Trees Park (Kenyon) Limited

Kenyon Lodge

Inspection report

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Manchester
Greater Manchester
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Date of inspection visit:
26 October 2016

Date of publication:
09 January 2017

Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 26 October 2016 and was unannounced. The last inspection was undertaken on 25 and 26 May 2016 and there was a continued breach of the Health and Social Care Act (Regulated Activities) Regulations 2014 with regard to consent and mental capacity assessments. This breach had been identified at the previous inspection and at the inspection in May we found insufficient progress had been made in this area. At this inspection we found progress had now been made in this area and the service was now meeting this requirement.

Kenyon Lodge provides nursing and personal care for up to 60 people. The single room accommodation is arranged over two floors and has lift access. A car park is available and the home is close to bus routes and a motorway network. On the day of the inspection there were 36 people using the service, of which 14 were in residential placements and 22 in nursing.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The inspection had been brought forward due to a significant number of safeguarding issues. Some of these were subsequently substantiated and failings identified within the service. Corrective measures were now being put in place and needed to be sustained in the future to help ensure people's continued health and well-being.

People told us they felt safe and secure at the home. The service's recruitment procedures were robust and helped ensure people employed at the service were suitable to work with vulnerable people.

Staffing levels were sufficient to address the needs of the people who used the service and were based on a dependency tool. This was to be updated to ensure busy times were always covered appropriately.

Individual and general risk assessments were in place and these were reviewed and updated as required. We saw evidence of health and safety checks and regular maintenance of equipment.

Medication systems were safe and medicines were ordered, administered, stored and disposed of appropriately. Some issues, such as the application and documentation of topical creams needed to be tightened up.

Staff demonstrated a good understanding of people who used the services. Induction was thorough and training was on-going. This helped ensure staff's skills and knowledge were kept up to date.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and

Deprivation of Liberty Safeguards (DoLS) applications were made appropriately. Consent was sought for all interventions and there was no use of restraint at the home.

People's nutritional and hydration needs were assessed. Referrals to other agencies were made appropriately and advice followed where necessary. Special diets and requirements were adhered to by the service.

People told us they were cared for with kindness and we observed good interactions between staff and people who used the service throughout the day. We saw that staff respected people's privacy and dignity at all times.

People who used the service, and their relatives where appropriate, were encouraged to be fully involved in care planning. People were supported to be as independent as possible.

Staff had undertaken training in end of life care and efforts were made to ensure people's end of life wishes were adhered to.

Care plans were person-centred and included a range of health and personal information. This helped staff care for people in the way in which they wished to be cared for. Care plans were regularly reviewed, but we found a few inconsistencies in documentation. There were a range of activities on offer at the home.

Complaints and concerns were dealt with appropriately and people were aware of how to make a complaint or raise a concern.

People who used the services and relatives described the manager as approachable. Staff said they were well supported and supervisions and appraisals took place on a regular basis. Staff meetings were also held regularly so there were a number of forums for staff to discuss issues or raise concerns.

Notifications had not been submitted in a timely manner to CQC prior to the inspection. Although this had now been addressed by the registered manager, they needed to demonstrate that appropriate notifications would be submitted in a timely manner in the future. We are following this up outside the inspection process.

The home had effective systems in place for quality assurance and audit. Results of audits were analysed in order to drive improvement within the service.

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 safe.

People told us they felt safe and secure at the home. The recruitment procedures were robust and staffing levels were sufficient to address the needs of the people who used the service.

Individual and general risk assessments were in place and these were reviewed and updated as required. We saw evidence of health and safety checks and regular maintenance of equipment.

There had been a significant number of safeguarding issues; these were now being addressed and needed to be sustained in the future to help ensure people's safety and well-being.

Medication systems were safe.

Is the service effective?

Good

The service was effective.

Staff demonstrated a good understanding of people who used the services. Induction was thorough and training was on-going.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) applications were made appropriately.

People's nutritional and hydration needs were assessed. Referrals to other agencies were made appropriately.

Is the service caring?

Good

The service was caring.

People told us they were cared for with kindness and we observed good interactions between staff and people who used the service throughout the day.

People who used the service were encouraged to be fully involved in care planning. People were supported to be as

independent as possible.

Staff had undertaken training in end of life care and efforts were made to ensure people's end of life wishes were adhered to.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and included a range of health and personal information. There were a range of activities on offer at the home.

