Care Quality Commission

MOP Healthcare Limited

Barrowhill Hall

Inspection report

Barrow Hill
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Tel: 01889591006

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Ratings

Overall rating for this service	

Is the service safe?	
Is the service effective?	
Is the service caring?	
Is the service responsive?	
Is the service well-led?	

Summary of findings

Overall summary

We inspected this service on 18 December 2017. It was an unannounced inspection. Barrowhill Hall is a care home which accommodates 74 people in two buildings, some of whom are living with dementia. In the main hall, 50 people with nursing needs are supported in three separate households, arranged over two floors. Each has a communal lounge and dining area. Churnet Lodge is a separate, purpose built building which supports 24 people with residential needs in accommodation arranged on one level, with an open plan communal lounge and dining area. On the day of our inspection visit, 69 people were living at the home.

The service had a registered manager in post. 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.

At our last unannounced inspection on 3 November 2016, we rated this service as Requires Improvement. This was because the provider was not meeting all the regulations; improvements were needed to ensure that risks associated with people's care were always safely managed and that there were sufficient staff on duty to meet people's needs at all times. We asked the provider to complete an action plan to show what they would do and by when. At this inspection we found that the provider had taken action to meet the regulations but some further improvements were
needed.

Improvements were needed to ensure people always received their medicines as prescribed and that the legal requirements and good practice were always followed when people lacked the capacity to make decisions about taking medicines.

Risks to people had been identified and staff understood how to support people to reduce risk and protect them from potential harm whilst maintaining their independence. However, improvements were needed to ensure staff supported people in a consistent manner when they presented with behaviours that challenged.

People had been consulted about how they wanted to be supported and had care plans which reflected their needs and preferences. These were kept under review to ensure they remained relevant. Recruitment checks were made to confirm staff were suitable to work in a caring environment and sufficient staff were available to meet people's needs.

People felt safe living at the home. The staff knew how to protect people if they suspected they were at risk of abuse or harm and how to report concerns. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the

service support this practice.

Staff knew people well and provided care that met their preferences. Staff promoted people's independence and maintained their privacy and dignity at all times. People were supported to eat a healthy diet and had regular access to healthcare professionals. People were offered opportunities to take part in activities and follow their interests.

People and their relatives felt there was a positive, inclusive atmosphere at the home. They knew how to raise any concerns or complaints and were confident these would be acted on. People were offered opportunities to take part in activities and follow their interests. The registered manager and provider carried out checks to ensure the quality and safety of the service and encouraged people, relatives and staff to give their feedback to make improvements where needed.

This is the second time the service has been rated Requires Improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not well managed to ensure people always received their medicines as prescribed. Risks to people's health and wellbeing were assessed and managed. However, improvements were needed to ensure staff supported people in a consistent manner when they presented with behaviour that challenged. There were sufficient, suitably recruited staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

Improvements were needed to ensure the provider was fully meeting the requirements of the Mental Capacity Act 2005. Staff received the training and support they needed to care for people. People received sufficient amounts to eat and drink and had their health needs met.

Is the service caring?

Good

The service was caring.

Staff had caring relationships with people and respected their privacy and dignity. People were able to make decisions about their daily routine and staff encouraged them to remain as independent as possible. People were supported to maintain important relationships with family and friends who felt involved and were kept informed of any changes.

Is the service responsive?

Good

The service was responsive.

People felt able to raise any concerns and complaints were investigated and responded to. People had support plans which reflected their individual needs and preferences and were happy with the care staff provided. Plans were kept under review to reflect people's changing needs. People were offered opportunities to follow their interests and take part in activities.

Is the service well-led?

Good

The service was well-led.

People and their relatives were encouraged to give their feedback on the service and where possible this was used to make improvements. The registered manager and provider had systems to monitor the quality and safety of the service. Staff felt supported in their role.

