Life Style Care (2010) plc

Kingsley Court Care Home

Inspection report

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Ratings

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

Overall summary

The inspection was carried out on 11, 12 and 13 November 2015 and the first day was unannounced. This was the first inspection under the current registration with the Care Quality Commission.

Kingsley Court Care Home provides accommodation for a maximum of 85 people. The service has three floors and accommodates people in single rooms each with en suite facilities. The ground floor provides general nursing care for up to 30 older people. The first floor provides nursing care for up to 30 older people with dementia care needs. The second floor provides personal care for up to 25 older people with dementia care needs. Each floor has communal dining, sitting rooms and bathing facilities. At the time of inspection there were 77 people using the service.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (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

Summary of findings

Act 2008 and associated Regulations about how the service is run. The service had a manager who had applied to CQC to become the registered manager for the service and was going through the process of registration.

People were happy with the service and confirmed they felt safe living there. Staff treated people with dignity and respect, listening to them and supporting them in a caring and friendly way.

Risk assessments were in place to reflect the risk to individuals and the care and support they required to minimise these. Systems and equipment were being maintained to keep them in good working order. Infection control procedures were in place and being followed and the environment provided a clean, homely place for people to live.

Medicines were managed safely. Effective systems were in place so that people consistently received their medicines as prescribed.

Staff understood safeguarding and whistleblowing procedures and were clear about the process to follow to report any concerns around abuse. A complaints procedure was in place and people and relatives were confident to express any concerns so they could be addressed.

Staff recruitment procedures were in place and being followed to ensure only suitable staff were employed at the service. Staff received regular training and updates and had a good understanding of people's individual choices and needs and how to meet them.

The service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA). DoLS are in place to ensure that people's freedom is not unduly restricted.

People's nutritional needs were identified and were being met. Input from the GP and other healthcare professionals was sought and provided to address any health concerns.

The majority of care records reflected people's individual needs, interests and wishes and staff demonstrated a good understanding of these and provided person-centred care. Auditing of care records was in progress to identify where improvements were needed with personalising records. People's religious and social needs were being identified and met and work was ongoing to further improve the activities provision in the service.

The manager was visible throughout the service and promoted good practices, listening to people, relatives and staff, all of whom provided us with positive feedback about their experience of the manager.

Systems were in place for monitoring the service and these were effective so action was taken promptly to address any issues identified.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People and relatives we spoke with were happy with the service provided and confirmed people were kept safe. The provider had arrangements in place to safeguard people against the risk of abuse.

Risk assessments were in place for identified areas of risk and records were audited to identify any trends and action needed to address these. Maintenance and cleaning processes were in place and being followed to maintain a safe environment.

Staff recruitment procedures were in place and being followed. There were enough staff on duty to meet people's needs and there were processes in place to monitor staffing within the service so staff numbers were being maintained.

Medicines were managed safely. Effective systems were in place so that people consistently received their medicines as prescribed.

Is the service effective?

Good

The service was effective. Staff received training to provide them with the skills and knowledge to care for people effectively.

Staff understood people's rights to make choices about their care and the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff acted in people's best interests to ensure their freedom was not unduly restricted.

People's nutritional needs were assessed and monitored. People's dietary needs and preferences were being met.

People's healthcare needs were being monitored and they were referred to the GP and other healthcare professionals when necessary.

Is the service caring?

Good

The service was caring. Staff treated people with dignity and respect and provided person-centred care. They communicated well with people and provided care and support in a gentle and caring way.

People were involved with making choices and decisions about their care and where they were not able to do their appointed representatives would act on their behalf.

Is the service responsive?

Good

The service was responsive. Care plans were in place and were kept up to date so staff had the information they required to meet people's needs.

Hobbies and interests were identified and activities and events were planned to reflect these and to provide people with cultural experiences.

People and their relatives knew how to raise concerns and records showed any complaints raised were being appropriately addressed.

Summary of findings

Is the service well-led?

Good

The service was well-led. The manager was appropriately qualified and people, relatives and staff found the manager approachable and supportive.

Meetings took place and surveys were carried out for people, staff and relatives to express their views about the service. Action was taken to address any areas they identified for improvement.

