Viridian Housing

Chestnut Lodge

Inspection report

3 Woodfield Road
Ealing
London
W5 1SL
Tel: 02032020436
Website: www.viridianhousing.org.uk

Date of inspection visit: 26 and 27 August 2015
Date of publication: 03/11/2015

Ratings

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

Overall summary

This inspection took place on 26 and 27 August 2015. The visit on the 26 August was unannounced and we told the service we would return on 27 August to complete the inspection.

The last inspection of the service was in September 2013 when we found no breaches of legal requirements.

Chestnut Lodge is a care home that provides residential and nursing care to up to 64 older people living with dementia. When we carried out this inspection, 61 older people were using the service.

The service had a registered manager, although they were on leave at the time of this inspection. 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.

Summary of findings

Risks to people's health, safety and wellbeing were not always identified and assessed, therefore strategies for reducing risk and helping keep people safe were not in place.

Some people did not always get the support and care they needed from staff when they were upset or distressed.

Staff spent a lot of time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service.

It was not always possible to obtain a full picture of people's care needs and risks or track progress as some care records were not up to date.

Some aspects of care suggested a uniform approach rather than individually tailored care.

Staff had received safeguarding training. They told us they understood how to recognise the

signs of abuse and knew what action they needed to take to ensure people were protected if they suspected they were at risk of abuse or harm.

Managers understood when a Deprivation of Liberty Safeguards (DoLS) authorisation application should be made and how to submit one. This helped to ensure people were safeguarded as required by the legislation. The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that providers only deprive people of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them.

Staff supported people to keep healthy and well. They monitored people's health and made sure they had access to healthcare services when required.

People were supported by caring staff who respected their privacy and dignity and promoted their independence.

The provider had arrangements in place to respond appropriately to people's concerns and complaints. Relatives told us if they had any concerns, they would speak to the managers or staff and they would be listened to.

The service was well led and promoted a culture that respected and valued each person. People, relatives and staff said the home was well run, spoke positively about the registered manager and how they ran the service in an inclusive and transparent way. People using the service and their relatives were encouraged to give feedback on the service so the provider could develop and improve the service.

Systems were in place to monitor the quality of the service people received. The provider used this information to help them make changes and improvements where necessary.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not always safe.

The service did not always assess the risks to people using the service and act on these assessments.

Staff spent a lot of time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service.

The provider had taken appropriate steps to protect people from abuse, neglect or harm.

People received the medicines they needed in a safe way.

Is the service effective?

Good

The service was effective.

Most people and their relatives told us staff had taken time to understand people's care and support needs.

People received care and treatment from staff who were appropriately trained and supported.

The provider understood and met their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Requires improvement

Some aspects of the service were not caring.

Some people did not always get the support and care they needed from staff when they were upset or distressed.

There was sometimes little personal interaction between some people and staff and there were sometimes no attempts made to engage with or converse with people.

People using the service, their relatives and other visitors told us staff were kind and caring.

Staff considered issues of equality and diversity as part of their care planning.

Is the service responsive?

Requires improvement

Some aspects of the service were not always responsive.

It was not always possible to obtain a full picture of people's care needs and risks or track progress as some care records were not up to date.

It was not always possible to evidence that people received the care and treatment detailed in their care plan.

Summary of findings

People's health care needs were assessed and recorded and staff were given guidance on how to meet these in the service.

Is the service well-led?

Good

The service was well led.

People using the service, their relatives and staff all described the service positively.

The registered manager had developed positive working relationships with people using the service, their relatives and local health and social care professionals.

The provider had arrangements in place to monitor the quality of the service.

Chestnut 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.

This inspection took place on 26 and 27 August 2015. The visit on the 26 August was unannounced and we told the service we would return on 27 August to complete the inspection.

The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience for this inspection had experience of visiting and supporting a relative who lived in a care home.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This 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 also looked at the last inspection report and notifications of significant incidents and events we had received from the service since our last inspection in September 2013.