Care Quality Commission

Barrowhill Hall

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 18 December 2017 and was unannounced. The inspection team comprised of three 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 had knowledge of services for older people and people living with dementia. Following the last inspection in November 2016 we asked the provider to complete an action plan by January 2017 to show what they would do to improve the key questions, 'Is this service safe, effective and well led?' to at least good. This was because we found risks associated with people's care and medicines were not always safely managed; there were insufficient staff to meet people's needs at all times and quality monitoring systems were not always effective. At this inspection, we found the provider had increased staffing levels and had made improvements in relation to managing risks and the systems used to monitor the quality and safety of the service. However, some further improvements were required with the management of medicines and meeting the requirements of the Mental Capacity Act 2005.

Barrowhill Hall is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Barrowhill Hall accommodates 74 people in two buildings, some of whom are living with dementia. In the main hall, 50 people with nursing needs are supported in three separate households, arranged over two floors. Each has a communal lounge and dining area. Churnet Lodge is a separate, purpose built building which supports 24 people with residential needs in accommodation arranged on one level, with an open plan communal lounge and dining area. At the time of our inspection 69 people were living at the home.

This inspection was supported by information received from the provider which included the provider information return (PIR) and statutory notifications. The PIR is information we require providers to send us

at least once annually to give some key information about the service, what the service does well and improvements they plan to make. A statutory notification is information about important events which the provider is required to send to us by law. We also reviewed information we had received from commissioners and people who used the service. Commissioners purchase services on behalf of people. We used all this information to develop our inspection plan.

We spoke with seven people who used the service and four relatives, five care staff, two nurses, the cook, the housekeeper, two activities co-ordinators, the deputy manager and the registered manager. We did this to gain views about the care and to ensure that the required standards were being met. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for seven people to see if they accurately reflected the way people were cared for. We also looked at staff duty rosters, three staff recruitment files, ten medicine administration records and the provider's quality assurance audits. Following the inspection we asked the provider to send us information in relation to staff training and appraisals, records of visits made by the directors, minutes of meetings held with people who use the service and their relatives and staff meetings. We also asked the provider to demonstrate how initiatives identified through a member of staff's studies in dementia care had been used to improve people's care. We received all the information we requested.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, we found that risks associated with people's care were not always managed in a safe way. Improvements were also needed to ensure staff had suitable guidance to ensure they took a consistent approach when administering medicines prescribed on an as and required basis. This was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection, we saw some improvements had been made and they were no longer in breach of Regulation 12 but some further improvements were needed.

We found that suitable arrangements were not always in place to ensure people received their medicines as prescribed. We found that one person's medicine had not been administered as required on the day before our inspection visit. The nurse told us they had identified that it had been missed but had not administered it because the person had eaten, and the prescriber's instructions stated that the medicine was to be administered before food. However, this was not recorded on the medicine administration record (MAR) and the nurse had not alerted the registered manager or contacted the person's GP for advice on the consequences of missing it. We discussed this with the registered manager who ensured the GP was contacted and later confirmed that there was no impact on the person. However, failure to follow up such omissions places people at risk of not receiving their medicines as prescribed.

At the last inspection, staff did not have clear guidance on when medicines prescribed on an as and when required basis should be used. The provider's action plan and PIR stated that a clear plan was in place on when and how to administer these medicines. However, we found this was not always the case. For example, there was no plan for a person prescribed medicine for anxiety and no plan for another person who was prescribed medicine for epilepsy. Where plans had been put in place, they did not always provide staff with enough information about when people might require their medicines. For example, plans for pain relief did not always provide guidance for staff about how people who were unable to communicate might show they were in pain. Whilst staff we spoke with were able to describe when people required these medicines, the provider had not ensured that suitable guidance was always in place to ensure staff adopted a consistent approach and people always received these medicines as prescribed.

We were aware that a medicines error had occurred for a person who had recently moved into the service and had been referred by the registered manager to the local safeguarding authority for investigation. We saw that the registered manager was also carrying out a thorough investigation alongside that by the local safeguarding team to ensure action was taken to minimise the risk of reoccurrence. This showed us the provider ensured lessons were learned and improvements made when things go wrong.