Complaints and concerns were dealt with appropriately and people were aware of how to make a complaint or raise a concern.

Is the service well-led?

Requires Improvement

The service was well-led.

People who used the services and relatives described the manager as approachable. Staff said they were well supported and supervisions and appraisals took place on a regular basis.

Notifications had not been submitted to CQC in a timely manner prior to the inspection, but this had now been rectified. The service needed to demonstrate that this would be sustained in the future.

The home had effective systems in place for quality assurance and audit. Results of audits were analysed in order to drive improvement within the service.

Kenyon Lodge

Detailed findings

Background to this inspection

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

The inspection took place on 26 October 2016 and was unannounced. The inspection was undertaken by two adult social care inspectors from the Care Quality Commission (CQC) and a Specialist Advisor (SPA). A SPA is a person who accompanies the inspection team and has specialist knowledge in certain areas. The SPA at this inspection was a specialist in all aspects of nursing care.

Prior to the inspection we gathered information about the service in the form of notifications and safeguarding referrals. We contacted the local authority safeguarding team and the local Clinical Commissioning Group.

During the inspection we spoke with three people who used the service, two visitors and one professional visitor. We spoke with seven staff members including the registered manager and carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at six care records, six staff files, meeting minutes, audits, training matrix, staff rotas, health and safety records and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

People living at the home told us they felt secure and safe and they would not hesitate in speaking with the manager or one of the nurses if they felt unsafe. One person said, "I am very reliant on the staff to help me getting out of bed and transferring to my wheelchair. I am a big chap yet I never feel at risk."

We looked at six staff personnel file and saw that the recruitment procedures were robust. All relevant information, such as Disclosure and Barring Service (DBS) checks, which help ensure employees are suitable to work with vulnerable people, were in place. Each file contained evidence of references obtained from previous employers. We saw evidence that the service's disciplinary procedures were followed appropriately where necessary.

The service had experienced difficulties in recruiting qualified nursing staff to the home, which was indicative of a wider national problem. They had decided not to admit on to the nursing unit until they had recruited sufficient qualified staff, which they had now begun to do. On the day of the inspection there was one newly recruited qualified nurse on duty. Two other nurses had been recruited and were due to commence their employment, one as a deputy manager and the other on the night shift within the next few weeks. Agency nurses were being block booked in the meantime to ensure there were qualified staff in place at all times.

We saw that there were sufficient staff on duty to attend to the needs of the people using the service and staff were visible in the lounge areas throughout the day. The service used a dependency tool to assess the level of need of each person who used the service and staffing levels were based on the results of this. We saw evidence of the dependency tool within people's care files and the analysis of the hours required was produced. This showed that, at present, staffing levels were sufficient and this was confirmed by looking at recent rotas. We discussed the dependency tool with the registered manager for when the home was full again and she agreed to consider using a new tool to reflect busy times, such as early mornings. She told us this would be discussed with the regional manager at the forthcoming planned visit. Staff we spoke with felt there were generally enough staff, other than the odd occasion when someone rang in sick at the last minute.

People's care plans included any necessary risk assessments based on actual and perceived risk. The identified areas of risk depended on the individual and included issues such as skin integrity, falls, mobility and health needs. The home used recognised tools for assessing areas such as nutrition and tissue integrity. We saw how one person had been found to be at potential risk of tissue damage. The assessment had looked at predisposing factors such as diabetes, reduced mobility and loss of sensation and we saw where risks had been found, risk reduction strategies had been identified. Care plans showed nursing staff had identified the need for the person to sleep on a pressure relieving mattress and for care staff to check the person on a regular basis overnight. Risk assessments were regularly reviewed and kept up to date.

We saw fire safety assessments had been conducted to produce a personal emergency evacuation plan (PEEP) for each person. These were kept within each person's care file and were updated on a monthly basis

to ensure the information was correct. There was evidence of monthly fire equipment checks and regular maintenance. We pointed out a potential fire hazard under the stairs at the front of the building, where excess paper for the photocopier was kept. This area was cleared on the day of the inspection. Similarly excess furniture items, which were stored under the stairs at the rear of the building, were removed on the day of the inspection.

There were weekly checks of emergency lighting, water outlets and alarms and general maintenance checks carried out daily. We saw up to date servicing and maintenance certificates for electricity, gas and legionella testing. Small appliances had been (Portable Appliance Testing) PAT tested and equipment such as the passenger lifts and hoists were serviced and maintained as required.

