent. The registered manager shared the findings of audits with the staff team. She said this was to raise awareness and to seek their help in implementing and embedding change.

We found that the areas for improvement identified at our last inspection had been addressed and that there was an effective system in place to monitor the day-to-day running of the service and to make improvements for people and staff.