Systems were in place to monitor the quality of the service, so areas for improvements could be identified and addressed.

Kingsley Court Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 11, 12 and 13 November 2015 and the first day of inspection was unannounced. Before the inspection we reviewed the information we held about the service.

The inspection team consisted of three inspectors including a pharmacist inspector, a specialist advisor in dementia care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. They had experience with older people including those with dementia care needs and of care services for older people.

During the inspection we viewed a variety of records including 11 care records, some in detail and some looking at specific areas, the medicine supplies and medicines administration record charts for 28 people, five staff files, servicing and maintenance records for equipment and the premises, audit and monitoring reports and policies and procedures. We observed the mealtime experience for people and interaction between people using the service and staff on all floors.

We spoke with 16 people using the service, six relatives, the manager, the nominated individual, the deputy manager, the in-house trainer, two registered nurses, seven care staff, an activities coordinator, two domestic staff, the chef, the maintenance person, the administrator and the receptionist. After the inspection we contacted four health and social care professionals, those being a GP, a palliative care specialist, an optician and a community matron and received feedback from three of them.

Good

Is the service safe?

Our findings

People confirmed they felt safe at the service. Comments included, "I like it here as I am near my [relative] and feel happy with the way the staff look after me. I can go out on my own, but I usually go with my [relative] as I feel that I might lose my way back. The staff do my medicines, but I know that they are for heart, blood pressure and I have them at the right times." "I love living here and I want to die here. The staff do all my medicines and if I need some more for pain I know that they will give them to me." and "I would prefer to be in my own home, but I know that here is now the best place for me and am quite happy. Look my call bell is here, clipped onto my blanket at the side of my chair, so that I can reach it. They come as fast as they can" and "I feel nice and comfy here. The assistants are always friendly. When they have time they will sit and talk with me. The activities people are very helpful and sit and chat with us." A relative told us, "I'm happy to leave [relative] here and they couldn't be safer."

People were being protected from the risk of abuse. Staff told us they had been trained in safeguarding and were able to provide clear definitions of different forms of abuse. Staff knew about the provider's safeguarding and whistleblowing procedures and said that they would inform their line manager if they had a concern about abuse or neglect. They knew the outside agencies they could report concerns to including the local authority and the Care Quality Commission (CQC).One member of staff told us, "If I saw another member of staff being abusive to a resident, I would tell the nurse in charge and the manager if the nurse could not address it and I know that there is a number that I can phone if I needed to go further about the abuse. Abuse can mean all sorts like taking or using their money inappropriately, it is not just about hitting people." There was information about safeguarding in the office on each floor for reference. Incidents were clearly recorded alongside the action the service had taken, for example, referral to the local authority. Staff wore different uniforms according to their designation so that they could be identified easily by people and visitors.

Risks were assessed so action could be taken to minimise them and keep people safe. Each person had a range of risk assessments which were updated monthly, including those to monitor nutritional status, assess skin integrity and monitor the risk of falls. These were up to date and where risk levels had changed this was reflected in the care records. Assessments and care plans covered different aspects of care, including environmental risks, physical risks such as aggressive behaviour and other health risks, for example, those related to medical conditions. Assessments contained details of ways to minimise or avoid each identified hazard or risk. Each care file had a personal evacuation plan which specified the person's level of mobility and the equipment and staff support required in the event of an emergency evacuation such as fire. Maintenance and servicing records were up to date and we saw systems and equipment including gas appliances, hoists, fire safety and equipment and lifts were being serviced at required intervals. Risk assessments for equipment and safe working practices were in place and had been reviewed in the last 12 months, to keep the information current.

Systems were in place to manage incidents and accidents and to protect people from harm. Staff were able to explain the procedure for reporting accidents and incidents at the service and knew the documentation to be completed. Body maps had been completed and dated to record any bruises or wounds and these were being reported, so action could be taken to investigate them. A register of injuries and accidents had been commenced in April 2015 and clearly identified the event and the action taken to report and address it. For people prone to falls an individual falls 'tracker' document was in place. These comprehensively identified the event, the action taken and recommendations to minimise the risk of recurrence. There was an Incident Management policy that clearly identified the action to be taken in respect of any incidents occurring and any organisational learning to come from them. The Business Continuity Plan had been reviewed in September 2015 and identified two local homes if, in the event of an emergency, an alternative place of safety was required.