There was a policy regarding safety of the premises, which was appropriate and up to date and an up to date infection control policy and procedure was in place. We saw that staff used personal protective equipment (PPE), such as aprons and gloves, when appropriate. This helped prevent the spread of infection within the home.

We looked at the service's safeguarding policy and procedure, which was appropriate and up to date. Staff we spoke with had undertaken safeguarding training and were aware of how to recognise safeguarding issues and were confident to report them. They were also aware of the whistle blowing procedure and told us they would not hesitate to report any poor practice they may witness.

The comprehensive inspection had been brought forward in response to being made aware of a number of safeguarding alerts and concerns within the service. We looked at the safeguarding file and saw that recent safeguarding incidents had been recorded on a matrix; minutes of meetings attended were retained and follow up actions documented appropriately.

As part of our inspection we looked at the care management of three people who had pressure ulcers. One person had acquired a pressure ulcer and a recent safeguarding meeting had established staff had not responded in a timely way. The manager told us they accepted the outcome and would learn from the experience. Actions agreed included all nursing staff to receive wound care, recognition and identification of pressure damage training, all nursing staff to ensure that monthly body maps and wound care plans were in place and nurses to ensure that these plans were regularly reviewed.

Following the inspection we found that other safeguarding issues had been substantiated. Failings within the service and actions required to address these shortfalls had been identified by the local safeguarding team. Although they had responded to these findings and put corrective measures in place, the service now needed to ensure these measures were sustained .to help ensure people's continued health and well-being and minimise the risk of further safeguarding concerns.

We saw two further people with pressures ulcers which were being appropriately managed. One person was being managed with input from a podiatrist. Documentation in care plans suggested the ulcers were healing and no further skin damage had developed. We looked at the risk reduction measures being taken to prevent pressure ulcers and found them to comply with good practice. For example, people were assessed to determine the need for pressure relieving mattresses and where these were not used people were helped to reposition themselves if they were unable to do so unaided. We saw pressure relieving mattresses were in use and inflated correctly.

A further example of compliance with good practice was with regard to repositioning. The National Institute for Health and Care Excellence (NICE) document on Pressure Ulcers dated June 2015 states "For safety

reasons, repositioning is recommended at least every 6 hours for adults at risk, and every 4 hours for adults at high risk". Our observations of care records and staff activity during our inspection showed this guidance was being adhered to. We saw the effective use of risk assessments and health and safety advice to ensure people who had bed rails in use were not in danger of injury through entrapment from ill-fitting equipment. Bed rail risk assessments were seen in people's care plans and were regularly reviewed and kept up to date.

Whilst care planning described good practice in the prevention of pressure ulcers we observed one area of suboptimal practice. The maintenance of skin integrity is vital for the prevention of pressure ulcers and moisture lesions. With the ageing process, the skin becomes thinner and is more prone to the effects of incontinence, which can result in the skin becoming increasingly vulnerable to damage. Some people were prescribed protective skin barrier creams yet our observations showed these were not being applied as directed by the prescriber. For example, one person was prescribed Conotrane cream to protect the skin from moisture, irritants and chafing all of which are contributing factors to pressure ulcer formation. The records showed the cream had not been applied on eight occasions in the past two weeks. This was discussed with the registered manager who agreed to ensure that the qualified nursing staff would take responsibility in future for checking that all topical creams had been applied appropriately. The registered manager said she would complete random checks in this area to ensure that agreed actions were happening.

The service had an up to date medication policy in place, which included the use of covert medication, which is medication given without the person's knowledge when they are unable to make an informed decision and the medication is given in their best interests. Medicines were administered to people by trained nursing and care staff. No person at the home had been found to have the capacity, physical ability or desire to self-medicate. Most medication was administered via a monitored dosage system supplied directly from a pharmacy. Individual named boxes contained medication which had not been dispensed in the monitored dosage system.

We inspected medication storage and administration procedures in the home. We found medicine trolleys and storage cupboards were secure, clean and well organised. We saw the drug refrigerator and controlled drugs cupboard provided appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. Drug refrigerator and room temperatures were checked and recorded to ensure that medicines were being stored at the required temperatures.

