Burlington Care Limited

Foresters Lodge

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

Summary of findings

Overall summary

This inspection took place on 27 April 2016 and was unannounced. We previously visited the service in October 2013. We found that the registered provider did not meet all of the regulations we assessed. We carried out a follow up inspection on 18 February 2014 and found that the registered provider had met the regulations.

The home is registered to provide accommodation and care (including nursing care) for up to 55 people. The home provides support to younger adults and older people, people with physical disabilities and sensory impairment, and people who are living with dementia. On the day of the inspection there were 52 people living at the home, including three people who were having respite care. The home is situated in Bridlington, a seaside town in the East Riding of Yorkshire. There are two units within the home, Maple and Oak. Each unit has lounge areas, dining areas, bedrooms, bathrooms and toilets, although the main dining room is used by people in both units for eating meals and taking part in activities. There is a passenger lift so people are able to access the first floor if they cannot use the stairs.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager who was registered with the Care Quality Commission (CQC). 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.

On the day of the inspection we saw that there were sufficient numbers of staff employed to meet people's individual needs. New staff had been employed following robust recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people were working at Foresters Lodge.

People told us that they felt safe living at the home. People were protected from the risks of harm or abuse because there were effective systems in place to manage any safeguarding concerns. The registered manager and care staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff told us that they were well supported by the registered provider and registered manager, and felt that they were valued. They confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. This included training on the administration of medication. We checked medication systems and saw that medicines were stored, recorded and administered safely.

People told us that staff were caring and that their privacy and dignity was respected. They said that they received the support they required from staff.

People's nutritional needs had been assessed and people told us they were very happy with the food provided. We observed that people's individual food and drink requirements were met.

We saw that any complaints made to the home had been thoroughly investigated and that people had been provided with details of the investigation and outcome. There were also systems in place to seek feedback from people who lived at the home, relatives and staff.

Staff, people who lived at the home, relatives and a social care professional told us that the home was well managed. Quality audits undertaken by the registered provider and manager were designed to identify any areas of improvement to staff practice that would promote people's safety. Staff told us that, on occasions, feedback received at the home was used as a learning opportunity and to make improvements to the service provided.

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.

Staff adhered to the home's medication policies and procedures and this meant people who lived at the home received the right medication at the right time.

Staff had been recruited following robust procedures, and there were sufficient numbers of staff employed to ensure people received a safe and effective service that met their individual needs.

Staff had received training on safeguarding adults from abuse and this meant they were aware of how to refer any concerns to the safeguarding authority.

The premises had been maintained in a safe condition.

Is the service effective?

Good

The service was effective.

Staff undertook training that equipped them with the skills they needed to carry out their roles, including training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's nutritional needs were assessed and people told us they liked the meals at the home. We saw that different meals were prepared to meet people's individual nutritional needs.

People told us they had access to health care professionals when required.

Is the service caring?

Good

The service was caring.

People who lived at the home told us that staff were caring and we observed positive relationships between people who lived at the home and staff.

People's individual care and support needs were understood by staff, and people were encouraged to be as independent as possible, with support from staff.

People told us that their privacy and dignity was respected and we saw evidence of this on the day of the inspection.

Is the service responsive?

Good

The service was responsive to people's needs.

People's care plans recorded information about their life history, their interests and the people who were important to them, as well as their preferences and wishes for care.

People were encouraged to take part in meaningful activities and keep in touch with family and friends.

There was a complaints procedure in place and staff told us they would support people to make a complaint if they had difficulty in doing so. People who lived at the home were invited to comment on the care and support they received.

Is the service well-led?

Good

The service was well-led.

There was a manager in post who was registered with the Care Quality Commission, and people told us that the home was well managed.

There were sufficient opportunities for people who lived at the home and staff to express their views about the quality of the service provided.

Quality audits were being carried out to monitor that staff were providing safe and effective care.

Foresters 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 registered 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.

