CareQuality Commission

The Paddocks Care Home Ltd

The Paddocks Care Home

Inspection report

45 Cley Road
Swaffham
Norfolk
PE37 7NP

Tel: 01760722920

Date of inspection visit:
13 June 2017
15 June 2017

Date of publication:
21 September 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 13 and 15 June 2017. Our inspection visit on 13 June was unannounced but we the provider knew we were returning to complete our inspection on 15 June.

The service provides residential and nursing care for up to 100 people, some of whom are living with dementia. The service is divided into three separate buildings providing residential, nursing and dementia care respectively. At the time of our inspection at total of 80 people were using the service including several for respite care.

A registered manager was in post and had been very recently registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.
At our last inspection we rated the service Good. However some concerns were raised in the earlier part of this year about the unsafe management of medicines on the dementia unit and about other poor practice. The local authority investigated concerns and the provider worked hard to address all concerns. At this inspection we found that the new registered manager had put plans in place to bring about the required improvements. This was still a work in progress but the management team demonstrated good oversight of the work needed and had plans and strategies in place to continue to develop the service.

Medicines were managed safely and people received their medicines as prescribed. Robust new auditing and checking procedures ensured errors had been reduced and staff were confident in the management of medicines.

Staffing levels, and the deployment of staff, were a concern for some people and had an impact on the timeliness of care provided. Measures had been put in place to review staffing levels and these had already been increased. However, people on one unit reported occasionally having to wait too long for staff to meet their care and support needs.

Risks were assessed, documented in care plans and measures put in place to reduce these them. Health and safety audits and learning from 'near miss' incidents contributed to ensuring people were safe.

Infection control measures were in place and staff had a good understanding of how to limit the risk and spread of infection.

Staff were trained in safeguarding people from abuse and the manager referred incidents appropriately to the local authority safeguarding team for investigation.

Staff received a good induction and relevant training to help them carry out their roles. Staff were supported

with regular meetings, supervision and appraisal.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals and relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. Practice related to MCA and DoLS was good and the service operated in line with legal requirements. Staff sought consent appropriately for day to day care support.

Oversight of people's nutritional needs was good. People who used the service praised the food and those at risk of not eating or drinking enough were appropriately monitored and referred to dieticians if needed.

People were supported to access the healthcare support they needed promptly. There was evidence of good partnership working with the GP, GP matron service and district nursing team. Feedback from healthcare professionals was positive.

Staff were very caring and treated people respectfully, ensuring their dignity was maintained.

People who used the service, and their relatives, were involved in planning and reviewing their care and had opportunities to feedback about the service.

People received care that met their individual needs and took account of their likes, dislikes and preferences. Staff respected people's individuality.

People were supported to follow a range of hobbies and interests and to be involved in their local community.

A complaints procedure was in place and complaints were very well managed with information shared with staff and lessons learned. Verbal and written complaints were thoroughly investigated and responded to in writing.

The new registered manager had introduced new systems and procedures to drive improvements. Their approach had been well received by the people who used the service, relatives and staff. Audits were in place to monitor the safety and quality of the service and were effective in identifying concerns and effecting change. The manager had innovative ideas and maintained good oversight of issues which affected the service. Where issues still required some further work we had confidence in the provider to continue to address these.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

There were not always enough skilled and experienced staff to meet people's needs promptly.

Medicines were managed safely and people received their prescribed medicines as directed.

Risks were assessed and action taken to reduce risks as much as possible.

Staff understood their responsibilities with regard to safeguarding people from abuse and had received appropriate training.

Is the service effective?

Good

The service was effective.

Staff received a comprehensive induction and training although some relevant training was in the process of being refreshed.

Most staff had received training in MCA and DoLS and more was being provided. The staff were operating in line with the legal requirements of MCA and DoLS.

People were positive about the food and people at risk of not eating or drinking enough were supported and well monitored.

People were promptly supported to access appropriate healthcare professionals when they needed to.

Is the service caring?

Good

The service was caring.

Feedback was positive about the kindness and patience of the staff.

People's privacy and dignity was maintained and the service promoted good practice.

People, or their relatives, were involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed before they were admitted to the service and they, and their relatives, were involved in assessing and planning their care.