Creams and ointments were prescribed and dispensed on an individual basis. The creams and ointments were correctly stored and dated upon opening. We saw, within people's care plans, that where thickener had been prescribed for people experiencing swallowing difficulties, the consistency of the liquids to be given was outlined to help ensure this was given correctly. We discussed with the registered manager that the administration of thickened fluids needed to be recorded on the Medication Administration Record (MAR) sheets to ensure all drinks given were documented. This was resolved on the day of the inspection.

One person on the nursing unit was fed via Percutaneous endoscopic gastrostomy (PEG) feeding. This is when a person is unable to eat their food orally and receive it through a tube into their stomach. Clear instructions, such as ensuring the person was in an upright position to receive their food, were visible in the room for staff to follow.

We saw evidence that people were referred to their doctor when issues in relation to their medication arose. We saw periodic reviews of medicines were conducted by GPs and pharmacists; the outcomes of the reviews were filed with the current medicine administration records (MAR).

We observed a registered nurse whilst they conducted the morning medication round to 22 people. We saw the medicines were given safely and people were sensitively helped to take their medicines. We saw where medicines were prescribed to be given before food the prescribers wishes were being met. However during our review of medicines stored in the fridge we saw one person had been prescribed Co-amoxiclav suspension. The bottle clearly stated the remaining contents of the bottle should have been discarded on the day prior to our inspection. We reviewed the MAR sheets for non-nursing service users and found a member of care staff had administered the medicine after the expiry date. The carer confirmed the error and took appropriate action to inform the manager and the person's GP.

We saw all 'as necessary' (PRN) medicines were supported by written instructions which described situations, frequency and presentations where PRN medicines could be given. Some prescription medicines contain drugs which are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines. We saw controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

We carried out a random sample of supplied medicines dispensed in individual boxes. We found on all occasions the stock levels of the medicines concurred with amounts recorded on the MAR sheet. We examined records of medicines no longer required and found the procedures to be robust and well managed.

Good

Is the service effective?

Our findings

Staff with whom we spoke had good knowledge of people's needs. Some staff had worked at the service for a number of years whilst others giving care were from an agency. Our discussions showed whether staff were permanent or from an agency they were able to tell us about how they cared for each individual to ensure they received effective care and support. People spoke highly of the staff who worked in the home. One person said, "The staff are all great, I don't know what I would do without them."

We walked around the premises and there were no unpleasant odours on the ground floor. There was a slight odour on the first floor, which staff felt may be coming from a clinical waste bin in a toilet cubicle. They agreed to address this immediately. The premises were clean and tidy and there were pleasant seating areas in the corridors. The grounds and garden were well kept. We noted that a bathroom on the first floor required new flooring as did the nurses' office on the same floor. The registered manager agreed to address these issues in the very near future.

Staff we spoke with told us their induction was thorough. We saw from the staff files we looked at that induction included mandatory training and shadowing a more experienced member of staff. New staff were all undertaking the Care Certificate. This replaced the Common Induction Standards and National Minimum Training Standards and was developed by a recognised workforce development body for adult social care in England. The certificate is a set of standards that health and social care workers are expected to adhere to in their daily working life.

We saw the training matrix and this evidenced that over 90% of staff had undertaken training in dementia, diet and nutrition, equality and diversity, fire awareness, first aid, food safety, health and safety, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), manual handling, safeguarding, distressed behaviour and end of life care. The matrix showed that 100% of staff had undertaken medication training. The registered manager told us that all staff had now signed up to undertake National Vocational Qualifications (NVQ).

We saw evidence of regular supervision sessions with staff. Some of these were general one to one meetings to discuss progress, training needs and general work issues. Other supervisions were themed and we saw records of recent themed supervisions on the topic of dignity and respect. This helped to reinforce good working practices and values.

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 are called the

Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager was knowledgeable about the MCA and DoLS and knew the Care Quality Commission (CQC) needed to be notified when the outcome of any applications were known. We saw 16 standard authorisations had been approved by the supervisory body. A sample of these showed conditions had been attached to the authorisations. Our scrutiny of care plans and a discussion with the manager showed the conditions were either being met or were in the process of being enacted. For example, one person had few friends and family to visit. The condition required the managing authority to explore the possibility of engaging with a befriending support group. The manager told us of the challenges in doing so but informed us there appeared to be a real possibility of doing so in the near future. The manager told us if they had difficulty in adhering to conditions they would inform the supervisory body. There were a small number of discrepancies within care files, for example, one person had a DoLS in place but no care plan to reflect this. The registered manager addressed any discrepancies immediately.