The inspection took place on 31 March 2016 and was unannounced. The inspection team consisted of one adult social care (ASC) inspector and an Expert by Experience. An Expert by Experience is someone who has personal experience of using or caring for someone who uses / used this type of service. The Expert by Experience who assisted with this inspection had experience of supporting older people with dementia and other health problems associated with old age.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authorities who commissioned a service from the registered provider and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. The registered provider was asked to submit a provider information return (PIR) before this inspection and they returned it to CQC within the required timescales. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

On the day of the inspection we spoke with four people who lived at the home, five relatives, four members of staff, the registered manager, the deputy manager and the registered provider. Following the day of the inspection we received feedback from a social care professional.

We looked around communal areas of the home and bedrooms (with people's permission). We also spent time looking at records, which included the care records for four people who lived at the home, the recruitment and training records for three new members of staff and other records relating to the management of the home, including quality assurance, staff training, health and safety and medication.

Good

Is the service safe?

Our findings

The staff who we spoke with told us they had completed training on safeguarding vulnerable adults from abuse, and this was demonstrated in the training records we saw. They were able to describe different types of abuse, and the action they would take if they became aware of an incident of abuse or had any concerns. One member of staff told us that "Any abuse would be 'picked up' by staff" and that the information would be passed to the registered manager, who would listen to their concerns. We found that when safeguarding concerns had been identified, the safeguarding 'threshold' tool provided by the local authority had been used to identify whether the issue needed to be managed 'in house' or whether an alert needed to be submitted to the local authority safeguarding adults team. The registered manager had attended the 'threshold' tool training and it was clear that the new protocols were understood.

People told us that they felt safe living at Foresters Lodge. One person said, "Yes, there is somebody about day and night" and "Yes, I've never once felt unsafe." However, one person told us that staff sometimes took away the emergency call bell from them so they did not always feel safe. We asked the registered manager to investigate this issue and they sent us the outcome of their investigation, with a satisfactory explanation of events. They told us that there was clear documentation at the home showing that staff attended to this person when they used the call bell.

We asked staff how they kept people safe and their comments included, "Entrances are locked, we keep communal areas uncluttered, we monitor residents and we answer call buttons as quickly as possible", "We use proper equipment, answer call buttons quickly, make sure there are always staff about and complete observation charts" and "We risk assess to keep people out of any hazards or risks." Staff told us that they never used restraint at the home. Relatives told us they felt their family members were safe. One relative told us, "Yes, [name] can't get out and she is checked hourly throughout the night."

Risk assessments had been completed for any areas that were considered to be of concern. We saw that everyone had a risk assessment in respect of moving and handling and the risk of falls. These included a 'safe system of working' document that recorded any mobility equipment that needed to be used and how many staff were needed to assist the person with their mobility needs. Some people had more individual risk assessments in place for areas such as the use of bed rails, leaving the home un-noticed, smoking and use of the call bell. We saw that risk assessments had been reviewed on a regular basis to ensure they remained relevant and up to date.

We noted that care plans included details of equipment that was used by people to reduce the risk of pressure sores developing. One person had pictures / photographs of the positions they needed to be placed in to improve their posture and comfort in bed.

We saw that any accidents or incidents involving people who lived at the home were recorded. These were analysed each month to identify the type of accident, whether any patterns were emerging and if any areas that required improvement had been identified. We noted that the accident book recorded advice for staff on which accidents needed to be notified under the Reporting of Injuries, Diseases and Dangerous

Occurrences Regulations 1995 (RIDDOR). Body maps recorded any bruises, wounds or sore areas to assist staff in monitoring the person's recovery.

The registered manager told us that, during the day, nurses administered medication to people who needed nursing care and senior care workers administered medication to people who needed residential care. During the night, the nurse on duty administered all medication. People who lived at the home told us that they understood why they were taking their medication and that they received it on time.

We observed that there were safe systems in place to manage medicines and that medication was appropriately ordered, received, stored, recorded, administered and returned when not used. We looked at medicines and medication administration records (MARs) and we spoke with the registered manager and a nurse about the safe management of medicines, including creams and nutritional supplements within the home. We observed that medicines were stored safely and securely, including controlled drugs (CDs). CDs are medicines that require specific storage and recording arrangements. There was a suitable cabinet in place for the storage of CDs and two CD record books, one for people receiving nursing care and one for people receiving residential care. We checked a sample of entries in the CD book and the corresponding medication and saw that the records and medication in the cupboard balanced. We also saw that CDs were audited each week to ensure no recording or administration errors had been made.

