Bupa Care Homes (ANS) Limited

Alveston Leys Care Home

Inspection report

Kissing Tree Lane
Alveston
Stratford Upon Avon
Warwickshire
CV37 7QN

Tel: 01789204391

Date of inspection visit:
19 December 2017
20 December 2017
02 January 2018

Date of publication:
06 February 2018

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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 19 and 20 December 2017. We returned on the 2 January 2018 so we could speak with the registered manager and look at their quality assurance systems.

Alveston Leys Care Home is registered to provide nursing and residential care for up to 60 people. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home has a residential unit and a nursing unit which is spread over three floors. At the time of our inspection visit, 43 people lived at the home.

A requirement of the service's registration is that they have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and the associated Regulations about how the service is run. At the time of our inspection visit there was a registered manager in post who was supported by a deputy manager.

At the last inspection on 7 February 2017, the service was rated as requires improvement. We found a breach of the regulations because improvements were needed in the deployment of staff. We also found improvements were needed in the processes and procedures to support the provision of quality care within the home. Following the last inspection visit, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe and Well led to at least good.

This inspection visit was a comprehensive inspection and during this inspection we checked to make sure improvements had been made. Whilst some improvements had been made, we found improvements were still needed to ensure daily records were accurate and clearly evidenced the care provided.

There were enough staff to provide safe and effective care that met people's needs. Recruitment procedures ensured staff were qualified and safe to work with people who lived in the home. Staff understood their safeguarding responsibilities and the action they should take if they were concerned a person was at risk of harm.

The provider used a variety of risk assessment tools to identify any potential risks to people's health and safety and risk management plans guided staff on how to manage those identified risks. However, daily records to support risk management were not being consistently or accurately completed.

Accidents and incidents were recorded by staff and analysed by the registered manager to identify any emerging trends or patterns so appropriate action could be taken to minimise identified risks.

People received care from staff with the knowledge, skills and competencies to support their health needs.

Medicines were ordered, received, stored, administered and disposed of in accordance with good practice and overall, staff understood their role and responsibilities in relation to infection control and hygiene.

The provider assessed people's capacity to make their own decisions if there was a reason to question their capacity. Staff and the registered manager had a good understanding of the Mental Capacity Act. Where possible, they supported people to make their own decisions and sought consent before delivering care and support. Where people's care plans contained restrictions on their liberty, applications for legal authorisation had been sent to the relevant authorities as required by the legislation.

Staff supported people to eat and drink enough to maintain their health and referred people to other healthcare professionals when a need was identified. Managers and staff worked with other healthcare professionals to ensure people could remain at the home at the end of their life and receive appropriate care and treatment.

Staff were caring and compassionate. They knew people well so they could deliver care in the way people preferred and in a way that was meaningful to them. The atmosphere in the home was warm and friendly and conducive to building and maintaining relationships with others in the home as well as family and family. People's diversity was respected and staff responded to people's social and emotional needs in a person centred way. People told us their needs were met because they were supported and cared for in accordance with their wishes and choices.

There were processes and procedures for monitoring the quality of care provision in the home. However, some improvements were needed to ensure action was promptly taken when issues were identified. People and staff were positive about the leadership of the service, but some staff and relatives felt the management team could be more visible on occasions.

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.

There were enough staff to meet people's needs safely, and their suitability for their role had been checked before they started working at the home. Staff understood their responsibility to safeguard people from the risks of harm or injury and report any concerns they had. Systems were in place to ensure medicines were stored, administered and managed in accordance with good practice. The home was clean and tidy and staff knew how to support people in the event of an emergency.

Is the service effective?

Good

The service was effective.

People were cared for and supported by staff who had the skills and training to meet their needs. Staff understood their responsibilities under the Mental Capacity Act 2005. Where there were restrictions on people's liberty, the appropriate applications had been submitted to the local authority in accordance with the legislation. People were supported to eat and drink enough to maintain a balanced diet that met their needs and preferences. People's health was assessed and monitored and they were referred to other healthcare professionals when a need was identified.

Is the service caring?

Good

The service was caring.

People were content and happy and spoke positively about the friendliness and willingness of staff. Staff were kind, sensitive and caring in their approach and respected people's privacy and dignity. There was a relaxed and friendly atmosphere where people were encouraged to build and maintain relationships with each other and with family and friends. .

Is the service responsive?

Good

The service was responsive.