Care plans were detailed and person centred.

People were supported to follow their own interests and hobbies and to remain part of their local community.

A complaints procedure was in place and formal and informal issues were very well managed.

Is the service well-led?

Good

The service was well-led.

Staff were well supported and motivated by a strong manager. The manager was an effective role model for good practice.

There was a comprehensive system of audits in place to monitor the quality and safety of the service. Action followed promptly when any issue was identified.

The management team had good oversight of the service and was focussed on continuous improvement.

Care Quality Commission

The Paddocks Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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.

The inspection took place on 13 and 15 June 2017. The first day of the inspection was unannounced but we told the provider when we would be returning.

The inspection team consisted of one inspector, a nurse specialist adviser and two Experts by Experience on the first day and one inspector on the second day. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our experts had experience of services for older people and of dementia care.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with 26 people who used the service, four relatives, two visiting healthcare professionals, ten care staff, four senior care staff, an activities co-ordinator, a chef, the registered manager and the regional manager. We observed staff providing care and support and 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 communicate with us easily.

We reviewed 17 care plans, 17 medication records, three staff files, staffing rotas for the weeks leading up to the inspection and records relating to the quality and safety of the service and its equipment.

We received feedback from the Norfolk County Council safeguarding team and from the West Norfolk Clinical Commissioning Group Quality Assurance team both before and after the inspection visit.

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe at the service. One person said, "The girls are so good. They make me feel safe just by being there for me". Another person commented, "It's reassuring that they're there when you want them".

People trusted the staff to keep them safe, although several people on the residential unit, and their relatives, felt that sometimes there were not enough staff. A relative also told us, "I think they can be short staffed – often bells are continuously going". A second relative agreed, "A quicker response, a few more staff". Some people's comments were very negative and indicated a lack of staff at critical times. One person said, "Mostly that's alright [staff response to call bells] but this morning I rang to go to the toilet and it was practically an hour before they came". Another person had a similar issue saying, "They say 'We'll be about five minutes' [to help get the person up] but it can take three quarters of an hour". A relative commented, "The night staff, they can be an awfully long time and [my relative] can't wait and wets the bed",

However we noted that negative comments related to only one of the three units. On the other two units people were much more positive with one person saying, "They come when I press my buzzer" and another, "Yes they do come quickly". One person was keen to stress how quickly staff responded when they pressed their call bell saying, "They know I need a lot of help and they do it. I've only got to ring my bell and they do it". Another person explained, "Sometimes they tell me they're just doing something. They say 'I'll just be five minutes' and they always come – they're not long".

We looked at the rota for the residential unit where people had raised concerns and saw that staffing levels had been set according to the assessed needs of the people who lived on that unit. Rotas mostly reflected the assessed numbers, with the occasional shortfall through last minute staff sickness. The manager told us that staffing hours had recently been reassessed on this and one other unit had been increased by four hours a day and would be kept under review.

Most staff told us that there were enough staff to meet people's needs and that staff from other units helped out if needed. One staff member said, "If we need help [the unit manager] is here and others from other units. We all work together. It has to be done together….Out of hours [assistance and guidance from managers] works well. I've found if I need them, they're there".

Some staff on the residential unit expressed concern about staffing levels with one saying, "With the amount of residents [staffing numbers are] ok but the layout of the building makes it difficult". Another added, "The carers are brilliant. They care, they really do but there's not enough time. It feels like home here but there are not enough". Many staff acknowledged that things had recently begun to improve and were positive about the changes the new manager had made with regard to staffing levels and the deployment of staff. The manager in turn gave us assurances that they would continue to keep staffing levels under review and would give particular attention to the residential unit.

Staff employed at the service had been through a recruitment process before they started work. Staff and volunteers had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. Interviews took place to establish if staff had the skills and qualities needed to carry out the role safely and effectively. We noted that checks for one staff member had not fully investigated their previous employment history to ensure they were suitable for the role. We fed our concern back to the registered manager.

Before our inspection we had been made aware that there had been concerns raised about the safe management of medicines, including controlled drugs, at the service. Since these concerns had been highlighted the registered manager had introduced a number of new checks and audits to reduce the likelihood of any further issues. During our inspection people told us they were happy with the way staff supported them to take their medicines. One person said, "I put the tablets in my mouth. They make sure I've got enough water – they never leave me until I've taken them".