The temperature of medication fridges and rooms were checked and recorded each day to ensure medication that needed to be kept cool was stored at the correct temperature. The packaging of medication that was stored in boxes or bottles was dated when the medication started to be used, to ensure it was not used for longer than the recommended period of time.

We found that medication records were clear, complete and accurate, although we discussed how it would be helpful to record more information when medication was discontinued mid-cycle and that more care was needed to use codes accurately. There was an audit trail to ensure that medication prescribed by the person's GP was the same as the medication provided by the pharmacy. Medication was supplied by the pharmacy in a 'biodose' system; this is a monitored dosage system where tablets are stored in separate compartments for administration at a set time of day. The system was colour coded to identify the time of day the tablets needed to be administered and the same colour coding was used on MARs; this reduced the risk of errors occurring. There was a separate chart to record where on the body pain relief patches should be applied.

We checked the recruitment records for two members of staff. These records evidenced that an application form had been completed, references had been obtained and checks had been made with the Disclosure and Barring Service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and helps to prevent unsuitable people from working with children and vulnerable adults. Staff who we spoke with confirmed that they were not allowed to start work until these recruitment checks were in place. These checks meant that only people who were considered safe to work with vulnerable adults had been employed at Foresters Lodge. There was a system in place to check that nurses had active registrations to practice with the Nursing and Midwifery Council (NMC) and we saw this information recorded in staff personnel files.

Staff were issued with a staff handbook and a job description when they were new in post. This ensured staff were aware of what was expected of them.

The registered provider told us that they used a dependency tool to determine whether people had low,

medium or high needs. This had resulted in staffing levels being reduced during the day. On the day of the inspection we observed that there were sufficient numbers of staff on duty to enable people's needs to be met. We noted that call bells were answered promptly and that people did not have to wait for attention. The registered manager told us that the standard staffing levels were four care workers until 2.00 pm, reducing to three care workers for the rest of the day shift, on both Maple and Oak units. In addition to this, there was a senior care worker on Maple unit and a nurse on Oak unit throughout the day. At night there were two care workers on each unit, with a nurse on duty to cover both units. We checked the staff rotas and saw that these staffing levels were being consistently maintained. The registered manager and deputy manager were supernumerary and the team leader was supernumerary for three days a week. In addition to care staff, there was an activities coordinator, domestic assistants, a chef and an administrator on duty. This meant that care staff were able to concentrate on supporting people who lived at the home.

People who lived at the home told us there were enough staff on duty although one person added, "But they are overworked." They went on to say that they regularly had to wait a long time during the night for attention. We asked the registered manager to look into this; they told us that they had spoken with the person concerned and informed them about the current staffing levels during the night. They had reassured them that they would not have to wait for their needs to be attended to and the person had been satisfied with this response.

Staff told us that they worked well as a team. They said, "Staffing levels are quite good. Teamwork is really good. We all pull together; I'm happy with staffing levels." Other staff told us that as staffing levels had recently been reduced they occasionally struggled to meet people's needs, especially if someone went off sick. They said that the registered manager always tried to cover any staff sickness but this was not always achieved. A relative told us, "There are not enough staff at night – I think there are only two staff on at night in this area." However, other relatives told us they felt there were enough staff on duty and said that they had observed that staff responded quickly to the emergency call bell.

We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for gas safety, the electrical installation, the passenger lift, mobility hoists, bath hoists, portable appliances, the fire alarm system, emergency lighting and fire extinguishers. There was a fire risk assessment in place and we saw that fire drills were taking place at six-monthly intervals. This helped to make sure that people who lived and worked at the home understood what action to take in the event of a fire. The home's maintenance person carried out a weekly fire test including checks on the fire alarm system, emergency lights, fire doors, fire extinguishers and exit routes. This helped to make sure the fire safety arrangements in place at the home were robust. The maintenance person also carried out checks on water temperatures, window opening restrictors and the safety of bed rails each week to ensure that the premises remained safe for the people who lived and worked at the home.