During the inspection, we spoke with 13 people using the service, nine visitors and relatives, eight members of staff, the Head of Nursing and the home's GP. We reviewed care records for eight people using the service and other records, including medicines records, the personnel files for four staff working in the home, health and safety records and audits the registered manager and senior staff team carried out.

We also used the Short Observational Framework for Inspection (SOFI) during lunchtime on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Following the inspection we received information from the local authority's safeguarding adults and contract monitoring teams.

Requires improvement

Is the service safe?

Our findings

People using the service and their relatives told us they felt safe at Chestnut Lodge. Their comments included, "My mother has had a few falls but staff have told me about them appropriately. I feel there are enough staff and that my mother is safe. The staff come when she calls" and "The doors are locked. I do feel safe. They come when I need them. I rely on them." A relative said: "I feel my relative is safe and I feel safe. When he lived in sheltered accommodation, he used to go out and he would fall and end up in hospital. Nothing like that has happened since he has been here."

The provider carried out a range of risk assessments to ensure the safety of people using the service and others but these were not always effective. There were risk assessments in care files that covered the risk of falls, other environmental risks and regular monitoring charts assessing nutritional status, skin integrity and weight. Staff updated these charts monthly. However, in one case the risk assessments were out of date and difficult to follow, as information was incomplete. In another care record, staff had not updated the nutritional assessment since April 2015 and had not recorded the person's weight since March 2015. However, staff had updated another record and this showed that the person had lost 6kg since the beginning of the year. The lead nurse told us staff were aware of this and had introduced a fortified diet. We saw there was mention of a high protein diet in the person's eating and drinking care plan but the information was poorly recorded or absent and there was no reference to any dietician referral.

In another file, the nutritional assessment showed the person was at risk of malnutrition and staff should weigh them weekly, but they had not done this. We discussed this with the Head of Nursing during the inspection and they told us they had introduced a new system for care planning and risk management. The issues we identified during the inspection concerned care records that staff had not yet updated. The Head of Nursing told us they would make sure staff updated all risk assessments as part of the introduction of the new care planning systems.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All of the people using the service were living with a diagnosis of dementia and many had a high level of physical care needs and poor mobility. This meant that staff spent a lot of time on practical tasks and physical care and there was sometimes little interaction or conversation between staff and people using the service. At mealtimes, people who ate in their rooms had to wait a long time to receive their food. Staff were not able to serve some people until almost 1.30 although lunch commenced at 12.30.

We used the Short Observational Framework for Inspection (SOFI) during lunchtime on one unit. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. Our observations showed that staff worked well as a team to serve people with their meals, encouraged some people to eat and physically fed others. However, some people were left with their meals and staff were not able to spend time supporting and encouraging them to eat. Other people had to wait until staff had supported people in the dining room before they were able to have their meal in their room.

Other risk assessments were accurate and up to date. They identified the hazard, the risk of harm and action for staff to take to minimise this risk. For example, one person who was a smoker had a risk plan in place to avoid risk of fire. Another care record included a risk assessment and a clear, practical and specific risk management plan for supporting someone who challenged the service.

The provider had taken appropriate steps to protect people from abuse, neglect or harm. Training records showed staff had received training in safeguarding adults at risk. Staff were all able to provide definitions of different forms of abuse and all said they had received training in safeguarding, including the procedure to follow if there was a concern. They told us there were telephone numbers of the local safeguarding team in the office on each floor that they could use if they were unable to report a safeguarding concern to their line manager. Their comments included, "If I thought someone was being abused, I'd report is straight away" and "I'd tell the nurse, the Head of Care, the manager and their manager until someone did something."

Staff were able to describe the actions they took to keep the people safe, before, during and after activities. These included personal care and activities in the home, garden and local community. This showed nurses and care staff had a good knowledge about the risks involved and the actions that they took to mitigate such risks and keep people safe.