Overall we found that medicines on all three units were managed safely and people received their prescribed medicines on time. There were robust systems in place for the ordering, storage, administration and disposal of medicines including controlled drugs. Information about what people's medicines were for and how they liked to take them was comprehensive and made very clear to staff. For example one care plan stated 'You will place tablet on my lap in a tissue and I will take it'. We found staff to have a good knowledge and understanding about people's medicines. Staff received training in administering medicines and received regular observations of their practice to ensure they were competent. This happened for one staff member on the day of our inspection.

Protocols were in place for PRN medicines and we saw that these were regularly reviewed. PRN medicines are given only occasionally and not on a consistent basis, such as paracetamol for pain relief. However we did note that one person's protocol for medicine to relieve constipation had not been reviewed appropriately. This person was receiving this medicine routinely rather than on an occasional basis.

Care was taken to ensure that medicines were given at the correct time with enough of a gap between doses. Newly prescribed medicines were made available without delay. For example one person had seen the GP due to a suspected chest infection and antibiotics were prescribed and the course started on the same day. We saw that syringe drivers were in place to deliver medicines directly under the skin. These are used when people are not well enough to be able to take medicines by mouth. The clinical lead had recently reviewed the provision of syringe drivers. New equipment had been purchased and refresher training was being provided.

We saw that risks, such as those related to moving and handling, prevention of pressure sores, choking and a person's risk of falling, had been assessed. Actions to reduce these risks were very well documented in care plans. Risk assessments reflected people's current needs and were subject to regular review.

We observed staff working safely according to people's moving and handling care plans and people confirmed this always happened. People's risk of falling was well managed. Equipment, such as sensor mats, to alert staff that a person at high risk of falling had got out of bed, were in place for some people. One person's relative told us, "There is a mat in [my relative's] room so if [they] get out of bed the alarm goes off and they check to see what[my relative] is doing".

Falls were analysed each month by the manager to try to detect any patterns or trends to see if any further measures were needed to reduce the number of falls. The service had begun to use a new pictorial way of recording falls and pressure concerns which staff told us made them more aware of a person's increasing

risk. This also made them more likely to refer the person promptly for additional healthcare support.

Risks from the environment had been assessed and measures put in place to reduce these risks. Near miss events were recorded, investigated and action taken to reduce the likelihood of further risk. For example a razor had recently been found in a waste bin. Action had promptly been taken to reduce the likelihood of this situation happening again.

Fire detecting and fire-fighting equipment was regularly checked and serviced. The majority of staff had received fire training and new evacuation equipment had been purchased. Fire drills were carried our regularly, with the most recent being 7 June 2017. Following the news in the national press of a fire in a care home the service had reviewed their fire procedures. The service had purchased additional equipment and created a risk register to ensure the risk of fire was given a higher priority. Hoists, slings and lifts were maintained and regularly checked and a robust health and safety audit was in place. Water tests were carried out to ensure the water temperature did not pose a risk. The risk of legionella bacteria had been assessed and actions taken to reduce the risk.

Infection control was well managed with staff demonstrating an understanding of how to keep people safe by limiting the risk and spread of infection. Equipment such as aprons and gloves was available for staff to use to reduce the spread of infection.

There were measures in place to help protect people from the risk of harm or abuse. Staff had received training in safeguarding people from abuse, although nearly all were due for to have this training refreshed, according to the service's own training schedule. Staff were able to tell us what they would do if they suspected or witnessed abuse and information was displayed in staff areas to guide them. Some staff were not clear how they would raise concerns outside of the organisation by reporting directly to the local authority or CQC for example. The service had reported safeguarding concerns appropriately to the local authority and had notified CQC of any safeguarding concerns they were dealing with.

Good

Is the service effective?

Our findings

People were positive about the skills and expertise of the staff. One person who used the service said, "They know what they're doing – I've no complaints". Another commented, "I trust the staff – you couldn't have better". They also told us that they thought new staff were well supported.