Although we had identified concerns, people who could offer us their views said they received their medicines when needed. One person said, "I get my medicines off the nurses and usually at the right time. They give me pain relief in the morning so that it eases the pain before they shower me". We observed staff administering medicines spent time with people and ensured they had taken their medicines before moving on to the next person. Staff told us and records confirmed that they received training to administer

medicines and had their competence checked periodically by the registered manager. We saw that medicines, including controlled drugs, were stored securely and disposed of in accordance with legislation.

Risks associated with people's care had been assessed and plans were in place to minimise the identified risks. For example, where people needed support to mobilise safely, plans were in place to guide staff on the way they should be assisted. One person told us, "I can weight bear but use a stand-aid to transfer. Staff explain what they are doing and talk me through it every time". Where people were at risk of developing damaged skin due to pressure, we saw they had pressure relieving equipment in place and staff repositioned them at regular intervals in line with their documented requirements. A relative told us, "[Name of person] is supposed to have two care staff to mobilise and turn and this is always the case. Personal evacuation plans were also in place, setting out the support and level of assistance people needed to leave the building in the event of an emergency, such as a fire.

During our inspection visit, we saw that at times people presented with behaviour that challenged themselves and that of others. Some people told us they found this unsettling at times. One person said, "Sometimes there is a lot of shouting and I find it hard to cope with". Another said, "I find it all upsetting, I wish they could get some peace themselves". We saw that the risks associated with people's behaviour had been identified and behaviour plans were in place. However, these were not always sufficiently detailed as they advised staff to offer reassurance and use diversion techniques but did not always identify what worked best for the individual. For example, one care plan described a person's behaviour and stated, '[Name of person's] shouts or bangs zimmer on the floor – staff to identify the reason". Discussions with staff and our observations showed that staff knew what worked best to divert people when they became unsettled. However, staff told us and we saw that this information was not always recorded in people's care plans. This meant there was a risk that new or temporary staff who did not know people well would not always have the information they needed to support people safely when they presented with behaviours that challenged. We discussed our concerns with the registered manager to ensure that staff would always have clear guidance to ensure people's safety and wellbeing.

At the last inspection, we found there were insufficient staff to meet people's needs at all times. This was a breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) 2014. At this inspection, we found improvements had been made, however people had mixed views when we asked them if there were sufficient staff to support them in a timely manner. Comments included, "I don't think there is always enough; there has to be two carers to support [Name of person] and I have found there is sometimes a wait. It's never very long but seems it" and, "I think the staff are rather stretched at certain times but on the whole there are enough" and, "There could be a few more but they do come quickly if you need them". On the day of our inspection visit, two staff left without giving notice and this meant the service was short staffed. Although the deputy manager was unable to source agency staff, we saw they moved staff around between the main hall and Churnet Lodge to ensure they had an appropriate skill mix. We saw that people did not have to wait long when they asked staff for assistance, although at times we heard staff asking people to wait whilst a second member of staff came to assist them when they were using equipment to support people. Staff worked together to ensure there was always a member of staff in the communal lounge and call bells were usually answered within five minutes. Staff felt there were usually enough staff on duty and told us there were normally only shortages when staff called in sick.

The deputy manager and registered manager told us and staff rosters confirmed that staffing levels had been increased since the last inspection. The provider had also recruited a new team of three activities co-ordinators that worked seven days a week. Recruitment was ongoing and we saw that staffing levels were monitored and reviewed on a regular basis with the provider. The deputy manager told us, "Staffing levels are based on occupancy and people's individual dependency levels; we are aiming to be over-staffed by

about 20% to ensure we can cope if there are unplanned staffing shortages. Staff told us that when needed, agency staff were sourced from a regular supplier. These arrangements showed us there were suitable arrangements to ensure there were sufficient staff to meet people's needs at all times.

People were cared for by staff who were suitable to work in a caring environment. Before staff were employed we saw the registered manager carried out checks to determine if staff were of good character. These included criminal records checks through the Disclosure and Barring Service (DBS) and with the Nursing and Midwifery Council, to ensure that nurses were registered to practice. This showed us the provider followed procedures which minimised risks to people's safety.