Requires improvement

Is the service safe?

The provider had a policy and procedures for managing people's medicines and they reviewed these in 2014. People's care plans contained information about the medicines they were prescribed. This included information about the reasons medicines were prescribed and administration directions including time, dosage and frequency. Records detailed the quantity of medicines received and disposed of to provide a clear audit trail. Appropriate arrangements were in place for recording the administration of medicines. Administration records were clear and fully completed and showed people were getting their medicines when they needed them.

Medicines were stored in a locked trolley in a lockable cupboard on each unit. Care records showed regular medicine reviews took place to make sure people were getting the right medicines for their health and wellbeing. The Head of Nursing completed a monthly medicines audit on each unit. The audits identified issues for nurses to address and the Head of Nursing followed these up at the next audit. For example, nurses on one unit were reminded to record clearly the reasons for the administration of PRN (as required) medicines. On another unit, the audit identified that nurses needed to arrange a medicines review with the GP and we saw they had done this.

Staff told us staffing levels were adequate and eight relatives confirmed that this was the case although one said that there was sometimes a lack of staff at weekends. This relative also stated that there were not enough staff to engage with and interact with people and some were often left sitting in one place or in bed for long periods of time as staff were busy attending to physical tasks and personal care.

The provider carried out checks to make sure they recruited staff that were suitable to work with people using the service. The staff records we checked all included copies of application forms, references, proof of identity and criminal records checks.

We recommend that the provider reviews the deployment of staff at mealtimes to make sure people have the support they need and do not wait for extended periods before eating.

Good

Is the service effective?

Our findings

Most people and their relatives told us staff had taken time to understand people's care and support needs. One person said, "The staff are kind and very capable. There are people I can call if I get into difficulties. In my opinion this place is very good in terms of comfort and care." Another person told us, "The staff are very good, I'm sure they care about all of us."

One relative commented, "He's not very social, but he likes the staff. They are getting to know him. They seem friendly and dedicated. They are never patronising. He talks softly and when they are with him, they lean in close. They seem to be fond of the residents. They gently encourage him to walk and he is doing much more than he was at home." A second relative commented, "The family are very happy with the care [relative's name] receives here. There were a few small problems when [relative's name] first moved in but they were soon sorted out."

Other relatives were more critical. One relative told us they found the treatment of her relative had improved after they changed units. They told us, "On this floor the care is much better. They are more expert, even on the social side, and interact more. There is a better vibe. They are more attentive and proactive. I like the facilities here." Other relatives commented, "They sometimes leave her for a while when her pad needs changing. They always seem to do my [relative] last" and "The rooms are lovely and bright and the hygiene is good. I did have a bit of a problem with them washing my [relative's] clothes too hot but I spoke to the manager and he said they would be replaced."

People received care from staff that were appropriately trained and supported. Nurses and care staff told us they had received a thorough induction when they started to work at the service. They said this had included training and working alongside other staff members and the manager. Staff also said they had received training that had helped them to understand their role and responsibilities and the care and support needs of people using the service. Training records showed staff had completed a range of training courses that were relevant to the needs of people they were supporting. The records showed most staff were up to date with the training they needed to complete and arrangements were in place to provide refresher training, where this was required.

Staff records showed the registered manager and Head of Nursing regularly assessed staff competency. Staff told us they regularly met with senior staff to talk about their job, individual people using the service and training and development opportunities. Staff records included reports completed by line managers during the person's initial probation period working in the home, supervision records and an annual appraisal of their performance.

The provider had procedures to obtain and record consent to care and treatment but this was inconsistently documented or absent in some care records. For example, not all consent forms were signed and dated. We did see evidence in some care records that managers met with people using the service, their relatives and professionals to discuss consent to care and treatment where the person was unable to make decisions themselves.

