Roseberry Care Centres GB Limited

Haythorne Place

Inspection report

77 Shiregreen Lane
Shirefield
Sheffield
South Yorkshire
S5 6AB

Tel: 01142421814

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This inspection took place on 4 May 2016. The inspection was unannounced which meant the staff and provider did not know we would be inspecting the service.

The service was last inspected on 26 August 2015. At that inspection we found the service was in breach of regulations in that people had not received care and treatment that met their needs, and not had appropriate arrangements in place to manage medicines, and had failed to effectively operate systems and processes to protect people from abuse and improper treatment. The provider had failed to ensure that there were sufficient staff deployed and had failed to ensure that staff received the appropriate training. The provider did not have effective systems to monitor the quality of the service, and had not ensured that accurate and complete records were kept in respect of each person.

As a result the service had been rated Inadequate. You can read the report from our last inspections, by selecting the 'all reports' link for 'Haythorne.Place' on our website at www.cqc.org.uk'

Haythorne Place is a nursing home for up to 120 people. The service is divided into six houses, each providing accommodation for up to 20 people. One house accommodates younger people with physical disabilities, another house specialises in people with mental health problems. Four houses accommodate older people. Two of these provide support for people living with dementia. At the time of the inspection there were 100 people living at the service.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law, as does the provider.

During this inspection we found significant improvements had been made since our last inspection in August 2015.

We found that people had care and support plans in place, and care records reflected the care they required. The plans had been reviewed and updated when people's needs had changed. People's risk assessments had also been reviewed to ensure their safety.

The provider had ensured that an accurate, complete and contemporaneous record was maintained in respect of each person.

We found significant improvement in the arrangements for the recording, safe keeping and safe administration of medicines. Staff were aware of how to raise any safeguarding issues. We found the provider had ensured the service effectively operated systems and processes to protect people from abuse and improper treatment.

The provider had ensure that there were sufficient staff deployed to meet people's needs and that staff received the appropriate training to enable them to carry out the duties. Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work.

The service had policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We found that staff were following the code correctly, although some records were not detailed enough about how best interests decisions had been reached.

People told us they felt safe and were treated with dignity and respect. People were happy with the quality of care they had received and made positive comments about the staff.

People's individual dietary needs and preferences were being met and we received positive comments about the quality of the food.

We observed some staff giving care and assistance to people throughout the inspection. Staff were respectful and treated people in a caring and supportive way.

Although we found that the standard of cleanliness, maintenance and décor was better maintained in some houses than in others, people were protected against the risks of inappropriate or unsafe care or treatment because the provider had effective systems to monitor the quality of the service provision. Most of the maintenance issues we found had been picked up by the provider's audits and included in their on-going maintenance action plan.

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.

We found there were sufficient staff in each house to keep people safe, and so that support could be delivered in a timely manner, although there remained room to improve in respect of the numbers of agency workers used.

There was a need to improve the cleanliness and infection prevention and control in some houses.

People told us they felt safe and people had individual risk assessments which were accurate and up to date.

The service had appropriate arrangements in place to manage medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

People were happy with the choices at meal times and their nutritional needs were met. The food we saw provided variety and choice and ensured a well-balanced diet.

The service was following policies and procedures in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). However, we found examples where the records of best interest decisions were not detailed enough.

We found that most staff has received the necessary training and support. Where there remained room to improve the regularity of the formal, one to one supervision for staff the manager was taking action to address this.

Is the service caring?

Good

The service was caring.

People made positive comments about the staff and told us they were treated with dignity and respect.

Staff we saw giving care and assistance to people were respectful and treated people in a caring and supportive way. They checked people's wellbeing and if they required assistance.

People were encouraged to be independent as possible and their views were sought about their care.

Is the service responsive?

Good

The service was responsive.

We found improvements had been made, so that people who used the service were receiving the appropriate care to meet their needs.

We found that people's records were maintained to ensure they were accurate, complete and up to date.

People had access to a range of activities, in the service and in the community.

Is the service well-led?

Good

The provider asked people, their relatives and other professionals what they thought of the service.

There was a robust system in place to assess, monitor and mitigate the risks relating to people's health, safety and welfare.

The provider had ensured that each person at the service had an accurate, complete and contemporaneous record, which included a record of the care and treatment provided to each person.