Care and support was provided in a way people preferred and people and their relatives were involved in planning and reviewing their care needs. Communication care plans described people's individual needs and how staff should engage with people to ensure they provided responsive care. People could remain at the home at the end of their life and received appropriate care and treatment. Complaints and concerns were dealt with in accordance with the provider's complaints policy.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Records to support risk management in the home were not being consistently or accurately completed. People and staff spoke positively about the leadership of the home but felt management could be more visible on occasions. The provider had systems and processes for reviewing the quality of the care provided and for gathering feedback from people and relatives to help it improve.

Alveston Leys Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 19 and 20 December 2017. The first day of the inspection was unannounced and was undertaken by one inspector. We told the provider we would return the following day. The second day of the inspection was undertaken by two inspectors, a specialist advisor 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 service. A specialist advisor is a qualified health professional. One inspector returned on 2 January 2018 to talk with the registered manager about their management of the service.

The provider had completed a provider information return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR was reflective of the service provided at the home.

Prior to our inspection visit we reviewed the information we held about the service. We looked at information received from relatives, the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. The commissioners did not share any information of which we were not aware.

During our inspection visit we spoke with 12 people and seven relatives about what it was like to live at the home. We spoke with the deputy manager, two nurses, 10 care staff and three support staff about what it was like to work at the home. We spoke with the registered manager and area operations manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed six people's care plans and daily records to see how their care and treatment was planned and

delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

At our previous inspection in February 2017, we had identified there were not always enough skilled and experienced staff appropriately deployed to support people safely and rated the service as requiring improvement. At this inspection we found the provider had taken the action they said they would take. They had reviewed staffing levels and the deployment of staff and the rating is now Good.

People's individual abilities and needs for support were analysed to identify how many staff were needed to deliver care safely. However, the registered manager told us they staffed above the identified staffing levels because of the challenges presented by the layout of the building. They explained, "If it was one unit of 30 people you can hear and see all the time, but it is different having the unit spread out over three floors."

People and staff felt there was enough staff to support people's physical needs safely. One person we spoke with said, "If I ring or ask for staff, they come quickly." They said the most they had waited was five minutes, but added, "You have to expect this if they are with someone else." People said whenever they needed assistance or support from staff, "You only have to ask." Staff member spoke positively about the increased staffing levels at night on the nursing unit. One member of staff explained, "It used to be two care staff but now it is always three. You can be more attentive and bells get answered quicker." Another said, "The staffing level is a huge improvement."

People and relatives said permanent staffing levels were supported by agency staff, which at weekends and evenings had some impact on staff knowing people's preferred routines. One staff member said there were enough staff but added, "We work better with all BUPA staff because agency staff don't have prior knowledge of people." They also said some people did not always feel comfortable receiving support from agency staff because they did not always know people well. The deputy manager told us the provider had recruited additional care staff and nurses since our previous inspection and agency use was gradually reducing as newly recruited staff started working at the home. A relative confirmed reliance on agency staff had improved.

However, staff also said at some times during the day they felt more rushed and had less time to be responsive to people's requests for support, particularly between 7.00am and 8.00am. One comment was, "At night we manage and everybody is safe. It is from 7.00am we struggle." The registered manager assured us they regularly reviewed staffing levels to ensure people received support that kept them safe and met their individual preferences.

People told us they felt safe living in the home. One person said, "Receiving care from experienced staff", made them feel comfortable and safe. They told us they chose to live at Alveston Leys because their first impression when they visited was, "Very good and welcoming." Another person told us they felt safe because staff took particular care when supporting them to have a shower.

We saw people were relaxed in staff's company and people's behaviour and response to staff's approach demonstrated they were comfortable with staff. Staff understood their safeguarding responsibilities and the

action they should take if they were concerned a person was at risk of harm. They told us they would be aware of people who became withdrawn or anxious as a possible indicator they were worried about something. One staff member told us, "It's ensuring people are safe….I would report any concerns to the manager, CQC or the police." Another staff member told us, "I wouldn't want any of my residents at risk because they are like my family. Some people can't speak up for themselves and it is our job to speak up for them."

Other staff told us they would have no hesitation in reporting poor practice and were confident action would be taken. Staff said if senior staff or managers were involved in safeguarding incidents, they would escalate their concerns to the provider. One staff member said, "I would use BUPA's 'speak up' policy and refer it to a senior manager."