There was a business continuity plan in place that advised staff on the action to take in the event of emergency situations such as winter emergencies, staff emergencies, heat-waves, flood, fire or a service user going missing from the home. This included information about evacuating the premises, alternative accommodation and important telephone numbers. There were also personal emergency evacuation plans (PEEPs) in place which recorded the support each person would need to evacuate the premises in an emergency.

We walked around the building and saw that communal areas of the home, bedrooms, bathrooms and toilets were being maintained in a clean and hygienic condition. People who lived at the home told us that their bedroom and communal areas of the home were clean. At the time of the inspection the home had

achieved a rating of 4 following a food hygiene inspection undertaken by the local authority Environmental Health Department. The inspection checked hygiene standards and food safety in the home's kitchen. Following the inspection the registered manager told us that there had been a further inspection and the home's score had increased to 5. Five is the highest score available.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 MCA 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.

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). We checked whether the service was working within the principles of the MCA, and whether authorisations to deprive a person of their liberty were in good order. We found that the registered manager and deputy manager had produced a list to record applications for authorisation that had been submitted to the local authority, applications that had been authorised and renewal dates. Approximately 50% of staff had received training on MCA and DoLS, and most staff had completed training on dementia awareness.

We saw in care records that staff had taken appropriate steps to ensure people's capacity was assessed and to record their ability to make complex decisions. Two people's care plans included information about a relative who acted as Power of Attorney (POA) for their family member. A POA is someone who is granted the legal right to make decisions, within the scope of their authority (health and welfare decisions and / or decisions about finances), on a person's behalf.
One care plan recorded whether this was in respect of finances and / or health and welfare.

We asked people if they were consulted about their care and if their consent was sought. They told us, "I tell them what I need" and "They ask if I mind and I say 'No'." However, another person told us, "They (the staff) are in control." We saw that there were consent forms in place to ask people to consent to having their photograph taken.

Staff told us that they supported people to make decisions about their day to day lives. Comments included, "We ask them about menus for dinner time, they choose what to wear and how they want their hair" and "They make decisions from the minute they wake up – when to get up, what to wear, activities – every decision is made by the resident". We saw that one person's care plan recorded, '[Name] is to be given as much information as required in a simple, straightforward manner / format he can understand. He should be given time to consider and respond to decisions and choices regarding his life and care'.

People who lived at the home and relatives told us they felt staff had the skills they needed to carry out their role. We saw that the training record identified which training was considered to be essential by the organisation; this was induction, fire safety, moving and handling, dementia awareness, safeguarding adults from abuse and health and safety / infection control. 'Desired' training consisted of the Qualification Credit Framework (QCF), previously National Vocational Qualification (NVQ) training at Level 2 or 3, safe handling of medication, emergency first aid at work, MCA / DoLS, food hygiene, end of life care and non-abusive

psychological and physical intervention (NAPPI) training. All senior staff had completed training on medication and 50% of staff had completed training on MCA / DoLS. Nurses had also undertaken training on phlebotomy, catheter care and percutaneous endoscopic gastrostomy (PEG) feeding. PEG feeding is a procedure in which a tube is inserted directly to the stomach to provide food and medication. The training matrix also recorded how often training needed to be repeated to make sure that staff knowledge and skills was up to date.

Records evidenced that new staff carried out induction training over a three day period and also shadowed experienced staff as part of their induction training. This was confirmed by the staff who we spoke with. One member of staff told us, "I had a three day intense induction. It covered MCA, safeguarding, moving and handling and health and safety" and another member of staff said, "Yes, I shadowed for two weeks."

Staff told us they had attended a variety of training courses in the last year; these included fire safety, dementia, managing challenging behaviour, food hygiene, end of life care, MCA and DoLS, medicines awareness and the use of thickening fluids (nutrition). One staff member said, "I have been on over 20 courses in the time I have been here."