When first employed staff undertook a comprehensive induction which was designed to ensure they had the required skills and competences to carry out their roles. New staff shadowed more experienced staff as part of the induction process. We reviewed staff files, and confirmed that people had received a structured induction, checks on their competency and supervision sessions. We noted that a new unit head had had a seven day induction and was being offered additional dementia training as this was an area of interest. Formal supervisions were held regularly and an annual appraisal system was in operation.

We found staff were knowledgeable about the requirements of their role and welcomed the recent training opportunities the registered manager had put in place. Care staff received relevant training including training in nutrition, first aid, dementia care, moving and handling people, diabetes and food hygiene. Staff received specific training according to their roles. For example, nursing staff completed syringe driver training and training about legionella bacteria for the maintenance staff who were responsible for testing the water. Nurses stated that they had had the training they needed. We saw that there was effective management of catheters, confident assessment and management of wounds such as pressure ulcers and robust blood glucose monitoring for those people with diabetes. We saw that there was evidence that some pressure ulcers had healed well following proactive management from the nursing staff.

Some training required updating but the provider had this in hand and was able to reassure us that sessions were already booked. As well as this refresher training other sessions had been planned – for example equality and diversity and infection control. Staff were very positive about training opportunities at the service

Staff worked in partnership with the district nursing service and we spoke with a healthcare professional who was visiting the service on the day of the inspection. They told us, "The patients are well managed. I've not had any issue with any of the patients here". They told us about one person who had transferred from another service and whose health had subsequently improved. They said, "[They are] a different person. We can see the change – it's dramatic. It's managed in a safe way. This is sensible working".

Staff were knowledgeable about people's healthcare needs and current health conditions. Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, psychiatrists, opticians, occupational therapists, dieticians and chiropodists.

People told us staff responded quickly to their healthcare needs. One person told us about a recent fall they had had saying, "One [staff member] was with me when I fell. I had the district nurse sort my arm out". Another person commented, "They will get a doctor. I saw him a fortnight ago [for chest pain". A third person said, "I do see a GP sufficiently. I'm sure they would [call a GP] if it was urgent. Opticians come here and gave

me new glasses. Someone came the other day to do my toenails and I do my own fingernails". We observed that one person told staff she had bad toothache and they made an appointment with the community dentist immediately.

Nursing staff had good systems in place to monitor and manage people's diabetes, pressure and wound care and catheter management. We observed one person, who had been admitted to the service the day before our inspection, had had their weight and Body Mass Index recorded and a wound had been appropriately recorded and photographed. The service was signed up for the GP matron service which ensured fast access to healthcare support and worked well.

People who used the service were happy with the food and the choice available. One typical comment was, "Most of the food is good. I think there's a reasonable amount of choice". Another said, "I get the choice of three dinners and three sweets. I asked if I could have the sea bass again and they brought it the next day". People told us they were consulted about the food on offer and alternatives were available if they changed their mind. People who used the service, and their relatives, acknowledged that there had been significant improvements in the food. One visitor said, "The food was pretty grim when my [relative] came here… but it's really good now".

The service catered well for people's specific food preferences and the cook demonstrated a good knowledge of people's dietary needs. One person told us, "I am slightly diabetic. I'm happy that they're watching that – sweeteners instead of sugar. They'll tell me if someone's brought in something inappropriate". Where people had difficulties swallowing their food we saw that referrals to speech and language therapists (SALTS) had been made to give staff additional guidance and support. Food and fluid records were well completed and kept under review by senior staff.

Where people were recorded as being at risk of not eating enough we saw that meals contained additional calories and build up drinks, cakes and milkshakes were supplied. People's weights were monitored and referrals made to a dietician when a person had lost a significant amount of weight. We noted one person who was eating a plate of food which was designed to be eaten with their fingers. This encouraged them to eat and helped maintain their independence. Staff told us that the person had begun to gain weight since they had been eating finger foods. However we saw a member of staff bring dessert to this person before they had finished their first course and person then stopped eating. This was poor practice and we fed this back to both the senior staff on duty and the manager who assured us they would address this with the staff member concerned.