Although some people had told us they sometimes felt unsettled by people's behaviour, they told us they felt safe and well supported by the staff. One person told us, "There is always someone around and that makes me feel safe". Another said, "The staff are all lovely and I feel I can trust them all. Relatives had no concerns about their family members. One said, "The building is secure and there are always staff members about". Staff we spoke with had received training in safeguarding and could tell us about the different types of abuse and what action they would take if they suspected someone was at risk of being abused. All the staff we spoke with were confident that any concerns they raised were acted on but told us they had the information they needed to escalate their concerns if necessary. Staff told us and records confirmed that any concerns were reported internally and referred to the local safeguarding team for investigation. This showed the registered manager and staff understood their responsibilities to keep people safe from harm.

The home was clean and staff understood their responsibilities to keep it safe from infection. The housekeeper told us, "We have a full cleaning schedule and there are always enough cleaning products and supplies of PPE [personal protective equipment] to wear; if we need it we can have long sleeve covers and masks". Staff had received training and had clear policies and procedures to follow. We observed they followed required standards and practices, for example using appropriate gloves and aprons when supporting people with personal care or when serving food. Records showed there were systems in place to review and monitor infection control and hygiene.

Requires Improvement

Is the service effective?

Our findings

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 authorisation procedures for this in care homes and hospitals 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.

We found that the provider was not consistently following the MCA. We saw that mental capacity assessments had been carried out where people lacked the capacity to make certain decisions for themselves, for example to consent to having their photograph taken and for professionals to access their care records. However, we found that the provider had not ensured that they were consistently following MCA and good practice guidance when people received their medicines covertly. This is when the person receives their medicine without their knowledge. For example, for one person there was no mental capacity assessment or record of a best interest decision to show that they were unable to make the decision for themselves. For another person, a mental capacity assessment had been carried out and a decision made to administer the medicine covertly in their best interest. However, there was no documentation to evidence this had been a multi-disciplinary team decision involving health professionals involved with the person, for example the GP and pharmacist. This is necessary to show that consideration had been given to how the medicine would be covertly administered, whether it is safe to do so and to ensure the continued need for the covert administration is regularly reviewed.

At our last inspection, we found that improvements were needed to ensure staff understood how people may be restricted of their liberty and that the provider consistently followed the requirements of the DoLS. At this inspection, we found that the required improvements had been made. We saw that DoLS applications had been made where needed and conditions detailed on approvals were documented in people's care plans. Applications were monitored by the deputy manager and approvals were notified to us as required. Staff had received training in MCA and DoLS and demonstrated an understanding of the legislation. One member of staff told us, "There has to be a DoLS because the doors are locked and we are keeping people here because they are not safe to leave". They also told us that they discussed MCA and DoLS in supervision and staff meetings, "The manager often stops us and asks a question about mental capacity or DoLS and we have a discussion; it helps us to understand things".

People said staff sought their consent before supporting them. One person said, "Staff ask if it's alright to do things – they don't just assume and come and do it". A relative told us, "Staff explain everything they are going to do and talk through the process as they do it. They talk to [Name of person] not over them". Our observations confirmed this and staff told us how they supported people to make day to day decisions as far

as they were able, for example by showing people choices of clothing or different meals or drink options. This showed us staff understood the importance of gaining verbal consent.

People's needs were assessed prior to moving into the home. The initial needs assessment was carried out by the care quality manager, who drew on knowledge of best practice from their recent dementia studies. A relative told us, "Staff visited us at home before [Name of person] moved in and there was a really detailed and through assessment". We saw that people's care was kept under review and referrals were made to other professionals where needed, for example to the community psychiatric nurse and occupational therapists to ensure people's needs were met holistically.

People told us they were supported to access other health professionals when needed. One person said, "I'm waiting to get physiotherapy and the home are helping me to chase it up". A relative told us the staff were proactive and acted on any concerns, "Staff are on the ball and seem to pre-empt problems at times. If anything is wrong they address it quickly and keep us informed. Records showed that people were referred to other professionals including the GP, occupational therapist, optician and dietician. This showed us people were supported to maintain their day to day health needs.