Employment checks were carried out to ensure only suitable staff were being employed at the service. Completed application forms included full education and employment histories and explanations for any gaps in employment. A medical questionnaire had been completed and pre-employment checks had been carried out including a Disclosure and Barring Service (DBS) check, references from previous employers, proof of identity including a photograph and evidence of people's right to work in the UK. People, their relatives and staff considered that there were enough staff to meet people's needs and

Good

Is the service safe?

support them effectively. This was confirmed by observation and staff responded promptly if people called for help or used their call bells. There were enough staff to provide the care and support people needed. Staff commented that staffing levels had improved in recent times, however they were sometimes short if staff called in sick at short notice. This was especially a problem when supporting people whose behaviour could challenge or if people were at risk of falls if they walked around unsupervised, as it was important to have a full complement of staff, particularly at such times. The manager was aware of these issues and worked to ensure cover for absence was provided.

Medicines were managed safely. Effective systems were in place so that people consistently received their medicines as prescribed. Nurses were responsible for medicines on two of the units, and care staff were responsible for medicines on the residential dementia care unit. The deputy manager was based on the residential unit to oversee care and medicines, which staff told us worked well. Medicines were administered at times which suited people's preferences. There was very little use of sedating medicines for agitation, and we saw that there was input about medicines from specialists such as the community mental health team, the palliative care team and the Parkinson's nurse. Although the palliative care team visited weekly, anticipatory medicines such as pain relief were not kept at the service. The registered manager said if these were needed, the local pharmacy was able to supply these medicines within one hour of being needed.

When people were prescribed medicines to be given only when needed, or 'PRN', such as pain relief and medicines for agitation, there were protocols available for staff giving them instructions on how and when to administer these medicines, and pain assessment charts were in place, so we were assured that effective arrangements were in place to manage people's pain medicines. High risk medicines such as anticoagulant medicines and insulin were managed safely. Falls risks due to medicines had been identified in people's falls risk assessments, such as if four of more medicines were prescribed, and if any sedating medicines were prescribed. When people needed their medicines to be administered covertly, care plans were in place, Mental Capacity Act assessments and best interest decision records were in place, and there was authorisation from the GP and pharmacist regarding whether to crush or administer medicines whole in food.

All medicines were stored safely in clean, well ordered clinical rooms. Controlled drugs were managed safely. Medicines records were clearly completed and up to date, including people's allergy status. We were told that arrangements with the GP and pharmacist for ordering medicines were reliable and prompt, and we found that all prescribed medicines were available. Daily medicines stock balance and medicines administration record checks were carried out by staff on each floor, to check that medicines had been given correctly. We noted that a few of the balance checks were overwritten on several days in succession, indicating that staff sometimes did not carry out these checks accurately. The registered manager had also identified this as an area to be addressed. The GP visited weekly, and there was evidence that staff made referrals to the GP and that people had regular reviews of their medicines.

There was an effective quality assurance system in place to audit medicines. A copy of current national NICE guidance about medicines was available and being used. We looked at the last two medicines audits. These had highlighted some issues with the completion of medicines records. "Corrective and preventative action request" forms had been completed on the same day as the audit, and the issues noted at the previous audits were already in the process of being addressed. We suggested some minor good practice improvements. To specify the timing of Parkinson's medicines, to record the removal of transdermal patches as well as the application, and for nurses to check that prescribed creams stored in people's rooms were being applied as directed by care staff. We also made a good practice recommendation that in line with NHS recommendations, people's medicines should be taken with them when people were admitted to hospital. This was to ensure continuity of treatment in hospital and reduces the risk that medicines changes made in hospital would not be noticed and implemented once the person was back at the service. The registered manager told us they would consider these good practice recommendations.