We saw the supervision schedule on the office wall. The deputy manager acknowledged that staff supervision had become infrequent but said that they were working hard to ensure that staff supervision meetings were held more often. We saw that most staff had attended a supervision meeting in March 2016. There were three types of supervision meetings; to discuss a specific topic, one to one meetings and appraisals. We saw that the topics covered were the five principles of the MCA, dignity in care and infection control. Staff told us that they felt supported and that their views were listened to. One member of staff said, "Things are better now we have supervision meetings" and another told us, "I can go into the office any time and have a chat - there is always someone to listen." The registered provider told us in the PIR that managers were 'on call' outside of normal working hours and were required to attend the home if telephone contact did not solve the problem or query. This provided additional support for staff when managers were not on the premises.

We saw that 'handover' meetings were held at the beginning of each shift; there was one meeting in each unit. These meetings ensured that staff were made aware of any changes to a person's care needs, and that they had up to date information about each person who lived at the home.

People told us that their individual dietary needs were met. One person told us that they suffered with a bowel condition and said, "I have lots of fruit and fibre which is good." People also told us that staff were aware of their food likes and dislikes, and that they enjoyed the meals at the home. One person said, "Beautiful food – soups are my favourite." Staff told us that people's nutritional needs were recorded in their care plan, and that they recorded people's food and fluid intake on monitoring charts when any concerns about diet had been identified.

The cook confirmed that they had a list in the kitchen recording people's likes, dislikes and special needs, such as soft or pureed diets. They said that they always used a low sugar substitute so meals were suitable for everyone, including diabetics. The cook told us that some days there was a choice of main meal, although there was no alternative choice on the day of the inspection. However, we saw that alternatives were provided if people required them, as one person was provided with an omelette and salad. People were offered a choice of dessert. We saw that each component of liquidised meals was prepared separately so that the meal remained appetising. We did not see a menu on display, either written or in picture format.

We saw that staff encouraged people to eat and when they required assistance, this was done on a one to

one basis and was unhurried. Some people had adapted crockery that helped them to eat independently. There was music playing and staff chatted to people and they chatted to each other; this made the mealtime a social experience. We saw that people were provided with ample drinks throughout the day, and that staff encouraged people to drink.

Care plans recorded the equipment people required to enable them to eat independently, such as adapted crockery and cutlery. Nutritional assessments and risk assessments had been carried out and we saw that advice had been sought from dieticians and speech and language therapists (SALT) when there were concerns in respect of eating and drinking. People were also being weighed on a regular basis as part of nutritional screening. These arrangements enabled staff to monitor people's nutritional well-being.

People told us that they were able to see a GP if they needed one. One person said, "They would ring one if I needed one" and another person told us, "Easy, I saw one yesterday." A relative told us that they were always informed about their family member's GP visits and general well-being. We saw that any contact with health care professionals was recorded, including the reason for the contact. People's records evidenced that advice had been sought from health care professionals such as dentists, district nurses, the community learning disability team, chiropodists, and speech and language therapists (SALT) and that any advice received had been incorporated into care plans. We saw that care plans recorded signs staff should look out for that meant a person's health was deteriorating. One person's care plan recorded, 'Any of above symptoms, ring GP.'

We saw that one person had a patient passport in place; these are documents that people can take to hospital appointments and admissions when they are unable to verbally communicate their needs to hospital staff.

We saw that there was signage to help people orientate themselves around the home and people who lived at the home and relatives told us they did not have any concerns. One member of staff told us that there had been problems with the passenger lift, but it had always been repaired quickly. They added that there were plans in place to refurbish the home and that a new lift was included in the plans. Another member of staff told us that the carpet was "A bit busy" for people living with dementia. The registered provider showed us the redevelopment plans and confirmed that the environment would be made more suitable for people living with dementia and that a new passenger lift would be installed.

Good

Is the service caring?