People and their relatives told us the staff had the skills, knowledge and experience to meet their individual needs. One person said, "The staff here are very good, they know what my care needs are. On the whole they have the right skills and are very competent. A relative said, "I think the staff know [Name of person] very well and have the necessary skills to care for them. Staff received a range of training relevant to the needs of people living in the home. Staff were also supported by a dedicated training manager, who was an accredited trainer in dementia care. As noted in safe, we saw that they were developing more detailed training in behaviours that challenged. In addition, more in depth training was planned for January 2018 in MCA and DoLS. Staff were encouraged to develop their skills and knowledge and gain nationally recognised qualifications in health and social care. Where new staff had not completed a recognised care qualification, they were supported to complete the care certificate. The care certificate is a nationally recognised set of standards which support staff to achieve the skills needed to work in health and social care. Staff received supervision and an annual appraisal which gave them an opportunity to review their performance, discuss any training needs and reflect on their practice and how they supported people. These arrangements showed us staff were trained and supported to fulfil their role effectively.

People were supported to have sufficient amounts to eat and drink. We saw that people were offered a choice of meals. One person told us, "The food here is good, there's always a choice". People's individual preferences were catered for. Breakfast was available until 11.30 am and included a range of cereals, toast, yoghurt and fruit was available and we observed that people could have a hot option cooked to order, such as poached eggs. At lunchtime there was only one main meal but a list of alternatives was available if people wanted something different. At the last inspection, we found that the lunchtime meal was not well planned and people waited some time for their meals to be served. At this inspection, we saw that the meal was served in a timely manner and people were supported to have a positive mealtime experience. Equipment was provided to support people to eat independently and staff assisted people to eat their meals when required. We observed staff talking with people and involving them whilst they sat with them. Staff did not rush people and checked they were ready before offering more food.

At the last inspection, people's specific dietary needs were not always met. At this inspection, we found the required improvements had been made. Staff knew about people's individual needs and information was recorded in people's care plans and the kitchen to minimise the identified risks. We saw that people received meals in accordance with their assessed needs. People's weight was monitored and they were referred to the GP and dietician if any concerns were identified. This showed us people were supported to

maintain a healthy diet.

The home had been designed and adapted to enable people to promote people's independence. Churnet unit's open plan lounge and dining area had been specifically designed to enable people to move freely around the home. In the other units, the décor featured bold colours and pictures with nostalgic themes were on display throughout the home. People and their families were encouraged to display personal items to help them identify their own room. People had been consulted about the development of the gardens at the home to enable them to have access to outside space, for example when they wished to see their visitors. A seating area had been put in place and the gardens had been maintained to make it an enjoyable space to use.

Good

Is the service caring?

Our findings

People who were able to give us their views told us they liked living at the home and that the staff looked after them well. Comments included, "All the staff here are very kind. They are friendly, caring and efficient", and "Staff are caring and skilled in what they do", and "No grumbles at all. Happy with the home and staff. We saw that people had positive relationships with staff and heard friendly light hearted banter between them. One person said, "The staff are really friendly and if I'm not happy then I tell them. They are very caring and you can have a bit of banter with them but they are always professional". We saw staff members greeted people when they came into a room and people responded positively. Staff showed concern for people's wellbeing and responded to their needs quickly by offering people reassurance and support. For example, we observed a member of staff checking on a person who seemed unsettled. The person was cold and in some pain. Staff brought a blanket and pain relief and settled them in a chair as they wanted to remain in the lounge area. Staff knew people well and chatted with them about things they had been doing over the weekend and about their families. Staff told us they enjoyed working at the service and it was important to them that people had good care. One member of staff told us, "We set high standards – I think of the residents as my mum and dad and everything needs to be right". Another said, "I love it here, it's like having all your nans and grandads in one place".