Staff told us they received regular updates on infection control and this was confirmed in the training records. We saw domestic staff using colour coded cleaning equipment. We spoke to one of the domestic staff who correctly outlined the colour coded system for cleaning equipment. Sluice rooms were clean and uncluttered and were locked as were cupboards used for storing cleaning

Good

Is the service safe?

equipment and control of substances hazardous to health (COSHH) materials. People and relatives reported that the home was always clean and well cared for. We visited the laundry room and saw that different laundry items, such as soiled bed linen or clothing were collected and washed separately, using appropriate wash cycles. All areas of the home were clean, including communal areas, bathrooms and toilets. We noted a malodour on the first floor and the registered manager explained the corridor carpet had been identified for replacement and a date had been set for this in early in January 2016. There were hand sanitizers available throughout the home in communal areas and toilets had liquid soap dispensers and information on hand hygiene on display. Staff wore protective aprons and gloves when delivering food at meal times. Water testing was carried out and the risk assessment for legionella was carried out annually and action taken to address any points identified.

Good

Is the service effective?

Our findings

Staff told us they received induction and then regular training and updates in all aspects of their work, which was also evidenced in the training records. One said, "I am on induction at present and feel that so far it is very good. I need to learn more about the residents before I feel fully confident to work on my own." Training was delivered in-house and there was a schedule of forthcoming training sessions displayed in the staff office on each floor. One member of staff was working towards gaining recognised management qualifications in health and social care and another was being supported in management and leadership training. During the inspection staff received training in "challenging behaviour". Staff found it useful and said the trainer talked about how to approach people and what caused people to display such behaviours. They had used role play, group work and discussed real life examples, which made the training very relevant. Staff were familiar with people's individual needs and characteristics and were able to explain how to support specific people. For example, when one person was agitated a carer was able to explain the cause of their distress and how best to manage and reassure the person. Outside one dining room there was a colourful poster regarding basic life support and easy to read instructions in case of an emergency.

Staff had received training in many topics including first aid, moving and handling, infection control and equality and diversity. They had also received training in caring for people living with dementia and those unable to make decisions for themselves. They displayed a good level of understanding of these needs and how best to manage them. One told us, "I have been on dementia training and activities training and feel that these have both helped me to understand more about the condition and behaviour and how I can help. For example, I had one resident who was quite challenging, but when I did painting with them and when we made dough, they became more quiet and settled. So we will do more of the same with them in the future." The chef told us that all catering staff received relevant training in nutrition as well as food hygiene and other health and safety training topics, for example, first aid, infection control and safeguarding. Staff had one to one supervision every two months and said this was helpful and identified any training needs.

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 Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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). Policies and procedures for MCA and DoLS were in place. Staff had received training in MCA and DoLS and understood when it was necessary to apply for a DoLS authorisation. Mental capacity assessments had been completed relating to specific decisions, for example, use of bedrails, personal care and resuscitation wishes. These were all well completed and dated and recorded best interest decisions where a person lacked capacity to make their own decisions or provide consent. The manager had applied for 30 DoLS authorisations, five of which had been approved and for the others they were waiting for the assessments to take place. Communal doors and the lift had key pads for security purposes. To enable people who had capacity to move freely around the building, the keypad codes were displayed above the doors.

Documentation confirming consents were seen in care records signed by people, or where they had the right to do so, relatives, including consent to photographs and, where appropriate, the use of bedrails. The provider was introducing a form to record people's consent to care and treatment and the manager showed us an example of this on the second day of inspection. Do Not Attempt Resuscitation (DNAR) forms were in place, had been signed by the GP and were easily accessed at the front of the care records. These were linked to advance care plans which recorded people's capacity, if an enduring or lasting power of attorney for health and care matters was in place and wishes around end of life care and support. On two floors care record files displayed a red sticker of the spine to indicate if a DNAR was in place and a green sticker if not. This meant that staff could refer quickly to a person's resuscitation status in the event of an emergency. The manager said this was being planned for the ground floor also.

Good

Is the service effective?