The provider's recruitment process was robust and staff had references checked and a full disclosure from the Disclosure and Barring Service (DBS) before starting work at the home. Clinical staff had their registration with the Nursing and Midwifery Council verified to ensure there were no restrictions on their practice.

We looked at the arrangements for managing medicines in the home. Systems were in place to ensure medicines were ordered, received, stored, administered and disposed of in accordance with good practice. Staff understood the legal requirements for managing controlled medicines which may be at risk of misuse and the necessary records were maintained.

Each person had a medicines administration record (MAR) with their current photograph on the front, information of any allergies they may have and details of how they preferred to take their medicines. MAR charts contained clear protocols and guidance for medicines that needed to be given on an 'as required' basis, for example for agitation or anxiety. Limited use of these medicines indicated the guidelines were being followed consistently by staff. Where medicines were not given to people, the reason was recorded on the back of the MAR.

Some medicines require checks to be completed before they are given, such as blood sugar levels or pulse rates. Other medicines, for example for pain relief, are administered through patches applied directly to people's skin. It is good practice to check these daily to ensure they have not fallen off or been accidentally removed by the person which could lead to them experiencing unnecessary pain. Records demonstrated that overall the necessary checks had been completed as required, although there were occasional gaps in the records. The clinical lead nurse assured us they would remind staff of the importance of maintaining accurate records.

Staff who gave people their medicines had attended training in medicines management and their competency to give medicines safely had been assessed. We observed a staff member followed safe administration practice when giving medicines. They made sure the person was appropriately supported to sit up and told them what their medicines were for. People told us they were happy for staff to manage their medicines and they received them as prescribed. One person confirmed, "They bring medicines at the right time of day."

The home was clean and tidy and there were no unpleasant odours in any areas of the home. Clinical equipment was clean and in working order, except for the suction machine for excess secretions. The clinical lead nurse told us this was not in use at the time of our visit as it did not work properly. They told us a new machine had been ordered.

Staff had received training so they understood their responsibilities in relation to infection control and hygiene. Apart from one incident when a staff member did not demonstrate good hand hygiene, staff were seen to wear the correct personal protective equipment, such as disposable gloves and aprons, when preparing and serving food or supporting people with personal care. Paper towels and had wash solution were available to use in communal bathrooms and toilets.

We checked a selection of equipment used to transfer people who were not able to mobilise independently. For example, hoists, stand aids and bath chairs. We saw these had been examined in November 2017 by an external company to ensure they were safe to use. Staff told us they felt confident using specialist equipment because they had been trained to use it safely. They explained they always checked equipment was working properly prior to using it.

The provider used a variety of risk assessment tools to identify any potential risks to people's health and safety. Risk management plans guided staff on how to manage those identified risks. This included risks of falls, those at risk of skin damage and how many staff were needed to transfer people safely. For example, one person used a frame to move around the home. Staff encouraged the person to mobilise safely and information provided to staff told them about appropriate footwear and what to do if the person became unsteady which helped reduce the risk of the person falling. Staff we spoke with knew how to support this person and keep them safe.

During our visit we found some risk assessments had not always been completed in a timely way and records to confirm management of risks were not consistently completed. However, staff knew about risks to people's health because they were handed over in regular meetings during the day. There had only been one incidence of damage to a person's skin in the last 12 months and any weight loss could be explained on an individual basis. This indicated that staff were managing risks appropriately within the home.

The provider had a policy for recording and reporting any accidents and incidents that occurred. Records showed these were analysed by the registered manager to identify any emerging trends or patterns. Records showed action had been taken to minimise identified risks. For example, one person had been given a meal that was not in accordance with their dietary needs. The registered manager had carried out a full investigation into the circumstances of the incident and implemented an action plan which had been shared with staff to ensure it could not happen again. This included a sign in the person's bedroom to remind staff of the person's specific dietary needs. We saw the sign in place during our inspection visit.

We saw risk assessments were in place for the environment, including a fire risk assessment. This was available in the entrance hall, together with an evacuation register which gave information about every person in the home, together with what support they would need to evacuate the building safely. This was updated every week to ensure it accurately reflected any new admissions or anyone who no longer lived there. Staff told us they had regular fire drills and knew what action to take in the event of an emergency.

The provider shared any patient safety alerts in respect of medicines or equipment with the registered manager. The registered manager told us these were shared with staff during clinical meetings.

Good

Is the service effective?