People told us the staff respected their privacy, promoted their dignity. One person said, "I am very dependent on the staff here for my personal hygiene and I cannot fault them. I have to be helped out of bed and taken to the toilet and they make sure I am safe and stand outside my en-suite until I have finished. I have a shower daily and they make sure I am covered with a towel". A relative told us, "[Name of person] needs two carers and they always ask first and explain what they are going to do before doing anything. They close the door and talk to them throughout; they never talk over [Name of person] and discretely cover them with towels when assisting with personal care". We saw that staff spoke discreetly with people and took them to their rooms to support them with personal care.

People and their relatives told us they were involved in making decisions about their care and treatment and staff listened and respected their wishes. One person said, "We are both very involved in decisions about my care; we both want me to have the same sort of lifestyle that I had at home". Relatives told us they felt involved and were kept informed about changes in their relation's care and treatment. One relative said, "I know about the care plan and was involved in drawing it up when [Name of person] came and we both signed it. They keep us informed about any changes". People chose what time they got up and settled for bed and we saw staff offered people choice about what they wanted to eat and drink and who they sat with. One person told us, "I spend all the time in my room now. That is my choice. I ring for the staff at about 8:30 for my breakfast and then have a shower at about 10:30. They clean my room for me when I am having a shower – I have asked for it to be done then as it makes sense to do it when I am not there". Staff encouraged people to be as independent as possible, for example we observed a member of staff asking a person if they needed support and walked alongside them to ensure they were safe. One person told us, "I like to be independent and can wash and dress myself most of the time but need help if having a bad day like today. I don't need to tell the staff; they notice and offer to help".

People were encouraged to maintain links with family and friends. Visitors were encouraged to come in whenever they wanted and we saw staff welcomed people's relatives and engaged them in conversation to enquire how they were and tell them how their family member had been. A relative told us, "Staff are empathetic and look after visitors as well and always ask how you and are ready to spend time with you. I remember being told when I was upset. 'we are here to look after you as well'.

Good

Is the service responsive?

Our findings

People were consulted about their choices for their care and support and their family members were involved in accordance with their wishes. One person told us, "My wife and I have been fully involved in my care plan from the start. She is more involved than me now as my memory for dates has declined and so I don't always attend review meetings now. I rely on her and that is my decision – no one else's. A relative told us, "We have discussed practical things and care needs but the staff also asked about past and current interests, hobbies and work history – all sorts of things really. Both [Name of person] and us as a family were fully involved in this". Another relative told us, "We are fully involved in care planning and as [Name of person's] needs have changed and their illness has progressed, we have discussed this and feel the care is focussed on their individual needs".

People told us the staff listened to them and acted on their wishes. One person said, "I stay in my room now, this is a conscious decision on my part not to get to know people like I did in my previous home as they die on you. I have my TV and staff are very good and pop in and we have a bit of a laugh". People's preferences for the gender of carer supporting them were identified and respected. A relative told us, "We were asked about male carers and said there would be no problems with this". We saw that staff knew people well and provided care and support in the way that people wanted it. For example, we saw that a person living with dementia was cradling a doll. We saw staff chatting with the person, asking how the 'baby' was and the person smiled and engaged with them. Staff told us the person liked to hold it when they were feeling anxious. The use of dolls can bring great benefit to some people with a diagnosis of dementia, particularly those in later stages.

We saw that the information and communication needs of people with a disability of sensory loss were identified and met. For example, one person's care plan identified how staff should communicate with a person who had a hearing impairment and an interpreter had attended the service during a recent review of their care. Another person's communication difficulties had been met through the use of pictorial aids, for example staff showed them a photograph of a cross when the priest was visiting the service and this enabled them to indicate if they wished to receive Holy Communion. This showed us the service understood the diverse needs of people living at the home.

People told us they were able to follow their interests and take part in activities that met their needs and preferences. There was a programme of activities which included baking, card making and quizzes. A relative told us, "I've seen people making cards and colouring and things like that but they are always appropriate to the ability of the people here. [Name of person] is very limited in what they can do now but the activities staff encourage people and try to find things they can take part in". We saw that activities co-ordinators supported people on a one to one basis by playing board games and using sensory items, which people enjoyed and encouraged them to engage with staff. We saw that the service had developed links with local community groups and entertainers to minimise the risk of social isolation for people. One person told us, "The children from a local nursery come in and last week we had a school choir – I really enjoyed that".