Our findings

People who lived at the home told us that they felt staff really cared about them, although one person told us, "They treat me like a child." A relative told us that they observed staff with people who lived at the home and had noted, "Staff are good; very caring." They added, "I feel confident enough to go away and leave [relative's name] at the home." Other comments included, "I have noted that staff have empathy with people who lived at the home", "From what I have seen, they are very friendly" and "They give [my relative] kisses and cuddles." Staff told us that they felt staff who worked at the home really cared about people. One member of staff said, "Yes, we all build a bond with our residents" and another told us, "Yes all staff really care."

Relatives told us that they had observed staff were very careful to respect a person's privacy and dignity. One relative said that personal care was "Done discreetly" and another said they had noted, "Staff always knock on doors before entering." People who lived at the home confirmed that staff respected their privacy and dignity. One person gave the example of staff covering them with a blanket when assisting them with personal care to protect their modesty. A social care professional told us that they had witnessed people being treated with dignity and respect, such as being asked about their food and drink choices or where they would like to sit, and they had seen that staff had respected people's views and choices. Staff described how they respected people's privacy and dignity. Comments included, "We close doors, close curtains when personal care is being done – be discreet" and "Dignity is a big thing here. Personal care is done in private – we shut doors and keep people covered up." One person who we spoke with told us they were a dignity champion. Their role was to promote good practice within the service. We noted that care plans recorded whether a person wished to be supported with personal care tasks by a staff member of the same gender.

We asked people if staff communicated with them in a way they understood and people were uncertain about this. However, on the day of the inspection we saw that staff were patient with people and took time to explain things to them clearly and in a way that they could understand. This varied from person to person to take account of their specific ways of communicating and level of understanding. Relatives told us that they were happy with the level of communication between themselves and the home. One relative said, "Yes, they tell me the things I need to know."

Discussion with the staff revealed there were people living at the service with particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that those diverse needs were adequately provided for within the service; the care records we saw evidenced this and the staff who we spoke with displayed empathy in respect of people's needs. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

Relatives told us that people were supported to be as independent as possible. One relative said, "[My relative] is allowed to do her own thing." Staff told us that they encouraged people to retain their independence. One member of staff said, "People make their own choices and we encourage their mobility" and another told us, "We speak to them and get them to do what they can – we encourage them."

There were information leaflets on display and available for relatives and visitors to take away with them, such as advice from the Alzheimer's Society and information about safeguarding adults from abuse. The home's notice board included information about the outcome of surveys, the outcome of quality audits, the home's newsletter, the dates of forthcoming resident / relative meetings, the home's duty of candour policy and the five principles of the MCA.

We saw that people had care plans in place that recorded their wishes for care at the end of their life. Some people had 'Do Not Attempt Resuscitation' (DNAR) records in place and those we saw had been completed appropriately. One person's care plan recorded that they had a DNAR in place and detailed information about an advanced directive.

Good

Is the service responsive?

Our findings

A relative told us that they had shared information about their family member when they were first admitted to the home, such as their medical history and previous lifestyle, to help develop their care plan. They said that staff seemed interested to know about their family member. A social care professional supported this view. They told us, "I got the impression that the assessor was keen to know as much about the lady as possible in order to meet her needs - the people in charge do listen with regard to understanding a person's needs." The social care professional went on to tell us about this person's significant improvement in presentation and mood following their admission to the home. "I felt the staff improved the lady's quality of life tremendously and she seems much happier."

The care records we saw included care needs assessments, risk assessments and care plans. Initial assessments included the person's medical history and a life map; these contained details of the person's education, employment, marital status, holidays / interests and pets. There was a dated photograph of the person, details of any known allergies and of their family relationships. Any risks that were identified during the assessment process were recorded in risk assessments that detailed the identified risk and the action that needed to be taken to minimise the risk. Assessment and risk assessment information had been incorporated into an individual plan of care. Topics covered in care plans included eating and drinking, elimination / continence, mobility, personal hygiene / dressing, skin care / pressure relief, health needs (including medication), breathing, communication, pain, end of life care and social activities. One person was assisted to eat via PEG and we noted there was a separate care plan to guide staff on how to carry out this process safely, including diagrams.