People's nutritional needs were being identified, monitored and met. People were complimentary about the food provision. Comments included, "The food is very good. I can have poached egg on toast which I like very much." "Look at the menus and all the choices that we have each day" and "I eat well here for my breakfast and lunch. But I am not so hungry in the evenings so can have just a sandwich or soup if I want to." People's nutritional status was assessed on admission and this was updated each month. They were weighed weekly and a daily food and fluid chart was completed during their first two weeks, to monitor them. Risks such as swallowing difficulties were identified and care plans were in place to address them. When people's nutritional status changed care plans had been updated to reflect this. People were usually weighed monthly and their Malnutrition Universal Monitoring Tool (MUST) assessment was updated to monitor their nutritional status and identify any new risks. Where a concern had been identified, for example, significant weight loss, people were referred to a dietician, weighed weekly and had their food and fluid intake monitored daily until their weight stabilised and improved. Food and fluid charts were maintained in daily files and these were up to date, reflecting people's intake.

There was a notification form for any special dietary requirements such as allergies or the need for a diabetic, fortified or soft diet and people's likes and dislikes, copies of which were given to the chef so they had this information. There was a weekly menu plan for each month which offered a varied and balanced selection of food. There were choices available for all meals, including vegetarian options. Food choices were selected on the day by people and if they were not able to understand the choices then staff showed them the meal options so they could see and smell them and make a choice. The chef said ethnic or cultural requirements, for example halal food and Asian food, were catered for and people could change their mind at any time about their meal choice. The dining rooms looked welcoming, with linen tablecloths and a menu for that day which was clearly displayed on a stand and showed options for each meal, so people knew what was available. Staff were available to provide help and support to people and the atmosphere at lunchtime was unhurried and calm. Hot and cold drinks were available at all times during the day.

People's healthcare needs were being identified and met. We received positive feedback from healthcare professionals. One told us, "Staff are very friendly, they know the patients and they always update me." Another said, "All staff we work with are very helpful, they communicate clearly and concisely allowing us to provide our services in a timely manner." People were registered with a local GP practice and a GP visited the service each week and more frequently if required, for consultations or to conduct general health or medication reviews. We saw that details of these visits had been recorded in a separate log kept in the unit offices with a note of the date, symptoms and outcome for each person seen. Visits from health care professionals were recorded in a separate section of each care file and these were well documented. We saw people received input from healthcare professionals including opticians, dieticians, dentists, specialist nurses such as palliative care and diabetic care nurses, and details of hospital appointments and relevant correspondence.

Each care file contained a transfer/discharge form in case of hospital admission with an overview of the person's needs, medical history and current risks and conditions, so this information was to hand in an emergency. People and relatives confirmed people were supported to access health services and attend appointments as required and the home arranged transport and staff to accompany them if necessary. The service had input from the rapid response service who attended for non-emergency situations and to give advice, for example, in the event of someone's mental health deteriorating or developing a high temperature. This provided additional support to the service and avoided unnecessary admissions to hospital.

The environment and premises at the service were of a good standard throughout and were suitably adapted for the needs and comfort of people living there. The service had modern furnishings, fixtures and fittings and many of the rooms had views across the well maintained garden. There were lifts to all floors and these along with doorways, corridors and other access points were wide and easy to navigate for those with walking aids, wheelchairs or limited mobility. The communal lounges and dining rooms on each floor were bright and well furnished. The corridors had hand rails and these were easy for people to see. Bathrooms were painted in line with dementia research, for example, the bathrooms and toilet doors were painted bright yellow and had the word and a picture of bath or toilet. People had their name and a photograph of them on

Good

Is the service effective?

their bedroom door, and staff said this was done with their permission, so they recognised their room. Pictures on the walls were colourful and there was a homely feel to the service.

Good

Is the service caring?

Our findings

People living at the home and their relatives were very positive about the care provided and the attitude of the staff. One relative had been concerned about the care provided at night but said that this had been dealt with promptly and effectively when it was reported to the manager.

Comments included, “The staff are lovely – very obliging and they assist you whenever you need it. They come and chat to me and will take me out if I want. It’s very clean here – we get clean bedlinen every day and the food is good, you get whatever you want” “I’m very happy with the care, the staff are lovely, so caring. I can’t fault it” “Many of the staff are lovely – absolute angels. We had problems with some of the night staff but that has been dealt with” and “We’re very happy with the home, the staff are very kind and [relative] is always very cheerful.”