Cognitive assessments were included in people's care files and there was clear information about the level of people's capacity to make decisions. Where they were unable to make decisions, these were made in their best interests. We saw within the care files that some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. These had been discussed with the person involved, where appropriate. If the person did not have capacity, this was clearly documented and a best interest decision had been made, involving family members where appropriate. Staff we spoke with demonstrated an understanding of capacity issues and best interests decision making.

We spoke with the manager about the use of restraint and any policy documents to underpin restraining methods. We were told all forms of restraint were not a feature of the service. Any need to protect people or staff from harm was provided by attempts to de-escalate situations. Our subsequent discussions with care staff showed the philosophy of care was well understood.

We looked at a sample of care plans for people who we saw had bed rails attached to their beds. Assessments of people's needs demonstrated bed rails were used only to prevent people falling out of bed or where people were anxious about doing so. We saw risk assessments were carried out to ensure the potential risks of using bed rails were balanced against the anticipated benefits to the user.

We observed three people in the lounge who were seated in bespoke chairs with the intention of tipping the person slightly backwards. We looked at the care plans but we could find no evidence health needs assessments had taken place which identified the need for the observed posture to be maintained. A discussion with the manager revealed the people concerned had undergone a professional assessment prior to the chairs being ordered. The manager assured us the outcome of the assessments would be placed in the care plans. Our observations and scrutiny of the people's care plans showed the use of the chairs was likely not to be for the purpose of restraint. For example one person was recorded to be fearful of being seated in traditional chairs as they may fall.

People we spoke with were very complimentary about the food at the service. One person who used the service said, "Food excellent as always, lots of choices", another told us, "The food is lovely and you get plenty to eat. A relative commented, "The food is lovely".

We looked at the menu and saw that breakfast consisted of cereals, porridge, cooked breakfast or toast and preserve. Lunch was the main meal of the day and on the day of the inspection consisted of roast ham, roast and creamed potatoes and vegetables. Other choices were available and there was a choice of dessert. Tea

consisted of homemade soups every day, sandwiches or a hot option. On the inspection day this was chicken nuggets and beans. There was again a choice of dessert. Supper was available and people could have items such as crumpets, toast, cereals and a choice of milky drink. Drinks were offered throughout the day and water coolers available of both floors.

We undertook an observation of the lunchtime meal. The tables were set nicely and we saw that appropriate equipment, such as plate guards, clothes protectors and napkins were used. We saw adapted cutlery was available for people with a weak grip or a limited range of motion. This allowed people to remain independent whilst eating. We saw staff who were assisting people with their food sat down so that they were at the same level and assisted in a discreet way. Staff interacted pleasantly with people who used the service throughout the meal. We saw that pureed food was served in separate portions for colour taste and texture. Fortified diets were served to people who had been assessed as requiring extra nutrition. We spoke with the chef who confirmed they received fresh deliveries regularly and there was always plenty food in the home.

The service used the Malnutrition Universal Screening Tool (MUST) to assess people. This is an objective screening tool to identify adults who are at risk of being malnourished. As part of this screening we saw people were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition. Where people had not been weighed, because of a refusal or where they were unable to do so, this was clearly documented and other methods, such as measuring the upper arm, were employed. We saw where people were prescribed food supplements these were given in accordance with the prescribers wishes. People who had diagnoses requiring dietary needs were cared for appropriately. For example, one person had insulin dependent diabetes and coeliac disease. We saw an appropriate diet was available and staff were aware of the person's specific dietary needs.

We saw a written daily report existed which determined each person's specific needs. This included dietary and fluid intake requirements. We saw a daily record was maintained which showed food intake and portion size consumed. Fluid intake records were completed which showed which drinks were consumed and in what amounts. However whilst the daily written reports mentioned some people requiring encouragement to take fluids this was not always successful. For example fluid records showed a target intake of 1500mls yet three people's records showed an intake of less than 1000mls per day. In contrast we spoke with one person who had an indwelling urethral catheter. They told us "I have no problems with the catheter probably because the staff are always telling me to drink plenty". The manager said they would continue to reinforce the need to maintain people's fluid intake. Care records showed the service was referring people to a dietician or speech and language therapist (SALT) if they required support with swallowing or dietary difficulties.