Staff made sure they obtained consent for people before they provided care and support. We saw staff explained to people what they were going to do when they needed support with personal care and gave people choices. For example, staff offered one person a bath or shower and when the person said, "not now," staff respected their decision and said they would ask later in the day. Staff told us, "You must ask people for their agreement before you do anything, if they don't agree, we can't force people to do anything".

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people were only deprived of their liberty in a safe and least restrictive way, when it is in their best interests and there is no other way to look after them.

We spoke with the Head of Nursing and staff about their responsibilities in relation to the Mental Capacity Act (2005) and DoLS. Three staff were able to explain the meaning of mental capacity when we asked them and cited best interests decisions as an integral part of caring for people who did not have capacity to make their own decisions. The Head of Nursing told us they had made applications to the local authority for authorisation for deprivations that were in place for three people. For example, where people required one to one outside the home. The provider had also applied to the local authority for authorisation of deprivations for another 18 people. The applications showed staff had completed assessments under the Mental

Good

Is the service effective?

Capacity Act 2005 and had arranged meetings with people using the service, their relatives and professionals involved in their care to agree decisions in the person's best interests.

People and their relatives had mixed views about the food people received. People's comments included, "The food's usually pretty good, big portions," "No complaints about the food, it's OK," "The food is very good. In the beginning, they don't know your likes and dislikes but they persevere and gently ask and they are very caring. Everything here is to my wanting" and "The food is lovely, the staff cook well and they know what I like."

However, one relative commented, "The food is very boring – the same food rotated over and over" and another told us the food was very repetitive and that vegetables were always overcooked. Other relatives said, "He is always well-fed" and "The food seems to be good. He's on a soft diet with lots of fibre and they make sure he gets that."

Care records had varied level of information in relation to nutritional status and dietary needs. Where care plans had been updated, they were clear, with an assessment of the person's dietary needs and monthly assessments of nutritional status. There was an eating and drinking care plan for each person that outlined any dietary or nutritional needs, for example, the requirement for diabetic, fortified or pureed food. Plans also provided information on food preferences and mealtime routines. This was generally well documented and clear and provided information on any risks, for example, difficulty in swallowing. Kitchen staff maintained a file with information on each person, including their dietary needs, favourite foods, likes and dislikes. The chef informed us that catering staff always attended relatives and resident meetings and got good feedback and suggestions about the food they provided.

We saw a board in each dining room that displayed the menu for the day with pictures of the food on offer and choices at lunch and suppertime. However, the boards in most units and the entrance hall were not up to date and staff had not changed the menu from the previous day. We pointed this out to staff during the first day of the inspection but found staff on some units had still not changed the boards on the second day we spent in the service.

Staff supported people to have a balanced diet. Staff recorded most people's weights and where they identified risks, they had referred people to the GP. Care plans detailed people's food and drink preferences, the level of support individuals required, any risks associated with eating and drinking and any equipment people needed to promote their independence.

People received the support they needed to manage their health and wellbeing. People's care records included assessments and plans to meet their health care needs, including pressure care, diabetes and mental health issues. Staff monitored people's health and welfare and referred them to healthcare professionals when required. Care records showed people had received care and treatment from healthcare professionals including GP, podiatrist, dentist and psychiatrist, to make sure their healthcare needs were being met. Relatives told us the staff were proactive in arranging GP appointments if their family member was unwell or there had been a change in their general condition. People's care records showed staff acted on any changes and advice provided by the GP such as administering antibiotics for an infection. During the inspection we spoke with the home's GP who told us staff referred people appropriately and made sure they saw the GP when they visited the home. The GP also told us staff followed any treatment plans they recommended.

We recommend that the provider continues work to ensure that consent is obtained and recorded when people using the service are unable to make decisions for themselves.

Requires improvement

Is the service caring?

Our findings

People using the service told us staff were kind and caring. Their comments included, "They are lovely here. I am very happy," "I think all the staff care, they are lovely people" and "They look after me."