We observed staff asking for people's consent before providing them with care and treatment. People's capacity to consent to aspects of their care and treatment was documented in care plans and where people had capacity to consent we saw that they had signed their plan to confirm this. We did note that one plan had been signed by a person's next of kin when they had in fact been assessed as having capacity to consent for themselves. We fed this back to the manager who told us they would review the plan.

We observed a member staff questioning why particular medicines had been recently prescribed for someone. This was because it contradicted the person's recorded wishes with regard to their end of life care. We saw that the medicines had not been administered and plans were made to return them. Where medicines were given to people covertly we saw that people's capacity to consent to this had been assessed by two GPs and the decision to give medicines in this way was reached in the person's best interest and according to the legal requirements of the Mental Capacity Act 2005.

Appropriate DoLS applications had been made to the local authority where it was thought necessary to

deprive a person of their liberty in order to keep them safe. Staff had an understanding of MCA and DoLS and some had received training. Additional training was booked for those staff who had not yet received this training.

Good

Is the service caring?

Our findings

People who used the service, and their relatives, were very happy with the way staff provided care and support. One person said, "I'm treated like royalty really – I have got no complaints about the staff. None". Another person echoed this saying, "Nothing is too much trouble. I feel we get on very well and they're helpful". One person told us that in spite of how busy the staff were they find time for them. They said, "They have very good patience. They sit down and have a little chat".

We observed staff, including some of the regular agency staff, treating people with patience, kindness and sharing a joke with them which we saw was greatly welcomed. A relative commented, "They do everything for [my relative]. I couldn't manage [them] at home and now I don't have to worry". One member of staff was observed to spend time offering reassurance to people when they became distressed by holding their hand, kneeling down next to them, chatting about things they like and redirecting their focus away from what was upsetting them. One person who used the service told us, "They understand me, they all understand me. Yes, they reassure me".

We also observed another staff member trying to engage a person who was in a very low mood. They spent a long time with them, talking to them in a gentle voice. Gradually they succeeded in getting them to stop biting their hand and to look up from the floor and take an interest in what was going on around them. Although staff demonstrated skills in calming people's distress care plans did not always clearly document how to do this, which would have been helpful to guide new staff.

Information in care plans was person centred. Plans documented what was important to the person and how best to successfully support them. Information was given to people in ways they could understand, with photographs and pictures for example. People had been involved in making decisions about their care and plans had been signed to confirm this. One person told us, "Care is arranged in the way I like it – being given my own space. I just like to have a chat." People, and their relatives if appropriate, were given the opportunity to provide feedback on their care at regular reviews and in response to feedback surveys. Where people did not have capacity to make their own decisions and did not have family members to advocate for them we saw that advocacy services could be made available to people.

Staff completed equality and diversity training as part of their core training to help them promote people's rights regardless of their gender, sexuality, religion or any other perceived difference. We noted a 'Dignity and Respect Tree' in one of the lobbies. This was a pictorial representation of how treating people with dignity and respect enhances their quality of life. We asked people if staff respected their privacy and their personal space. People confirmed that staff were respectful about knocking and waiting before being invited into the person's room. One person who used the service said, "[Staff are] polite. They call out to me and they keep the door closed".

We found that people were consistently treated with dignity and respect. One person told us, "They all treat me with respect" and another explained that staff were particularly sure to preserve the person's dignity when giving personal care. They told us, "They do give me privacy. They often say, 'Excuse me' with personal

care…..They treat me as they should. I've no complaints." Another person also stressed how staff maintained their dignity saying, "The staff helped me get washed and dressed when I first came here but I can do it myself now and they know this. They always respected my privacy and kept the door closed when they helped me".

The service was signed up for the Six Steps to Success programme which is designed to improve end of life care in services and reduce the need for hospital admissions at this stage in a person's life. People's wishes and preferences regarding the end of their life were clearly recorded. When people's health was declining significantly, preparatory medicines were made available to ensure pain was relieved as much as possible and people were kept as comfortable. We noted that these had already been received into the service for one person who was approaching the end of their life.

Staff received end of life training and we saw that further sessions of this particular training were planned for later in the month. Staff told us they felt confident in supporting people to have the best end of life care.

Good

Is the service responsive?