Staff told us the service continued to improve and most said they were well supported.

Haythorne Place

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 4 May 2016. This was an unannounced inspection which meant the staff and the provider did not know we would be visiting. The inspection team consisted of four adult social care inspectors and two specialist advisors. Both specialist advisors were qualified nurses, and were experienced in managing the care of vulnerable people.

Before this inspection we reviewed the information we held about the service and the provider. For example, notifications of deaths and incidents. We also used information received from professionals who had visited or worked with the home, such as service commissioners and visiting healthcare and social care professionals, including information about the outcomes of the most recent commissioner's contract monitoring visit.

We reviewed the provider's improvement plan to help us to assess if the shortfalls found at previous inspections had been addressed. We also spent time generally observing care throughout our visit.

We used a number of different methods to help us understand the experiences of people who lived in the service. We spent time observing the daily life in the service including the care and support being delivered. We spoke with 16 people living at the service, four relatives and one visiting healthcare professional. We also spoke with the registered manager, the deputy manager, four nurses, 18 care assistants, one team leader, one unit manager, an activities co-ordinator, one member of domestic staff and the housekeeper.

We looked round different areas within each of the six houses; including the communal areas, the kitchens, bathrooms, toilets, and where people were able to give us permission, some people's rooms.

We looked at records relating to people who used the service and staff, as well as the management of the service. This included reviewing 16 people's care records, medicines management documentation, three

staff personnel files; including records of their recruitment, training and support, minutes of staff and residents' meetings, complaints records, infection control and maintenance records, and how the home monitored the quality of service provided.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with said they felt safe at the home. For instance, one person said, "I feel safe with the staff here." Some people said they liked the front doors on their rooms and that they could lock their doors when they went out.

People had risk assessments in place regarding the risks that were relevant to their needs. These were individualised and kept up to date. The reviews we looked at demonstrated how the person and their relatives were involved in the process.

Some people whose records we saw had bed rails in place. However, the bed rails risk assessments did not state what other methods of falls prevention had been tried before resorting to the installation of bed rails. For instance, pressure mats, beds lowered to their lowest position with crash mats in place, or anti-roll mattresses.

All people who used the service had Personal Emergency Evacuation Plans (PEEPS) detailing the equipment and number of staff required to assist them in the event of the need to evacuate the home in an emergency. We also saw that there were evacuation slides available in the stairwells, which had pictorial instructions on the outside to aid staff in their use.

The service had a process in place to respond to and record safeguarding vulnerable adults concerns. It was clear from discussions with staff that they were aware of how to raise any safeguarding issues. Improvements had been made to address concerns we found at the last inspection in relation to reporting and investigating incidents. There were systems and processes for staff to follow, which were effectively operated to prevent abuse of people who used the service and all incidents had been investigated appropriately.

Some people presented behaviour that could challenge others. We found that challenging behaviour charts were used to monitor people's behaviour and to help staff to manage incidents more effectively. Where necessary people's records included guidance on how to minimise the impact of the person's behaviour for themselves and for others living in their house.

At the previous inspection we found that some of the entries in people's records made by staff describing people's behaviour were judgemental and opinionated. At this inspection we saw that the registered manager had addressed this issue and staff had been provided with additional training. All entries we saw were written in appropriate language to preserve people's dignity.

At our last inspection we found the provider had not ensured there was enough staff to meet people's needs in a timely manner. At this inspection we found that sufficient improvements had been made. People who used the service felt there were enough staff to meet their needs. They were supported by regular staff who knew them well. They told us that the level of agency staff had reduced significantly, as new staff were being recruited, and had started working in the home. We also noted that there were enough staff to make sure

that call bells were answered in a timely manner. Although this area had seen some improvement, there was still a need to use agency staff and the registered manager explained that it was a challenge to recruit qualified staff and recruitment was on going.

Staff told us there were enough staff on duty to keep people safe, and most staff said there were enough staff in each house to make sure people's needs were met. There were some mixed views from staff. For instance, the minimum daytime staffing had been decreased by one member of care staff in House 2, as the numbers of people living in the house had decreased to 14 people. The staff we spoke with were aware of the staffing decrease, but not clear about the rationale. One staff member felt that providing opportunities for people to go out was sometimes a struggle with the decreased staffing levels, while another did not perceive this to be a significant factor.