Our findings

At this inspection, we found staff had the same level of skill, experience and support to enable them to meet people's needs as effectively as we found at the previous inspection visit. People continued to have freedom of choice and were supported with their dietary and health needs. The rating continues to be Good.

Staff told us they had the right skills, training and experience to carry out their role effectively. Newly recruited staff said they completed an induction which involved working alongside experienced staff members on 'shadow shifts' before they provided care on their own. One recently employed staff member said, "My induction was four full days of training, some face to face rather than on-line. I covered a lot of training and it was very in depth."

Another staff member told us they had worked in a number of care homes and felt the training provided by BUPA was very thorough. This staff member particularly spoke about the training they had received to support people living with dementia. They told us they completed, "Virtual dementia training which made me see dementia from a person's perspective and what it is like. Dementia is horrible and the training made me think how difficult it is." They said the training helped them to tailor their own approach to people living with dementia because they now understood people reacted differently, dependent on the type of their dementia.

Clinical staff told us the induction, training and support they received helped them improve their confidence and clinical judgements. One member of clinical staff particularly spoke of how supportive staff and managers were when they started working in the home. They said, "Speaking with managers and other nurses helps me share any concerns I have." They said they had become more confident and the provider was supporting them with further training to enhance their professional skills and competence. Clinical staff had opportunities to reflect on their practice to identify areas where they could improve.

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).

Where the provider had reason to question a person's capacity to understand information about risks related to their care and support, their care plans included a mental capacity assessment. Where appropriate, care plans also contained information about when people might be more able to make their own decisions. For example, one person's care plan explained how their ability to make their own decisions fluctuated during periods of anxiety. Staff we spoke with understood this with one staff member explaining, "[Person] needs a lot of encouragement so we spend quite a lot of time with them because they get so anxious." Another person's assessment contained detailed information about their fluctuating capacity and

how staff should support them to make their own decisions and when they should make decisions in the person's best interests.

Staff we spoke with understood the principles of the Act and recognised the importance of respecting people's right to make decisions. Staff assumed people had capacity to make everyday decisions and offered people choices such as where they wanted to sit and what they wanted to eat and drink. One person who had capacity was refusing to follow the advice of a healthcare professional even though it presented risks to their health. Records showed the person's GP had fully discussed the risks with the person so they could make an informed decision about their care needs.

Staff understood the importance of ensuring people were consenting to the care they received and we saw this demonstrated throughout our visit. For example, staff checked with people first to ensure they needed or wanted assistance, rather than assuming they did. Records showed where people had capacity, they had consented to certain aspects of their care being provided, such as medicines, and how their care was planned and delivered.

The provider reviewed each person's care needs to assess whether people were being deprived of their liberties. Where people required a DoLS application to be made, the appropriate applications had been submitted to the local authority in accordance with the legislation. Whilst waiting for the outcome of the applications, the provider ensured staff continued to act in accordance with the MCA and care continued to be in the best interests of people and as least restrictive as possible.

Overall, people were happy with the quality and choice of food and told us they could eat in the dining room or their own bedroom, according to their preferences. Comments included: "It's very good food. I go down to the dining room when I can. I choose my food at the time" and, "It's good food with a lot of variety. We have a big lunch, then tea is a hot snack or sandwiches." One person did say the quality of food could be variable and on the second day of our visit a couple of people found the food difficult to chew. We shared this with the registered manager who assured us kitchen staff welcomed feedback so changes could be made. For example, some people had raised concerns about the quality of the pureed supper choices. In response, the chef had produced an extended supper menu for those on a pureed diet.

At lunch time we saw that where people had specific requirements around their dietary needs, these were known to staff. For those who chose to eat in the dining room we saw it was a social occasion. Where people needed assistance from staff, this was provided in a safe and unrushed way. People were offered a choice of hot and cold drinks throughout the day.

People were assessed before they moved to the home to ensure their needs could be met and any planned outcomes to support their health could be achieved. Staff continued to monitor people's health and made sure people accessed other services in cases of emergency or when their physical or mental health changed. The Provider Information Return explained, "The home works closely with other health care professionals in order to maintain residents' quality of life based on the best evidence available." Records demonstrated the involvement of speech and language therapy, psychiatric nurses, district nurses, dieticians and physiotherapists in people's care. McMillan nurses provided support for those people on end of life care. People were also encouraged to attend routine appointments with the dentist and optician to maintain their health and wellbeing.