Our findings

We saw that the manager comprehensively assessed people's care and support needs before admission to the service to ensure the service could meet their needs. Staff told us that they found the manager's assessments were very thorough and they very rarely admitted someone whose needs proved too great for this kind of service.

A care plan was written once people had moved in and we saw that care plans were person centred and included a 'Who I am' section which included important information about the person's likes, dislikes and preferences as well as their previous history. One person told us, "Staff really get to know us. I have not been here long but they chat to me about what I like to do". Staff were able to tell us about people's former lives and their likes and dislikes. We heard one staff member reminiscing about how a person used to like to cycle from King's Lynn back to their village. This conversation was intended to be a distraction technique as the person was becoming anxious.

Plans reflected how people wished to receive their care and support. Plans were reviewed each month, audited every three months and were updated if a person's needs changed. Care plans had mostly been signed by the person they concerned or their family if appropriate. Although we did note occasions where this had not happened we saw evidence that all care plans were in the process of being reviewed by the staff member with responsibility for quality assurance.

Plans detailed people's specific care needs and stated preferences. For example, people's ability to use a call bell had been assessed and plans put in place to regularly monitor those who could not manage to use one. Plans stated what time people liked to get up and go to bed and we saw that this was respected. One person said, "I get up about 6am. I like to get up early and then I have my breakfast at 6.30am". Another said, "We can get up and go to bed when we want".

People were mostly very well supported to make their own choices about their individual care and support needs. However we received a number of negative comments from people receiving personal care from a person of the opposite gender. We noted that care plans did not always record people's preference with regard to who supplied their personal care. A typical comment was, "When I first saw male staff I felt a bit embarrassed but you get used to it". We fed this back to the registered manager who was not aware of this issue and they assured us they would address this as a matter of priority. Following the inspection, they informed us that people's preferences had now been recorded, prompt cards stored in people's rooms to remind staff about people's preferences and this issue was now included in staff induction.

People were supported to follow their own interests, hobbies and spiritual beliefs. One person told us, "I went to the local church the other day and I played their organ. It was so lovely". A new vicar had just been appointed to a local church and had arranged to visit the service. Another vicar visited and one person said, "She comes to see me now and again. Somebody comes in Sundays to read the bible almost every week. I'm very happy with that".

The activities co-ordinator confirmed that, whenever possible they take people out on a one to one basis as well as larger group outings, such as a recent one to Sandringham which had been very well received. People praised the work of the activities co-ordinators. One person said, "We do the garden together. I didn't like gardening but she got me into it and I love it now".

There was a range of hobbies and interests available for people to choose from. One relative told us, "If there's something going on in the lounge [my relative] likes to be involved. [Staff] take them down for a quiz, bingo or if there's an entertainer. They have regular entertainment and talks. [My relative] enjoys them". A person who used the service was very enthusiastic about activities provided for people saying, "We do exercises…, sit in a chair, wave our arms about! I can do that, I like it. The quiz – some of the questions are quite hard. My brain goes click, click and I've done it! They use my DVD sometimes for the film afternoon. There's [an entertainer] every [two or three weeks] – we get a good variety".

On the day of our inspection one of the activities co-ordinators was off sick and this had an impact on the range of activities offered that day but people told us they were happy with the choice offered to them. One to one sessions were provided for people not wanting to join in group events and we noted a person being supported to go out to the local town. A fete was being planned for the following month and people told us they were really looking forward to this. The fete enabled people from the local community to come and enjoy the event. We did not see much specialised provision for people living with dementia on the day of our inspection but staff told us that they had a well-equipped reminiscence room that could be used when staff were available.

Resident meetings were held to gauge people's views and we saw that actions were recorded and followed up at the next meeting. People also shared feedback on their care with staff. One person told us, "I talk to [named carer], tell them what's what and they put it in their book".

Surveys were conducted with people who used the service and relatives to receive feedback. The most recent survey had been carried out in March 2017 and we saw that actions had been put in place as a result. For example, one person had complained that water jugs were not being changed frequently enough. They were now changed three times a day.

The service had a complaints policy and procedure in place and complaints were audited on a monthly basis. People told us they knew how to make a complaint and information on how to do this was displayed. We viewed written responses to recent complaints and found them to be in line with the service's policy and procedure. Before our inspection the CQC had been informed of a particular complaint. We reviewed this complaint in detail and found the investigation to be thorough and the response fair and proportionate. We noted that where there had been things which the service could have done better, they were honest and open about this and lessons were learned.