We observed staff providing attentive and gentle care and support during our visit and there was a friendly and welcoming atmosphere throughout the service. Staff showed they were familiar with the needs, background and characters of each person and knew how to support and interact with them. One relative said, “Staff go over and above. They chat about the locality and [relative] lived here. Care is instant and very good.” Staff were polite and respectful and supported people with patience and good humour. There was a positive cheerful atmosphere in the lounges with staff and people interacting and laughing together. One person told us, “The girls are lovely.” Another said, “They’re good, you can have a laugh with them.” If people wished to be left alone this was respected and we saw that staff knocked on doors before entering bedrooms and people confirmed this was usual practice. At lunchtime we saw a staff member supporting someone with a visual impairment. The carer explained what was on each mouthful and gave the person time to savour the food. The person told us, “This member of staff is lovely. She tells me what I am about to taste and she makes it so enjoyable for me.” We saw that people were offered drinks or something to eat when they wanted and were helped to move around the home as they wished.

Staff were able to give examples of how recent training in dementia awareness had helped them to deliver better care and understand the needs of people living with dementia, such as allowing them time to express themselves and having a better understanding of non-verbal communication. One person did not want to sit down for their pudding and so it was given to them standing up and they ate it. This avoided confrontation but still ensured the person ate. Another person was distressed and searching for a relative, staff offered reassurance, saying their relative would be in later and suggested tea and cake. Relatives and visitors were made welcome and said there was a positive and friendly relationship with staff. One person had a birthday during the inspection and a cake was provided for all those on the floor in celebration of this.

People’s preferences were documented in care plans, although the level of detail in some cases was limited. However, care staff demonstrated they were aware of individual routines, characteristics and choices, such as the type of music people enjoyed, or particular food dislikes. The chef and deputy chef were present at lunchtime and used this time to obtain feedback about the food served and talk to people and visitors. The chef also attended ‘resident and relative meetings’ at which food choices and menu suggestions would be discussed. We saw people were offered choices about what they wished to do or what they wanted to eat and staff were careful to allow people time to express themselves. People and their relatives confirmed people were free to follow their own routines, for example people went to bed and got up when they chose. One person said, “The staff will come into my room at 08.00 and if I am not quite ready to get up they will come back later.” People, relatives and staff confirmed people could choose the gender of staff providing personal care and this was respected. One person said, “Yes, I was asked if I wanted male or female carers and said that I did not mind which.” The manager said the care records would be reviewed to ensure information about people’s choices was person-centred.

Staff were actively encouraged to promote people’s dignity and respect and understood the importance of this. People’s privacy and dignity was respected and staff ensured that bedroom and bathroom doors were closed when delivering personal care. Staff described the methods they used to ensure that they respected people’s privacy and dignity such as offering choice before delivering personal care, explaining what they were doing before helping people and making sure that they were covered as much as possible when assisting with washing and dressing. One person said, “I like to have my bedroom

Good

Is the service caring?

door open so that I can see people coming and going and staff will leave it open. I can choose whether I want a shower or a strip wash." Another said, "The staff knock on my door before they come in." A member of staff explained they were a Dignity Champion, which meant they had undertaken training and been identified as a good role model for other staff. They said, "You need to know each individual person and all their needs. As a Dignity Champion I make sure that all staff are aware of how to respect each individual and if I need to challenge an attitude, and I have done it, I will give the staff gentle constructive criticism and then ask the manager if I can have time to guide the staff member with in-house training. But most of it is done, I feel, by me being a good role model. Staff are getting more aware of respecting culture of residents and ourselves as staff from different cultures. We also have a resident who is Dignity Champion." They showed us the Dignity Trees which were on each floor. People were able to write on a leaf what they would like to see in the service regarding respect, examples being Be Polite/Let me do things by myself/Treat everyone well.

Good

Is the service responsive?