We saw evidence that care plans were reviewed and updated each month to ensure they contained relevant information, and more formal reviews had been organised by care managers to review the person's care package. A relative told us that they had attended care plan reviews. They said they had been "Totally included and their opinions had been sought."

Care plans recorded that key workers should spend two hours each week with people, and the things people liked to do during this time, e.g. 'Likes to chat and tell stories from his past'. Staff told us that they got to know about people's individual needs by reading care plans and by talking to people and their family and friends. Comments included, "We talk to them. I feel personally I have enough time to chat with them" and "We talk to them. Talk when getting them up – residents love a nice chat." A relative told us that their family member regularly requested food and drink during the night, and it was always provided. This evidenced that people who lived at the home received care that was centred on them.

We saw there was a notice board displaying details of forthcoming events, such as entertainers, church services and exercise sessions. A relative told us that their family member took part in activities at the home and had made friends. People who lived at the home told us that there were activities available, but the people who we spoke with told us they chose not to take part. Staff described the various activities that took place at the home; these included craft work, bowls, dominoes and, bingo. They also told us that pets were brought into the home and that they had entertainers; there was a singer at the home on the afternoon of

our site visit and we saw that many of the people who lived at the home had enjoyed the occasion. The registered provider told us in the PIR that the activities coordinator was liaising with a local community bus provider so they could organise more trips out for people.

People told us that their relatives could visit at any time and that their relatives and friends were made welcome. One person said, "Yes, my husband comes every day." Relatives confirmed that they could visit at any time. Staff told us that they helped people to keep in touch with their family and that they would take a telephone to people so they could speak to members of their family and friends.

We asked people if they were kept informed about events at the home. Two people said they were not, but another person told us they read the information on the notice board so were well informed. Care plans included a sheet where any contact with family and friends was recorded. This evidenced that relatives were kept informed about their family member's well-being.

Relatives told us who they would speak to if they had any concerns or complaints and that they were confident their concerns would be listened to, although they had not had any complaints. One relative said, "I would go to [name of registered manager] and I know they would put it right." Two people who lived at the home told us who they would speak to if they had a concern or complaint and one person gave us an example of a complaint that they had made and the action that had been taken to improve the situation.

We saw that the home's complaints procedure was displayed in various areas of the home. We checked the complaints and compliments log and saw that any complaints made to the home had been recorded appropriately. Action had been taken following investigations (when appropriate) and people had been informed of the outcome.

Staff told us that they would deal with minor complaints and concerns themselves if they could. They said they would inform the registered manager of any more serious concerns. Staff were confident that people's complaints would be listened to and dealt with. One member of staff told us, "I would sit and talk to the person. If it was serious I would write it down, go to see the manager and discuss it. I feel it would be listened to and acted on." Staff told us that there were 'residents meetings' for people who lived at the home so that gave them another opportunity to express any concerns.

People told us that they had not been asked to give feedback about the care and support they received at the home. However, we saw that surveys had been distributed in January 2016. Twenty-one people who lived at the home had returned a survey; 16 said that they were happy with all areas of the care provided and we saw that any minor concerns had been addressed when the outcome of the survey had been analysed and collated. The outcome of the survey was displayed on the home's notice board and this included the comments, 'It's lovely' and 'Not enough room to move around in – it could be a bit bigger'. This showed that the registered provider was open and transparent about any comments they had received.

We saw the minutes of meetings that were held for people who lived at the home. Feedback was recorded on the notice board as 'You Said, We Did'. Suggestions had been received and acted on, such as 'You said you would like more bread and dripping and pork sandwiches for tea'. The homes response was 'We are going to save fat from roast dinners and do dripping and pork or beef sandwiches the next day'.

Good

Is the service well-led?

Our findings

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this; this meant the registered provider was meeting the conditions of their registration.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had informed CQC of significant events in a timely way by submitting the required 'notifications'. This meant we could check that appropriate action had been taken.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were
well kept, easily accessible and stored securely. The policies and procedures were in the process of being reviewed.