The staff recruitment records we reviewed included a range of information to show that appropriate checks had been undertaken before staff were employed in the service. This included written applications, and references, including one from the applicant's most recent employer. The provider had completed a Disclosure and barring check, Service Adult check for each staff member. The Disclosure and Barring Service (DBS) provides criminal records checking and barring functions to help employers make safer recruitment decisions. We also saw evidence where applicable that the nurses' Nursing and Midwifery Council (NMC) registration had been checked and were current.

There was no policy about updating DBS checks and some checks had been completed several years previously. We spoke with the registered manager who said they would look into updating DBS checks or finding a way of checking they were still accurate.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines, and a sample of Medication Administration Records (MARs), stock and related records, such as transdermal patch rotation charts. A transdermal patch is a medicated patch that is placed on to the skin to deliver a specific dose of medication into a person's bloodstream.

Considerable improvements had been made to address the concerns we found at the last inspection and the safe and appropriate storage of all medicines was maintained. We found no concerns relating to the labelling, administration or recording of transdermal patches. Improvements had been made to the way bulk prescription medication was managed and recorded. A bulk prescription is an order for two or more people, bearing the name of a service in which at least 20 people normally reside, 10 or more of whom are registered with a particular GP practice.

Some people were prescribed Controlled drugs (CDs), which are medicines controlled under the Misuse of Drugs legislation. Where necessary, improvements had been made to the placement of the CD cupboards, so they provided easier access for staff. We also found that there were adequate systems in place to ensure the denaturing and disposal of control drugs was carried out. With appropriate numbers of denaturing kit available. Staff used a denaturing kit to render CDs irretrievable and unfit for further use until they are returned.

Where people were prescribed medicines to be taken 'when required', sometimes referred to as PRN medicine, such as painkillers and medicines for anxiety. Information was consistently available for staff to follow in order to ensure that the medicines were given correctly and consistently with regard to their individual needs and preferences. Clear guidance and tools had been provided to staff to use, to help them know how a person expressed that they were in pain. If people were not administered any PRN medicines during a cycle this was reviewed to ensure they were being appropriately supported.

Each person had a profile that included their photograph, how they preferred to take their medicines, and guidance was in place to ensure that staff were made aware of any special instructions related to particular medicines. For instance, some people needed to take their medicines at certain times to ensure they were given before food for best effect. We saw that the arrangements in place were individualised around the person's preferred routine.

We found that staff who administered people's medicines had appropriate training and assessments of their competence had been completed. The systems in place to check how well medicines were managed had been improved and were effective in practice. Audit checks were carried out regularly and in sufficient detail to identify concerns. These audits recorded the actions taken to make the improvements and changes needed to ensure medicines were managed safely.

During the inspection, we found that action had been taken to address the hazards that were identified at the last inspection, as presenting a risk to people. Staff had been reminded about the need to keep fire doors free of obstruction and we identified no similar concerns. There was adequate monitoring and maintenance of equipment and the temperatures were monitored of each fridge in the service. We found the arrangements in place to ensure the maintenance of lifts and the call bells were in working order

Staff were trained in the prevention and control of infection, wore clean uniforms and wore appropriate personal protective equipment (PPE), such as gloves and aprons when providing care and when serving food.

However, when we walked around each house we found that some houses were cleaner and in a better state of repair than others. There were areas for improvement that were evident in all six houses. For instance, there were areas of chipped and damaged paintwork in a number of the shared areas and some woodwork was not glossed or varnished. This included the medicine cupboards in most houses, which made it difficult to clean effectively.

Several strips were missing between floor coverings, in doorways and the exposed areas had remnants of the previous strips, which made the areas difficult to clean effectively. In some houses the bathrooms and some carpets were 'tired' and would benefit from replacement. We shared these findings with the registered manager. They assured us that they would be addressed.

The arrangements for extracting smoke from the smoking rooms identified at the last inspection had been addressed. However, there remained a concern that the rooms used as smoking rooms throughout the service did not have forced extraction to the exterior of the building and we found that further improvement was needed. The access to the garden was via the smoking room in one house and there were also combustible materials in some smoking rooms, in the form of wooden book shelves, housing paperback books.

Requires Improvement

Is the service effective?

Our findings

All of the people we spoke with told us that the staff looked after them well. For instance, one person said, "It's great." And another said, "It's good here. They treat you as a human being." Additionally, we spoke with a visiting GP who provided positive feedback about the service.