Consent to care and treatment was sought in line with legislation and guidance. People told us they felt involved in their care and staff always asked for their consent as a matter of routine. Staff told us people's consent was gained before assisting them with care and support. One person said. "They always ask what time I want to go to bed and however late that is they never complain."

During our inspection, we observed staff gaining people's consent to support them. For example, during the medicine round we saw people were asked if they wished to have their medicines or would they prefer them a little later. Where appropriate care plans contained people's signed consent to show their agreement to their individual care plans and issues such as the use of photographs.

During the inspection we looked at six people's care records. These showed people had access to appropriate health care professionals such as GPs, dentists, district nurses, dieticians and speech and

language therapists to meet their specific needs. For example one person had been reviewed by a diabetes nurse specialist. The nurse had specified the method and frequency of monitoring blood glucose levels and the plan of action should the results be outside of the given range. We saw the advice had been translated into the care plan and our observations of practice showed the monitoring was being carried out.

Good

Is the service caring?

Our findings

People with whom we spoke made positive comments about the way the staff team supported them. One person told us, "The staff are very kind and know me well." Another person, who had been supported to become more independent and was hoping to move out to sheltered accommodation, said they were looking forward to the move. They told us "The staff have been marvellous, can't fault them. I have been safe, comfortable and well cared for. The girls give me my tablets; they are always on time with them. I have no complaints at all".

People who used the service told us staff made their visitors feel welcome. A friend who was visiting told us "I come every couple of weeks. [Friend] is always nicely dressed and clean. I have never seen or heard anything that I would be worried about. The staff are polite, respectful but friendly". Another visitor said, "I am happy with the care [relative] receives. They would soon let me know if they were unhappy. I am welcomed every day".

Staff we spoke with felt the care given at the home was of a good standard. One staff member said, "Yes, good care is given here". Another told us, "My heart is in it. I find it rewarding and enjoy working here. The care is good".

We saw people had been able to make choices about the decoration and furnishings in their rooms. Many rooms contained personal treasured items, family photographs and a personal television and some people had their own phone and/or fridge.

Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity. One person described to us how staff supported them with their personal care, whilst respecting their privacy and dignity. The person told us staff always explained what they were about to do before they carried out each personal care task.

We observed care throughout the day. People were assisted by staff to be as independent as possible. We saw staff encouraged people to do as much for themselves as they were able to and prompted people when needed, in a respectful way. We saw that people's mail was delivered unopened to their rooms, which demonstrated a commitment to protecting people's privacy.

We saw evidence within the care plans that people had been involved, where appropriate, in making decisions about the care and treatment they received. If they were unable to participate, a family member or close friend may be consulted, where appropriate. People were also encouraged to take part in care plan reviews.

Residents' and relatives' meetings took place regularly and we spoke with one of the people who used the service who participated in these meetings. They enjoyed the feeling of being involved in the running of the service, but asked that they receive a copy of the minutes after each meeting, as this had not always happened. The manager agreed to ensure minutes were given to residents as a matter or course in future.

We saw minutes of recent meetings and topics discussed included better menus, better laundry system, new ideas and garden improvements.

Staff had undertaken Six Steps training in end of life care. This is the North West End of Life Programme for Care Homes. This means that for people who are nearing the end of their life can remain at the home to be cared for in familiar surroundings by people they know and can trust. People's end of life wishes, where they had expressed them, were recorded in the care files to help ensure they would receive the care they wanted at the end of their lives.

Good

Is the service responsive?

Our findings

People we spoke with felt the staff responded quickly and effectively to their needs. Prior to living at the home, people's health care and support needs were assessed, planned and evaluated to agree their personalised plan of health care and support. Care plans were informed from a range of health and social care professionals which ensured care staff had all the information they needed to construct a meaningful plan. We saw the pre-admission assessment included a life history and a résumé of their medical history.

Care plans included personal information, including their preferred name. People's likes and dislikes and what was important to that person were documented. Each plan had a detailed personal history which included information about childhood, adolescence, young adulthood, middle age and later years. A social assessment included important people, favourite TV and radio programmes and music. There was information about what the person liked to talk about, whether they liked time alone, hobbies, interests, food and drink likes and dislikes, favourite colours and activities, religious and cultural needs and interests. We saw that people's preferences for times of rising and retiring were documented as well as whether they preferred a bath or a shower.