Eight people's relatives and visitors also commented positively on the staff. Their comments included. "They are special people. They are lovely, caring and patient," "[staff member's name] is pleasant and kind to all the staff and patients. He is very nice," "They can picture what a person will want or not want at any given time. They try to introduce new things but if you don't like it, you don't have to have it. Nothing's forced on you" and "People seem to be happy here, the staff are very caring" and "The atmosphere is one of kindness and that comes from the top. The vast majority of the staff are gentle and caring."

However, one relative did say, "There's very little going on here at weekends and there's often very little interaction between staff and the residents here, although the staff are not unkind and the physical care is very good"

We saw some people who were unable to mobilise were left unattended and we observed two people who were distressed who were left for almost 30 minutes, as staff were busy with other tasks. One person was in bed in their room and called for help during lunchtime, but all staff were occupied in the dining room / kitchen. We saw a second person crying in a communal lounge during the afternoon when staff were attending a group activity elsewhere. No staff were available to assist either person. When we asked staff about them, staff told us they were always like that and made no more than superficial attempts to assist or comfort either person.

This was a breach of regulation 10 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We did also see examples of positive interactions between staff and people using the service. For example, staff spent time with people in one lounge using reminiscence materials to stimulate conversation. We also saw a lively music and movement session in another lounge where 25 people and a number of staff sang, danced and played musical instruments. There was a lot of laughter and noise in the room and most people obviously enjoyed this activity very much. However, when two people said the music was too loud and they did not want to stay, staff immediately arranged to take them to other parts of the home.

However, we saw very little personal interaction between some people and staff and there were sometimes no attempts made to engage with or converse with people either in communal areas or in their rooms, unless staff were delivering personal care or assisting with meals. Apart from organised activities, staff did not support or encourage people to move around the home to make use of other areas such as quiet rooms, the sensory room, reminiscence room or library. Most people remained in their rooms or in the communal lounges all day.

There was evidence staff considered issues of equality and diversity as part of their care planning. Care records included information about people's cultural and faith needs and how staff would meet these in the service. For example, staff were aware of the need to support and encourage one person to attend a weekly Caribbean lunch club. The service had also arranged for ministers from local churches to visit the home to hold services and meet with individuals. Staff had recorded people's gender preferences for care workers in their care records and people and their visitors told us staff usually respected these. One care file noted that foreign language television programmes had been organised in one of the lounges to suit one person who did not speak any English.

We saw staff knocked on closed doors before entering and they told us they always respected privacy and dignity by ensuring they respected people's choices and closed bedroom and bathroom doors when they supported people with their personal care. Relatives also told us staff treated their family member with respect and dignity. Their comments included, "My [relative] is always clean and tidy. I've never seen him look uncared for" and "My [relative] looks so well since they've been here, they were struggling before to look after themselves, but here they are always clean and happy."

Staff supported people in promoting their independence according to their individual abilities. Some people were able to attend to their personal care needs and staff recorded this in their care records. Where people required support with their personal care needs, staff told us how they promoted independence. For example, staff told us they encouraged people to choose what time they had a

Requires improvement

Is the service caring?

bath or shower and encouraged people to use their walking aids to maintain their mobility. We also saw some people helped with household tasks such as laying the dining tables before lunch and staff always thanked them for their help.

Requires improvement

Is the service responsive?

Our findings

People using the service and their relatives told us staff were aware of people's care needs and always tried to meet these in the service. One person told us, "There are things to do but I don't always want to, the staff understand and know what I like." A relative said, "My [relative] can find it oppressive to be in a busy room, the staff are aware of it and they take him back to his room."

The Head of Nursing told us the service was introducing a new system of care planning and recording. As part of the introduction of the new system, the registered manager and Head of Nursing were auditing care records but we saw staff had not fully converted some files and these contained older records and information that was often confusing and contradictory.