The provider worked with other services to ensure specialist and adaptive equipment was made available as and when needed to deliver more effective support. For example, one person told us they had problems with their breathing but said equipment in their room had made them more comfortable. They explained, "I

can raise my bed electronically up and down which helps me sleep easier because I don't get so breathless." They also used a chair during the day that elevated their legs to reduce swelling. Communal bathrooms had electric chair lifts installed to allow easy and safe access in and out of the bath.

The home was spacious, warm, well-furnished and wheelchair friendly, with disabled access into the external gardens. People told us they were able to spend time with family and friends in communal areas of the home, or quieter areas such as conservatories, lounge rooms or their own private bedrooms. People accessed other floors in the home via a lift and group activities were held in rooms large enough to accommodate a number of people. People told us they particularly enjoyed the extensive gardens which were well maintained.

Good

Is the service caring?

Our findings

At our last inspection we rated this area as good because staff ensured the atmosphere within the home was welcoming and relaxed and people enjoyed living there. At this inspection we found the same level of compassionate support from staff who told us they liked working at Alveston Leys. The rating remains good.

People were content and happy and spoke positively about the friendliness and willingness of staff. Comments included: "I think the staff are marvellous. They don't cause trouble and there's a lot of good humour about" and, "I give this place five stars."

People told us all the staff were kind, sensitive and caring in their approach and did not rush them. We saw numerous occasions when staff were respectful and patient and took time to make sure people understood what was being said. They allowed people time to think for themselves and to move at their preferred pace. One person said, "The care is very good….whatever you ask for you get."

From speaking with staff it was evident they cared about the people in their care and wanted to do their best. One recently recruited staff member said they worked at Alveston Leys because they wanted to make a difference and felt they did this. They explained, "I go home thinking I have done something today which is good. I have made people happy and smile and it is good to get a 'thank you' from them because you know you have made that difference." Another said, "I just love my job. I love the residents and making them happy. They are like my little family. Anything I can do to make them smile, if they are happy I am doing my job right."

Staff explained the qualities they had which enabled them to give compassionate and understanding care to people. One staff member said, "Be patient, calm and tailor your approach to people." We saw examples of this during our inspection visit. Staff treated people as equals and listened to what they had to say. Staff used different ways of enhancing communication. For example, by touch, ensuring they were at eye level with those people who were seated, and altering the tone of their voice when speaking with different people. Staff provided explanations and reassurance when people were anxious and upset.

People's care plans contained key information which helped staff to get to know them well. This included details about their family relationships, significant life events, occupation, hobbies and their likes and dislikes. Staff we spoke with demonstrated a good knowledge of people's personalities and individual needs and what was important to them.

During our inspection visit it was clear people living in the home got on well with each other, as well as the staff. People sat and talked over lunch and shared a drink of whisky and sherry to celebrate the festive season. People forged their own relationships with each other and staff told us they knew which people got on well and considered this when seating people next to each other. However, we saw people were respectful when others wanted to be on their own or wanted space in communal areas to spend time with their visitors.

Staff had taken time to support people with their appearance. People were nicely dressed and their hair had been brushed. A relative told us they were pleased with the level of care provided and that the continuity of staff had recently improved. They told us, "The care is great; [person] is never unkempt." One person was admitted to the home from hospital during our inspection visit. Staff supported the person to have a shower and wash their hair and arranged for their clothes to be cleaned. They arranged for other clothes to be brought from their home so their dignity was maintained.

Staff understood the importance of promoting equality and human rights as part of a caring approach. Staff told us that whilst they were not formally aware of anyone living in the home who identified themselves as being Lesbian, Gay, Bisexual or Transgender, (LGBT), all relationships were equally respected. The registered manager told us people's diversity was explored as part of the admission process and they were confident the home would provide a safe and supportive environment for LGBT people.

People's privacy was respected. Staff knocked on bedroom doors and announced themselves before entering. Staff ensured they supported people in their rooms rather than in communal areas of the home and closed bedroom doors before assisting people with personal care.

Relatives told us staff welcomed and encouraged them to visit the home whenever they wanted to. One relative told us, "I visit every fortnight. I know the code to the door so I feel free to come and go as I wish." Staff recognised the importance of celebrating memorable family events and helping people share special moments with each other. Families were encouraged to spend quality time with their relatives and have meals with them if they wanted to. For example, we saw a book in reception requesting relatives and friends to let the provider know which days over the festive period they wanted lunch with their family members. One relative explained how staff had arranged a special birthday celebration for their family member, whilst another person told us, "My wife will come for Christmas dinner with me. They have supported my family well."