Care plans also provided details about people's personal care needs, their mobility, the support they needed with eating and drinking, managing continence and in one case indwelling catheter care management. The care plans we looked at were clear, appropriately detailed and filed in a logical order. Care plans evidenced that people were looked after in the way they liked.

The service undertook a service user of the day programme, where all the care documents were reviewed and evaluated. There was evidence that people who used the service and their families were involved in this process. On this day the person involved could choose a special meal which would be cooked for them. They could also participate in some pampering or activity of their choice.

We saw care plans were regularly reviewed however some inconsistencies showed the review process lacked rigor. For example, an end of life care plan stated Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) was not in place. The care plan had been reviewed each month with the comment "no change" yet three months earlier a DNACPR was put in place. The registered manager told us they would ensure care plan reviews were undertaken with more attention to detail.

We saw evidence of activities, such as games, reminiscence sessions and trips out. The home was about to participate in a scheme involving volunteers for activities. This was being piloted within the local area and the hope was that fresh ideas would be brought in, introducing new and stimulating activities to the people who used the service.

The complaints procedure was outlined in the reception area. Complaints and concerns were logged in a folder. We saw that there had been two complaints since January 2016. These had been dealt with appropriately and actions recorded. We saw there was a suggestions box in the foyer, which provided a way for people to put forward ideas for improvements to the service.

We spoke with one person regarding their knowledge of the home's complaints process. They told us they knew who to talk to if they had any concerns and said they would feel comfortable and confident in doing this. They were however keen to stress they had no complaints and were entirely happy living at the home.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager at the service who had been in post for a year. We saw that the registered manager was well supported by the higher management structure, one of whom was present on the day of the inspection and accompanied the manager to a safeguarding meeting.

People knew who the registered manager was and said that they talked with them regularly. One person we spoke with said, "Yes I know who she is and she is the one who makes things run smoothly". A relative told us, "I could talk to any of the staff, they are very approachable". Staff told us they felt supported in their employment. One staff member told us, "The manager is brilliant, very supportive and approachable. There has been lots of changes for the better". Another commented, "Management are approachable with anything and very supportive. Supervisions are helpful and constructive".

The inspection had been brought forward due to a significant number of safeguarding concerns being raised and prior to the inspection we found that not all relevant notifications had been submitted to CQC in a timely manner as required. The safeguarding issues were now being addressed and the registered manager had begun to submit notifications appropriately. They needed to ensure this was sustained in the future.

We observed the daily "Flash meeting". This was a daily meeting between the manager and leading members of care and support staff. On the day of our inspection the meeting consisted of laundry, catering, maintenance, care and nursing staff. The purpose of the meeting was for care and support staff to communicate pivotal issues to the manager and visa-versa. The meeting only lasted 20 minutes but provided a significant function in maintaining an efficient and effective communication system. For example, during the day we saw a number of light bulbs needed replacing. During the meeting discussion centred on the maintenance programme which included the replacement of faulty light fittings. The meeting gave us assurance that issues were responded to with speed and efficiency. The meeting was minuted.

We saw minutes of other staff meetings, which took place on a monthly basis, where topics discussed included nutrition, rotas, staffing, sickness and activities. We saw that staff had been told at a meeting about the importance of completing the training that was due and the training matrix evidenced that staff had taken this on board and completed the relevant training courses.

Supervision sessions and appraisals were regularly undertaken with staff. We saw documentation of some of the supervisions which evidenced good communication between staff members and their supervisors.

The home had effective systems in place for quality assurance and audit. Pressure mattresses and bed rails were checked on a weekly basis to ensure they remained appropriate and fit for purpose. We saw a number of audits for areas such as medicines, housekeeping, complaints, falls, pressure areas, infection control, maintenance, training and activities. Audits highlighted any issues found and actions to be taken were recorded as well as the person responsible for the actions. We saw an analysis of hospital admissions to look at any patterns or trends and for the service to try to address these. Accidents, incidents and falls were also

analysed to help identify any recurring themes that could be addressed in order to minimise these incidents.

We looked at the home's policies and procedures. The policies had been reviewed and were appropriate and up to date. Staff were made aware of the policies at the time of induction and could access them when they needed to, in order to check guidance.