People and their relatives told us they would feel comfortable approaching the staff if they had any concerns or complaints. A relative told us, "Never had to raise any concerns or complain but would be happy to do this and confident it would be dealt with". Relatives who had raised concerns were happy with how they had been resolved by the registered manager. One told us, "I went to the manager and he sorted things out; I was quite satisfied with the response and feel confident that I would be listed to if I had to complain again". We saw that complaints were recorded and investigated and where possible, action was taken to make any improvements needed.

At the time of this inspection, the provider was not supporting anybody with end of life care. However, we saw that staff were proactive in contacting a person's GP when they had concerns that their condition had deteriorated. Following the GP's visit, we saw that staff had acted on their advice and were obtaining anticipatory medicines to support the person. This meant the person would have rapid access to medicines to maintain their comfort and wellbeing.

Good

Is the service well-led?

Our findings

At our last inspection, we asked the provider to make improvements to ensure their quality monitoring checks were consistently effective in identifying shortfalls and making improvements where necessary. At this inspection we saw that monthly audits were now being carried out to monitor the safety and quality of the service. We found that the medicines audits were not always effective in identifying the shortfalls we identified and we have referred to this in the safe and effective key questions. The registered manager confirmed that they would review these audits to ensure that they were consistently effective in identifying and addressing errors to ensure people's medicines were always managed safely and in line with legal requirements.

A new audit had been introduced to ensure care plans were checked for accuracy on a regular basis and we saw that any concerns were addressed promptly. In addition, the provider was in the process of introducing an electronic care planning system which included a monitoring and reporting facility to identify and address shortfalls. We saw that the registered manager had made changes to the accident and incident reporting system since the last inspection. The records showed that these were monitored for trends and action taken, for example we saw that referrals were made to the falls clinic or for physiotherapy input. The registered manager told us the new care planning system would integrate accident and incident reporting and improve monitoring to minimise the risks of reoccurrence.

The provider carried out regular checks of the service, which included monitoring to ensure the service was safe and meeting the legal requirements. We saw that there was an electronic 'workflow' system which enabled them to monitor that improvement actions identified were being completed. This showed us there was suitable provider oversight at the service.

People and their relatives felt there was a positive, inclusive atmosphere at the home. One said, "It feels very comfortable, warm and welcoming". Another said, "The atmosphere is warm and welcoming. Staff work together as a team, very happy really". People were encouraged to give feedback on the service through 'resident of the day' meetings, whereby a member of staff from each area of the home, for example housekeeping, met with them to ensure they were happy about their care and support. One person told us, "They ask how things are and if I have anything to say about my care. People's views were also sought through resident's meetings and an annual satisfaction survey. The last survey was carried out in August 2017 and we saw that issues raised had been addressed, for example new activities co-ordinators had been employed to improve the range of activities on offer. This showed us the provider listened and acted on people's feedback.

Staff were clear about their roles and responsibilities and told us they would be happy to go to the registered manager or deputy manager if they had any concerns. One member of staff said, "The manager sorts things out, for example if staff are not getting on". Another said, "The manager's door is always open – I can always talk to them". Staff told us they had meetings with the registered manager which gave them an opportunity to give their ideas for improvements at the service. They told us the provider also used a secure

social media site to communicate with them. The registered manager told us, "We find it's a more innovative way to share information with staff, for example changes in policies and procedures or if we need staff to cover a shift". We saw that the registered manager recognised staff achievement by nominating them for care awards; one member of staff had won awards for dignity in care and another had been shortlisted. This showed us staff were supported to fulfil their role.

The service had a registered manager who understood the responsibilities of their registration with us. They reported significant events to us, such as safety incidents, in accordance with the requirements of their registration. It is a legal requirement that a provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this at the home and published it on their website.