Our findings

People's needs had been assessed and the majority of care plans we viewed were detailed and tailored to each individual with their identified needs clearly recorded. Care records were easy to navigate and followed a consistent format so it was possible to understand the care needs and the care and support to be provided to each person. Care plans had been updated to reflect any changes in people's needs. We did identify for some people care information was a bit vague, for example, for healthcare needs stated, "Any abnormal observation should be dealt with." Additional detail was needed to ensure the care plans were person-centred, to reflect the care people and their relatives confirmed staff provided. For others the care was very detailed, for example, one for the risk of aggressive behaviour with advice on how to approach the person, about explaining what you are doing and talking to them to develop a relationship. We saw a selection of care plans were audited each month and action taken to address any shortfalls identified. The manager said she would ensure this continued so all care plans were person-centred. Wound care records were complete and up to date and body maps were in place to identify any wounds or other skin marks. Records had been reviewed and updated each month to reflect any changes to the person's care or well-being.

Staff understood people's needs and had access to people's care plans. Daily records of care and monitoring charts were maintained by care staff for each person, including personal care records, food and fluid charts, repositioning charts as needed, activities records and night checks. These were all up to date and accurately reflected the requirements in the care plan, for example, one person required regular repositioning and had received the correct attention. There was also an overview of each person's care so staff had a simple plan to follow day to day. This meant daily care was current and person-centred, to suit their needs and wishes. There was evidence of regular contact with people's relatives recorded in service user participation forms in care files. People and their relatives said they had seen the care records and relatives confirmed that the service communicated effectively with them in respect of any updates or changes to health or well-being.

Each care file contained a 'This is me' profile to inform carers about personal preferences and characters. There was also a 'Life History' which provided background on each person including past employment and family life. Some were part completed, however it was clear staff understood people's individual interests and wishes and activities were planned with these in mind. The service had four activities coordinators and activities were provided seven days a week. One told us, "With our activities we are always on the lookout for more each month…..We have recently had Harvest and Halloween and Bonfire decorated cakes and a Diwali dance afternoon. We are planning for Christmas and then Burns Night and Valentines. We try to each month look at a country and do crafts and learn about it, as many of our residents come from various cultures." Staff also told us about one to one activities that took place with people who were unable or did not wish to join in group activities, so their needs were also catered for. Information regarding activities was displayed and we saw photographs of people enjoying the recent events.

People enjoyed the activities and comments included, "I do some of the activities and did enjoy Halloween and Diwali. You learn something new each day about different cultures and it is good." "We had a lovely afternoon the other day where we had a Diwali celebration with fun and dancing and staff dressing up in saris. And we have also had Halloween where we got dressed up." "I like reading the newspapers and the activities people bring one in most days. I did enjoy watching the Armistice two minutes silence on the BBC this morning and everyone was quiet." A relative told us, "Regarding the activities, my relative seems to have a great time painting and using glitter in the activities room and their painting may be on display there." The service had a newsletter and this was informative and easy to read, providing people with information about forthcoming events and celebrations. In the newsletter the activities staff had identified the importance of finding out about people's life stories and interests to help plan activities. It also provided updates about the service, for example, the new sensory patio area for people to sit out on and enjoy.

People and relatives were confident that that they could raise any concerns or complaints with the manager or a senior member of staff at any time. Comments from people included, "If I had a complaint I would probably tell my family as they come to visit nearly every day." "I have no complaints, but if I did, I would go to the manager." Relatives said, "We have had one or two issues and what I did was to speak to the most senior person on shift at the

Good

Is the service responsive?

time. Most of the time it was sorted out then. Issues usually arise when there is not enough staff on duty" and "I have raised concerns at the time and most of them were addressed. I just make sure that I keep an eye on things and if I see something I am not happy about I will see the senior nurse or manager at the time." Staff understood if people or relatives wished to raise a complaint they would refer them to the manager and the complaints procedure, which was displayed in the service. We viewed the complaints file, which contained a flow chart guide for staff for responding to complaints. We saw complaints had been recorded, investigated and responded to in a timely way. We noted there had been a reduction in the number of complaints being received each month and the manager was also recording compliments they received to show a balanced view. We found the service encouraged people to give feedback so any issues could be promptly addressed.

Good

Is the service well-led?