Good

Is the service well-led?

Our findings

The service had a manager who had very recently been registered with CQC. People who used the service, relatives and staff were very positive about the improvements the new manager had made and the changes they had begun to put in place. One person who used the service said, "The new manager has really sorted things out. It is so much better". Another commented, "I think this is a very well run organisation".

Staff were very positive about recent changes the manager had made. One said, "The things [the manager] is putting in place are working. Like the falls stick [a pictorial way of documenting falls]. It's an easy way to feed them through to the falls team. There are new observation charts which are loads better". Another staff member said, "[The manager] knows what needs to be prioritised and we are going in a very good direction". A visiting healthcare professional said, "We don't have an issue with The Paddocks. If we flag something up it's dealt with very quickly".

Before the new registered manager had taken up their post there had been some concerns over the standard of care and the safe administration of medicines on the dementia unit. Action had been taken to safeguard people at the time and the new manager had introduced further measures designed to improve standards and safety in all areas of the service. These included weekly audits of PRN medicines and health and safety, analysis of incidents and accidents, the introduction of a risk register and a weekly manager's audit. The weekly audit was carried out on different area of practice each week. We noted that a recent audit had highlighted that one of the clinical rooms was untidy and had been tidied and organised as a result. Some of the innovative procedures, such as the weekly health and safety check forms or the induction booklet regarding the role of CQC had been shared with other services.

All aspects of the service were regularly audited. This included equipment cleaning, medicines, complaints, care plans, falls, pressure sores, accidents and incidents and health and safety. A weekly report was compiled for the regional manager in order that they had oversight of all current issues at the service. Where issues were identified they were promptly addressed and audits were working documents. For example the phone system had recently been upgraded to one which required less staff time to operate. This enabled care staff to spend more time on other tasks. A quality assurance co-ordinator was in post and they, along with another senior staff member, were responsible for checking the service met the required standards. We noted that they had recently audited care plans on one of the units and identified a number of issues for staff to address.

There was an 'accountability folder' in operation. This documented who had particular responsibility for tasks such as changing beds, nail care, checking the hoist and slings and dental care for each person who used the service. This enabled any incomplete tasks to be quickly identified and addressed with the relevant member of staff. Where staff performance required intervention of the manager we saw that this took place. We noted that two staff had had a disagreement while working. This had been discussed with them and the manager had pointed out to them that their behaviour was 'not useful'.

The regional manager was a regular presence at the service and the manager welcomed the support and

guidance she received from him and from the provider. In turn the staff felt supported and valued by the manager. One told us, "Previously staff morale had been down but when [the manager] comes in she asks if we're alright. It's not just the residents who she cares about, it's the staff…You get a 'thanks'. Yesterday we were reviewing a care plan as someone's moving and handling needs had changed. Straightaway [the manager] said 'Well done'". Staff meetings were held regularly for all staff groups and a heads of department meeting took place each morning. This enabled the manager to have good oversight of issues facing the service that day and provided an opportunity for staff to raise issues.

Feedback surveys were carried out with staff to assess their views, as well as those of people who used the service, relatives and other stakeholders. The provider was open and transparent about issues raised within these surveys. We saw that an overview of feedback given and responses provided was available in the lobby for anyone to view.

Records were easily located and comprehensive. We found that some records needed reviewing but it was clear that an overall audit of care plans was already underway. Charts, including food and fluid charts were accurate and completed promptly.

The registered manager and the regional manager had an on-going plan for the service and had identified areas for further improvement. The manager told us that a new sensory room was planned and funded on the dementia unit and the service had been working with the Community Admission Avoidance Service and would continue to do this in the future. Plans were also in place to consider training or recruiting staff with additional skills and competencies to have them work as enhanced practitioners.

Most minor issues we identified, as well as the more significant concern regarding staffing levels, had already been identified and steps had begun to be taken to address them. This gave us confidence in the provider to continue to take the work forward. Our overall impression was of a good service which had a strong and confident management team which worked well together.