People's personal details and records were kept securely in the care office. This meant staff were able to access personal and sensitive information, but it was kept away from people who did not have reason to view it.

Good

Is the service responsive?

Our findings

At this inspection we found care and support was provided in a way people preferred and people and their relatives were involved in planning and reviewing their care needs. The rating for 'responsive' therefore remains Good.

Care plans provided a picture of the person and recorded the help and support they needed. Staff told us they referred to people's care plans when they needed to know about a person and how to support them. The information staff told us about specific people and what help they needed, matched their care plans.

People were involved in making choices and had control in how they lived their lives and spent their time. One person told us they were involved in their care decisions and if they needed additional support, they were confident it would be provided.

Staff understood the importance of providing care that was responsive to people's individual needs and preferences. One staff member explained, "We are person centred because we try to take their wishes and needs into account and deliver that." Other comments included: "We focus on the resident and everything revolves around them" and, "It is their home and I am just here to help them."

Staff said handover at the start of their shift provided them with useful information to enable them to meet people's needs. One staff member said, "At handover we discuss people's medical conditions, any appointments or family visitors." They said this information helped them to prioritise who they supported first to ensure people met their planned commitments.

The 'Accessible Information Standard' [AIS] aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support they need. The provider had recognised people's different levels of communication. Communication care plans described people's individual needs and how staff should engage with people to ensure they provided responsive care. For example, some people had limited eyesight, or partial hearing loss. Care plans recorded this and prompted staff to ensure people had their glasses or hearing aids with them whenever required. One staff member described how they supported one person who had poor sight to make choices. They explained, "I take their clothes up close and describe the colours. I talk to them and tell them what choices are available and explain where things are. It is basically being their eyes and ears for them."

One person was living at the home whose first language was not English. Two staff spoke this person's first language, whilst others used a whiteboard to communicate choice. The person was able to lip read, so staff faced the person when talking to them so they could see what message was being communicated. Staff gave 'thumbs up' signals, smiled and asked the person if they were okay. We saw the person smiled and gave a 'thumbs up' back.

Managers and staff worked with other healthcare professionals to ensure people could remain at the home

at the end of their life and receive appropriate care and treatment. This included having 'anticipatory medicines' available, so people remained comfortable and pain free. End of life care plans were in place for people, which meant staff had the information they needed to ensure people's final wishes were respected. Where people had chosen not to engage in these conversations, with the person's permission, discussions had been held with family and those closest to them.

One staff member described how they ensured people were physically and emotionally comfortable during their final days. "We make them comfortable and make sure their hair is nice and the way they want it, that they are wearing the clothes they want to wear and their skin is moisturised. We make sure music is playing they like and talk about memories we have made together." The provider had received various compliments from relatives about the care their family member received at the end of their life. These included: "The incredible care, affection and attention shown by the whole team made her last few days bearable" and, "A very big thank you to all the staff who cared so fantastically for [name of person] in her last few weeks."

People were offered a range of activities that supported them to follow and pursue their interests. The activities programme was planned for the month ahead and shared with people so they could decide which ones they wanted to be involved in. Planned activities included quizzes, film club, knit and natter, music therapy, creative mobility or one to one conversations with people. During our inspection visit some people enjoyed watching a festive film while others chose to spend time in their rooms. Local community groups were also invited into the home. For example, a local school choir were visiting to sing carols.

People's faith and beliefs were respected. A faith service was held once a month for people to pursue their religious beliefs.

The provider had a complaints policy and procedure, details of which, together with complaint forms, were available within the entrance to the home. Records showed any form of complaint or concern were taken seriously. Full investigations were completed and statements taken from all those involved in the complaint. Responses were provided to complainants of any action taken and demonstrated that the provider used complaints as an opportunity for reflection on the standards of care provided within the home.

One person we spoke with knew how to make a complaint, but said they were pleased with the service. They told us if they were concerned, they would speak with staff or the management and had confidence they would be listened to and positive action taken. Another person told us they had informally shared a concern with a senior member of staff and action had been taken. They said, "You only have to tell the senior carer once and it's sorted out."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection visit we found there had been significant changes at the home. A new management team were in post who acknowledged improvements were required to ensure people received consistently good care. At this inspection we found some improvements had been made, but further improvements were needed to ensure records accurately recorded the care delivered within the home. The rating therefore remains Requires Improvement.