Our findings

Relatives and people said that the manager was visible and very accessible if they needed to discuss any issues or answer queries. An open door policy was displayed in the reception area and people confirmed that the manager was always available, including later in the day and at weekends. Comments included, "The manager is very good – always available, even at weekends." "I have met the manager. I like it here. The people here are kind and helpful and help to make each day go by happily for me." "I am not aware of any relative meetings as such. I think that as long as there is enough staff and that they are trained properly in all aspects of my relatives care, then that is all I can ask for. I just want him to be happy." The manager said she currently met individually with relatives to discuss any issues they may have and found this was effective. A relative said, "She's always here, on the floor you know." Another said, "She is very approachable and not only is she approachable but she acts, if there's an issue she doesn't just dismiss it." They gave an example of a worry they had expressed and manager had looked into it and had come back to them and explained what had happened and how it would be taken forward.

Residents meetings had taken place in August and September and people were kept informed of issues, for example, staffing and the action taken to improve staffing levels and manage absence. The newsletter had a 'resident's forum' section and included discussions and comments about recent events, for example, the Queens 63rd year on the throne celebration, the new sensory patio and wartime memories for Armistice Day. Surveys for relatives had been sent out and the results collated with an action plan to address any issues identified, for example, staffing levels.

Staff were positive about the culture and atmosphere in the service, which they felt was supportive and inclusive. They reported a good level of job satisfaction and motivation and said they enjoyed working at the service. One member of staff told us, "They treat everyone as an individual here – there's no judging." Another said, "The manager is very good – staffing has improved and the care here now is very good, very well organised. There is a really good trainer who will spend one-to-one time if it's needed." An activities coordinator told us, "I find the manager very approachable and she is listening to what we feel the resident's needs are socially. Other staff, especially more recently, understand more about our role and work with us. We can have fun together. We borrow a coach for the occasional trip out." Staff confirmed that the manager was very visible within the home, with daily tours of each floor, and was always approachable and sympathetic to any concerns or comments. She attended the service at different times of the day and over the weekend in order to be available to speak with people, relatives and staff and to be able to monitor the service provision outside the normal working day.

Staff felt very well supported by the manager and senior staff and commented that they would feel confident to raise any issues or concerns with the unit nurse or the manager. One member of staff told us the manager had recently worked to improve the conditions of the staff working at the service. Staff confirmed there was good teamwork with regular meetings and staff briefings and good communication at handovers. Staff confirmed they had regular supervision sessions and annual appraisals, at which they could discuss their performance and work load and identify training needs. The manager encouraged staff to undergo training and improve their knowledge and skills. The manager was mentoring and supporting staff on management and leadership courses. Staff told us about the usefulness of the monthly staff meetings where information was shared. Daily 'flash meetings' took place to discuss any issues so these were known and action could be taken promptly to address them. They also followed up to ensure any issues raised previously had been addressed. The manager had corrective and preventative action request forms in place for any items noted, for example, staff absence and the action being taken to address it.

Systems were in place for quality assurance purposes and a full audit of the service had been carried out in September 2015. The manager had drawn up an action plan to address shortfalls identified and had actioned these, for example, getting the survey results published. The service also had regular monthly audits carried out on behalf of the provider. These were in two parts so over a period of two months all aspects of the service were covered. We saw there had been a steady improvement in the audit results and any issues were promptly addressed. A health and safety inspection was carried out in May 2015 and action

Good

Is the service well-led?

had been taken to promptly address shortfalls identified. Notifications were being sent to Care Quality Commission (CQC) for any notifiable events, so we were being kept informed of the information we required.

The manager had recognised qualifications in leadership and management. They also had nursing and mental health care qualifications and had accessed good practice guidance, for example, the National Institute of Clinical Excellence guidance for managing medicines in care homes, Public Health England and NHS England guidance, Health and Safety Executive guidance to health and safety in care homes and the Home Office employers guide to acceptable right to work documents. The manager was knowledgeable about the requirements of the Care Quality Commission and had done work to identify and evidence how they were meeting the fundamental standards. This demonstrated the manager worked to improve her knowledge and encourage good practice within the service.