There was evidence in people's care plans that referrals had been made to health care services such as speech and language therapy (SALT) optician, chiropody, and occupational therapy (OT) services, when needed. The care plans had a section for 'Professional Visits' to be noted and these verified when external healthcare professionals had visited and the outcome of the visit. Details of the outcomes of appointments people attended outside of the home were also noted in their records and people's care plans had been updated to reflect any changes.

We observed lunch time in some of the houses. In house one; all staff were involved in assisting people with their meal. Where people required assistance to eat and drink, this was provided at a pace that suited their individual needs. Staff sat with people and chatted with them, and some people enjoyed a good 'banter' with staff.

Food was plentiful and people indicated they enjoyed the food provided. Two people we spoke with said the food was, "Fine" and, "Good". They told us there were two choices at each mealtime but, if they did not want the choice offered on the day, they could choose something else. Although, the alternative offered was usually sandwiches. As sandwiches were also a main choice for the tea time meal, there was the potential that people could be served two portions of sandwiches, one at lunchtime and another at tea time.

One person was vegetarian and this was clearly recorded in their care plan and on the daily nutrition sheets. On the day of the inspection they were happy with the vegetarian 'shepherd's pie' they were provided with.

Some people had particular needs regarding swallowing and their care records included assessments made by the local speech and language therapist (SALT). For instance, we saw clear guidance that one person was to be assisted to eat by a qualified nurse, due to the risks associated with their swallowing difficulties.

Staff told us people chose their meals one week in advance, they then checked on a meal by meal basis, if the person still wanted what they had chosen. People said that they enjoyed their meals and that they were not rushed to eat. They told us they were able to have seconds and that snacks were available throughout the day.

There was access to snacks and drinks in each house. For instance, in house three, on the ground floor, there were snacks and drinks laid out for people throughout the day. Staff explained that on the top floor snacks and drinks were available, but were managed differently, due to the needs of the people living there.

We saw that people who attended hospital, or went out for trips over the usual lunchtime, were provided with their meal on their return, We saw two instances where members of staff sat at the dining table with a

person who was having a late lunch, and chatted about the events of their morning.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights.

The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom. We found the service to be meeting the requirements of the DoLS. The manager was aware of the guidance and people who were subject to a DoLS authorisation had the correct documentation in place.

Most staff had received training in these subjects and were able to discuss the relevance of the MCA and DOLs. Some of the newer care staff had not as yet completed this training. They told us that they were scheduled to complete it, and tended to rely on the nurses and senior staff for advice, as they were trained and better informed in this area. They were aware of the requirement to employ the least restrictive approach to people. However, some were not aware of the reasons that people had a DoLS in place or aware if there were any conditions attached to them.

It was clear that when decisions had been made on people's behalf, these were made in their best interests. Care records provided information about people's capacity to make decisions. We saw examples where people had been supported to make decisions in accordance with the MCA. There were a small number of people who were administered their medicines covertly (hidden in food or drink) and, where this was the case, we saw care plans and assessments and records of best interest meetings with staff, the person and their nearest relatives regarding this in their care records.

However, we did find some instances where people's records lacked detail about specific decisions made in their best interests. For instance, some people had bedrails in place for their safety. Assessments for the use of bedrails had been completed, which were signed by the nurse who had completed the assessment. However, there was no record available on their files of how the best interest decisions had been reached to support their use. Although not administered covertly, one person's medicines were crushed and there was a record of the GP and pharmacist being contacted. However, the records were not organised to reflect the best interest process followed. We discussed these shortfalls with the registered manager who said they would ensure all best interest decisions were recorded in a more consistent way throughout people's care files.

The staff we spoke with told us they felt well supported by the senior staff, nurses and managers. Discussion with staff and the records we saw showed improvements had been made in the regularity of supervisions provided to staff. Supervision is the name for the regular, planned and recorded sessions between a staff member and their manager. It is an opportunity for staff to discuss their performance, training, wellbeing and raise any concerns they may have. Most staff told us they received regular supervision. Of the ten staff we spoke about this with, one member of care staff told us they had not had one to one supervision for some months, although they had been involved in a 'group supervision'. Additionally, the housekeeper provided supervision to the domestic staff, but they, themselves had not had formal supervision as often as they should. We saw evidence that where there remained room to improve the regularity of the formal, one to one supervision for staff the registered manager was taking action to address this.