We found records to support risk management in the home were not being consistently completed. For example, some people received their nutrition and medicines through a tube directly into their stomachs. Charts for the cleaning and management of the tube were not fully completed. Such records are important to monitor and identify any early signs of infection. Repositioning records and food and fluid charts had gaps so it was not always possible to get an accurate picture of how regularly people were being repositioned in bed or how much they had to eat and drink. Charts to record the application of prescribed creams to the skin lacked information on where to apply the cream and when.

The provider's policy and procedure for people admitted to the home was not consistently implemented. One person with complex health needs had been admitted to the home on 18 December 2017. Staff had not implemented a 72 hour emergency care plan to inform staff about the safe management of the person's conditions until a full care plan had been formulated. When we returned on 2 January 2018 a full care plan was in place.

Some people were on pressure relieving mattresses because they were at risk of skin breakdown. Mattress types and settings were not recorded and there were no charts to indicate that the mattresses were checked to ensure they remained effective.

The registered manager assured us people were receiving appropriate care and support, but that staff were not always completing the daily records. They told us, "I am really proud of the fact we have only had one pressure sore (in the last 12 months) and no moisture lesions and that is down to the carers." They accepted the process for checking the daily records was not robust enough and told us they were introducing a system where nursing staff randomly checked a selection of charts and records at the end of each shift to ensure they were completed accurately and evidenced the care provided.

During our visit we found some doors which should have been kept locked were not always secure. For example, on the lower ground floor there was a door which had a sign on it saying that it should be kept locked at all times. The door was not locked and the cover to the drain in the room had been dislodged which presented an infection control risk and a trip hazard. Although immediate action was taken, the provider's environmental checks had not identified these issues.

On the third day of our visit, the registered manager advised us that immediate action had been taken to address some of the issues identified. Lead roles had been given to named staff in areas such as infection control, nutrition, continence and weight management. Each staff member would receive additional

training to support them in their responsibilities and provide other staff with someone to go to for advice and assistance. Learning would be reinforced through letters, meetings and individual supervisions with clinical and care staff.

Overall, staff spoke positively about the management of the home and commented: "They are really great. They are very understanding and they do listen", "You do get a lot of support from them" and, "They are very supportive." However, some staff said they would welcome more opportunities to see members of the management team as they felt communication around certain messages, for example staff deployment, was not always clear. One staff member commented, "We don't get to see the management team very often, so it would be nice for them to start earlier sometimes." This was supported by some relatives who told us, "I'd like to see the manager around the home more" and, "I am very concerned about the fact the management don't come out of the office."

Staff told us that opportunities to meet with managers and discuss their training and development within individual supervision meetings had not always been happening as regularly as they should. However, each Tuesday the registered manager had an 'open door' where staff could drop in to discuss any concerns, issues, suggestions or ideas for improving the care people received in the home. All the staff we spoke with felt the standards of care in the home were good with one staff member commenting, "The care for the residents is really good. I think we achieve everything they want." Another staff member felt there were some minor issues but said, "They are just little issues, things that need fine tuning."

The registered manager completed regular checks on the quality of the service they provided to highlight any issues. For example, infection control and medication audits and call bell response times. They also had weekly meetings with clinical staff to review the clinical risks within the home to ensure they were being appropriately and effectively managed. Every day the management team met with the heads of each department to discuss the key operational issues relevant to that day. The registered manager told us this level of engagement ensured they had an understanding of the day to day challenges within the home.

The provider had systems and processes for reviewing the quality of the care provided. These were reviewed on a monthly basis to ensure any identified actions had been taken. Some of the issues around record keeping that we identified had already been picked up in the provider's last audit in November 2017. The registered manager told us these would have been pulled through into the 'home improvement plan', but accepted that some actions should have been implemented sooner.

The provider had systems to get feedback on the quality of the service to help it improve. For example, people and relative were invited to attend regular meetings and surveys and questionnaires were sent to people on an annual basis. A board in the main lounge indicated what people had fed back over recent months and what action the provider had taken in response to that feedback.

The registered manager understood their responsibility to comply with the CQC requirements and was aware of the importance of notifying us of certain events that had occurred in the service. This was to ensure that we have an awareness and oversight of these to ensure that appropriate actions had been taken. The rating from our previous inspection was displayed in the entrance to the home.