The care files that staff had not updated were badly organised and difficult to navigate and much of the documentation lacked legible detail, relevant dates and did not reflect information in other records. Information was sometimes duplicated and there were omissions. This meant it was not possible to obtain a full picture of needs and risks or track progress. These files showed little or no evidence of review indicating that care plans may not reflect current needs.

There was some evidence of input from people using the service or their relatives to the care planning process. One relative told us communication was sometimes a problem as some staff spoke poor English or were heavily accented which meant that people using the service did not always understand them. This relative added that requests were not always dealt with. Their relative was deaf and they had requested that sub-titles be put on the television, that staff ensured that their relative always wore their hearing aid and that the hearing aid batteries were changed. Despite a notice above the person's bed to this effect, their relative told us this was still not being managed consistently.

Some aspects of care suggested a uniform approach rather than individually tailored care. For example, staff told us they monitored each person using the service hourly at night, although staff had not documented the need for this in the care records of people we reviewed. While this was done with the intention of protecting people's safety and welfare, this practice needed to be developed to reflect individual preferences and care needs.

Staff recorded daily notes for each person in their care files. The quality of record keeping varied. Some daily records gave a clear, detailed account of care and progress while others were repetitive and illegible. Some daily care notes did not reflect the person's identified care plan objectives and most daily care notes only covered personal and health care issues, with little mention of activities, outings or visits by relatives and friends.

The service had one full-time activities coordinator who told us they supported and encouraged care staff on each unit to run activities for small groups and individuals. However, care staff said they had not had training and did not have a clear idea how to approach this aspect of their work. We saw there was little to engage or entertain some people on the day of our visit and most people were left sitting in chairs in communal areas or in their rooms. There was a blackboard on each floor showing the activities scheduled for the day. We saw a 'balloon exercise' session conducted by care staff but this was half-hearted and brief, with little effort to involve people who showed no interest.

These were breaches of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The files that managers had updated and audited were much clearer, well indexed and easy to navigate with detailed and person centred information. The newer care records we reviewed were consistently ordered and indexed with a logical system of care planning and documentation. There were comprehensive assessments of people's needs and detailed, personalised care plans. Staff had reviewed care plans monthly and we saw these reviews were up to date. The reviews were detailed and clear and gave information on progress and any changes to care needs and risks.

People's health care needs were assessed and recorded and staff were given guidance on how to meet these in the service. Staff recorded visits by health care professionals in a separate folder. The records showed the date of the visit, profession, outcome and signature. Most visits were from people's GP's and we saw these were detailed, dated and signed.

Requires improvement

Is the service responsive?

People's care records included regular assessments of skin integrity. Documentation of current wounds and injuries was thorough and staff recorded wound management in a separate file for each person with an on-going wound, with clear assessments and a wound care plan.

One person's wound management record included photographic evidence of the wound, although this had not been updated since February 2015, a comprehensive dressing plan provided by the Tissue Viability Nurse, a good record of dressing changes every 2-3 days and a wound evaluation chart for each dressing change that was up to date. People's care records also contained body maps to indicate the presence of any bruises or wounds. These were generally well documented and dated, although there was little information to indicate if or when the issue was resolved.

The activities co-ordinator told us they felt there was always something they or care staff could do with people, even if they were showing no response. They told us they were focussing on smaller groups, for example, introducing small-group music therapy every fortnight. They also said they encouraged members of staff to take individual residents to have tea in the reminiscence room. In July the activities co-ordinator told us he organised three outings – for example to restaurants and on a picnic.

We saw the provider displayed their complaints policy and procedures around the home. The Head of Nursing told us managers and staff always tried to resolve complaints as soon as they were aware of them and there had been no formal complaints since our last inspection.

Good

Is the service well-led?

Our findings

The service had a manager who was registered with the Care Quality Commission (CQC). The manager was supported by a team of seniors, nurses and care staff. The registered manager had developed positive working relationships with people using the service, their relatives and local health and social care professionals. A local authority commissioner told us, "[The manager] has been a home manager for 20+ years, and is very proud of his home. He is very hands on and keeps up to date regarding each of his residents. [The manager] also has built good relationships with both his residents and relatives."