We saw that there were clear lines of communication between the registered manager and staff, and that the registered manager knew about the specific needs of people living at Foresters Lodge. We asked staff about management and leadership and their comments included, "I think it is great. I feel as a home we have finally come together – it's nice" and "We are moving forward. All progress – it is a good thing. We all support each other and feel supported." We asked people who lived at the home if they felt able to talk with the registered manager and we received mixed responses. One person said they did not know who the manager was, another said they knew the manager but "She is too busy to talk to" and another said, "I know her and I can talk to her."

We saw that the home's information leaflet recorded the organisation's values; these were compassionate, approachable, respectful and enabling (CARE). We asked staff about the culture of the service and they described it as "Very comfortable – everyone is approachable", "I'm happy with it now. If I have something to say I will say it" and "I feel we can express any concerns freely. It has gone from being a shut door office to one where I can express things and be listened to." A relative told us the home was, "Homely, welcoming and friendly. I would give the home ten out of ten." One relative said that the home "Just feels right. There is a nice atmosphere" and another relative told us that they would recommend the home to other people "As they take such good care of [my relative]."

One relative told us they were aware that there were meetings for relatives, although they had not attended any. The dates of these meetings were listed on the notice board and we saw the minutes of the meeting held in January 2016. Topics discussed included food and drink, activities and entertainment, facilities, fundraising and the resident and relative survey. Issues raised at the previous meeting were mentioned so that people could be given feedback on any action taken.

We saw that surveys had been distributed to relatives and external professionals in January 2016. Two relatives had rated the home as excellent and one had rated it as good. A relative told us they had received a

survey and had completed it in consultation with their family member. They told us they were aware that the feedback had been analysed and the analysis had been displayed on the notice board in the reception area. Eight surveys had been returned by external professionals; 62.5% had rated the service provided as excellent and 37.7% had rated the service as good.

Staff told us that they attended meetings. The minutes of the meeting in January 2016 showed that the topics discussed were notice boards, appraisals, staffing levels, the lift and call system, hours and new rates of pay, staff rotas, clients, activities and uniforms. We noted that most staff attended the meeting and that they were required to sign the minutes to evidence they had read them. This meant that all staff were aware of the issues discussed and any decisions made. Staff told us that they were able to express their views and make suggestions at these meetings, and that their views were listened to. One member of staff described the meetings as "An exchange of ideas."

There was an audit schedule in place and we saw a variety of audits were being carried out to monitor the safety of the service and measure whether the service was meeting people's assessed needs. This included a care plan audit where six to eight care plans were reviewed each month; we saw that there was also a copy of these audits in people's care plans. These included actions that were needed to bring care plans up to date, but we noted that there was no record of when the work had been completed. Other audits included those for compliance (training, medication, care planning and infection control), daily charts (these were audited monthly), domestic / laundry, staff meetings, meals / nutrition and dignity. We saw that the most recent daily chart audit included an action plan and recorded 'to be reviewed by deputy manager during the May audit'. The dignity audit identified that some staff were using inappropriate language such as 'flower' and 'darls'. There had been a discussion with staff about communication and dignity and further staff observations followed. In February an analysis of audits had been produced and this looked at trends and whether they were improving, stable or declining. This showed that audits were being used to improve staff practice and the service people received.

Staff told us they would use the home's whistle-blowing policy if they observed poor practice from a colleague, and that they were confident the registered manager would respect their confidentiality. One staff member said, "Yes, I would have no qualms about using it."

We asked staff if there had been any learning from incidents or complaints made to the home. Two staff described how someone had left the home un-noticed and the safeguards they had put in place to reduce the risk of this happening again, such as half hourly checks on the person's whereabouts and new locks on external doors. A member of staff told us, "This was actioned the same day."

The registered provider told us in the PIR that they had introduced an 'Employee of the month' initiative and that people who lived at the home, relatives, visitors and staff were able to complete a nomination form. We saw that the notice board displayed details of the 'Employee of the month' with a description of why they had been chosen. This stated 'She is always happy and she is very caring and patient with all the residents'. The registered manager told us that nurses were reimbursed by the organisation for their annual registration fee with the NMC, and that the organisation was holding workshops to support nurses with re-validation. This showed that the organisation valued their staff.