We reviewed the staff training spreadsheet and saw there was a system in place to highlight when staff required refresher training. The spreadsheet showed that staff were provided with appropriate training

when they started working at the service and on an on-going basis. A range of training was provided to staff to reflect their role at the service. This included nutrition and hydration, fire safety, safeguarding vulnerable adults, health and safety, food hygiene, infection control, and moving and handling.

Staff told us they also completed training in specific areas, which were relevant to the needs of the people they provided care to. This included supporting people living with dementia and managing challenging behaviour. This showed that the provider had ensured that staff received appropriate training for them to carry out their duties.

The environment was generally appropriate for people's needs in each house. For instance in the houses caring for people living with dementia there was safe space for people to walk around and, board games, books, quiet lounges and TV lounges are available for people. Relatives were able to spend time with their family member, in their bedroom or in various communal areas. There was appropriate signage for bathrooms and toilets, in accordance with recognised best practice. There was also a 'reminiscence' lounge in one house with décor appropriate to the era of the people living in the home.

Bedroom furnishings were well spaced and people were able to move around them with ease. The small dining areas had doors to gain access to the gardens in most houses. Nurse call alarms were in each bedroom and located near to people's beds. They were also found in communal areas.

While most areas had been redecorated and were reasonably well maintained, there were areas that needed attention. For instance, the smoking room provided access to the garden in house four, some carpets were frayed in places and in some people's en-suite rooms the flooring needed repair. We particularly noted that there was a dark, unkempt feeling on the ground floor of house four.

The provider was aware of the various requirements in relation to the redecoration and repair in each house and we were provided with a copy of the provider's plan for the larger items for this year. This included the replacement of a number of floor coverings and the redecoration of various areas. We discussed the plan with the registered manager, who said that it would be amended to reflect the priorities for further refurbishment.

Good

Is the service caring?

Our findings

The people we spoke with all made positive comments about the service, particularly the staff. For instance, one person said, "They [staff] are all lovely here. " Another person said, "This is home! I wouldn't be happier anywhere else" One person's relative said. "The care is unbelievable. Absolutely brilliant."

We observed that staff were very caring towards people, respecting their rights and choices. We saw staff treating people with kindness and compassion. They spoke in a respectful tone of voice and listened and responded to people. They consistently explained and asked people's permission before performing care tasks and, where people refused, this was respected.

In some houses we saw that during the afternoon, staff sat with people chatting with them about their day, offering choices of DVD's and music.

People looked well cared for and were wearing their glasses and hearing aids where necessary. Where there were challenges in supporting people with their general appearance this was documented in their care plans

People were provided with opportunities to make a range of individual choices, such as where they would like to eat their meals and whether they wished to stay in their room or to use the lounge areas. We noticed that bedroom doors had people's names on them, to help people to recognise their own room. People told us that they had chosen the décor for their bedrooms.

Staff told us that people's relatives were encouraged and welcomed to the home. People agreed that their friends and family were able to visit at any time. People's family and friends were able to stay with a person when they were ill or receiving end of life care, and there was a flat available for them to stay in overnight. People's records showed that their next of kin or relatives were often involved in the reviews of care plans.

Staff spoken with told us they enjoyed working at the service. For instance more than one staff member said, "I love my job." The care staff we spoke with were able to describe people they supported and their individual preferences.

At the last inspection an issue was identified, in relation to the way staff recorded entries in people's records when they displayed behaviour that could challenge others. At this inspection we found that the registered manager had effectively addressed the issues with staff, to make sure they had a good understanding of people living with conditions that may affect their behaviour.

One person had limited communication and did not always express their needs verbally. They had a comprehensive communication folder in place. The communication folder advised staff how to converse with the person. It included pictorial images to support the person to make and communicate their decisions, and to converse with staff. Another person who lived in another house had similar communication needs and would have benefitted from such a resource. We discussed this with the

registered manager who said they would ensure that instances of good practice were more effectively shared between all of the houses.