People using the service, their relatives and staff all described the service positively. They told us the registered manager and senior staff were visible, approachable and open to any suggestions they made about improvements to the service. Their comments included, "[The manager] treats everybody the same and that's a good thing. You can ask for anything. I never heard of anyone being turned down," "[The manager] is brilliant. He's got a human touch. He gets the residents up to dance. Look how good the care is here. I am very happy for my relative to be here."

Other comments included, "The manager is fantastic – he's very good with people and always has time for me" and "The manager is very good, very good people skills. Any concerns are dealt with here immediately, there's a good sense of discipline and the management recognise when things are wrong and react very quickly."

One relative who was unhappy about some aspects of their relative's care said: "I wrote lots of emails to [the manager] but I didn't feel my messages were getting through. People on the floor need to know what's needed. You get small improvements for a while and that's better than nothing."

All the nursing and care staff we spoke with were very positive about the culture and atmosphere in the home, which they felt, was supportive and inclusive. Their comments included, "There's a very good culture here and good team work. This comes from the manager who is very, very supportive and easy to talk to," "Anyone can talk to the manager even domestic staff. He's a real people person, very visible and very supportive," "I'm well supported here. The manager is very good and very approachable and I can ask for extra training if I want" and "It's a good place to work. The manager and senior staff really want to know what I think, I trust them completely."

Staff received the training and support they needed to provide care and treatment to people using the service. Staff we spoke with all felt very well supported by the management team and commented that they would feel confident to raise any issues or concerns with their line manager. They also told us they had regular supervision reviews and annual appraisals with the registered manager, at which their performance and work load was discussed and training needs identified. All reported that they received regular training updates and were encouraged to undertake additional training and obtain further qualification. There were regular staff meetings at which staff could raise issues and concerns.

The service had notified the Care Quality Commission (CQC) without delay of significant events and incidents that had involved people using the service, in line with their legal obligations.

The provider asked people using the service, their relatives, visitors, health and social care professionals for their views about the care and support provided in the service. We saw survey forms were available around the home for people to complete and return to the service. The Head of Nursing told us this was an annual survey and we saw the responses and action plan for 2014 that showed the provider acted on people's views and comments. For example, the service increased music therapy sessions to twice a month and managers kept people's families up to date about changes to the GP service at regular relatives' meetings.

The provider had arrangements in place to monitor the quality of the service. These included care plan audits, health and safety checks, medicine audits and staff training. Managers evaluated the audits and, if required, developed an action plan to make sure they addressed any issues.

The Head of Nursing told us they and the manager spent time on the units each day and any issues they identified were discussed with staff in group or individual supervision sessions. For example, managers identified some people waited more than an hour for their breakfast after staff

Good

Is the service well-led?

supported them to the dining room. The Head of Nursing told us managers discussed this with catering and care staff and the situation had improved, with people no longer waiting for their breakfast.

The provider reviewed their Business Continuity Plan in April 2015. This covered actions in the event of flood, fire or a heat wave. We saw each person had a Personal Emergency Evacuation Plan (PEEP) in their care records that detailed the support they needed in an emergency. The provider tested the service's fire alarm system weekly and arranged fire drills for all staff in January and April 2015.

The provider updated their fire safety risk assessment in February 2015 and we saw action had been taken to address identified issues, for example, the introduction of PEEPs for each person using the service.

We saw completed monthly health and safety audit checklists up to July 2015. However, these had not identified any health and safety issues the provider needed to address. We discussed this with the provider's area manager and the Head of Nursing who told us they would review the procedure for carrying out these audits.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not do all that is reasonably practicable to mitigate risks to service users.** **Regulation 12 (2) (b).**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Some service users were not always treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered person did not design care or treatment with a view to achieving service users' preferences and ensuring their needs were met.**