People told us they were treated with respect and that staff were mindful of people's privacy. Some people living at the service chose to lock their rooms. We saw that staff preserved people's privacy. For instance, staff were observed to knock on doors prior to entering the toilets and bathrooms, and people's bedrooms. However, some of the communal toilet and shower rooms provided limited access for people who required assistance, and in one house it was difficult to close one toilet door fully, when someone was using the toilet. A shower curtain had been erected and was used to help protect people's privacy, but this was not an acceptable long term solution. We discussed this with the registered manager, who said that an alternative solution would be sought that better preserved people's privacy and dignity, and added to the provider's maintenance plan.

Each person had an 'end of life' care plan. This gave details of any wishes they had including their wishes regarding resuscitation, and who they wished to be notified in the event of their death. Staff we spoke with said they discussed with people and their family their preferences regarding their 'end of life' care and this was clearly documented in the notes we saw.

Good

Is the service responsive?

Our findings

At our last inspection we found the provider had not ensured that all the people living at the service had safe and appropriate care and support to meet their needs. At this inspection we found the provider had made sufficient improvement. People's records were maintained to ensure they were accurate, complete and contemporaneous and we found that people were receiving the appropriate care to meet their needs. We also tracked seven people's care in two of the houses and the care provided on the day of the inspection corresponded with that noted in their care plans.

People we spoke with told us they were very happy with the quality of care and support they received. For instance, one person said, "I don't know where we would be without this place." Another person said, "They [staff] are fine. They are all good, every one of them." One person's relative said their family member could be reluctant to accept care. They went on to praise the staff for the way they managed this, saying "The girls [staff] are brilliant with [my family member]."

We saw positive interactions between staff and people who lived and visited the home. Care workers offered people options about their meal or where to sit, as well as providing the food, drink, or support they knew were preferred. During our visits call bells were answered promptly and staff were responsive when people needed care or support.

Assessments of people's needs had been carried out prior to admission. People we spoke with confirmed they had been involved in formulating their care plans. People's care files included detailed information about the areas the person needed support with and any risks associated with their care.

The files we looked at outlined people's needs, a summary of their life history and any risks associated with their care. For instance, one person, whose file we looked at had specialist needs and equipment, such as a PEG. PEGs are most commonly used to provide a means of feeding people when their oral food intake is not adequate. The person had a clear and comprehensive care plan regarding this and all other aspects of their needs.

Although most care plans we looked at were person centred, the way the information was presented was not very individualised in format.

People and their relatives were consulted on the care given and were invited to contribute to assessments. This was documented in people's records. There was evidence of reviews, whereby the person and, where appropriate, their relatives were involved in reviewing the person's care plan, discussing their progress and wellbeing and any changes in their care.

People we spoke with said they regularly had opportunities to be involved in activities, both in the home and in the community. We saw that people took part in a variety of activities in the houses, such as baking, pottery, and gardening, games, such as dominos and bingo, and crafts. One person told us they liked to go to one of the other houses for singing on a Tuesday. People who were cared for in bed were also able to take

part in activities as staff attended to them in their rooms. Photographs of the activities and trips people had taken part in were in books or displayed on the wall. For instance, we saw pictures of people enjoying Saint Patrick's day, Saint Valentine's day and Easter celebrations, as well as a barge trip. .

On the day of the inspection the activities co-ordinator asked people if they wished to go out for coffee and cake, and to buy some new games.

People's religious and cultural needs were noted in care plans. For instance we saw that one person regularly attended church services locally.

The services complaints process was on display in each of the six houses and in the office reception area. This included who to contact if a person was not satisfied with the initial responses. One person described what they would do if they had any concerns or complaints about the home. They said, "I would tell the nurse' and they would sort it out." The person went on to say, "I have never had a problem with the nurses, so I don't need to complain." One person's relative said, "I can't fault the people looking after [my family member] There has been no need to complain, ever."

We saw the record of complaints kept in the service. It was evident that complaints were investigated and responses provided to the complainant. What was not part of the written record was an analysis of any emerging themes and patterns, or how any lessons learned had been shared with the provider or the staff team. However, we did see that relevant discussions had taken place as part of the staff meetings.

Good

Is the service well-led?

Our findings

There was a registered manager in post, who was supported by a deputy manager and unit managers for each house. The registered manager was well organised and spoke positively about providing a high standard of service for people and sustaining the improvements made.

At our last inspection we found the provider had not ensured there was an effective system in place to regularly assess and monitor of the quality of the service provided. At this inspection we found that sufficient improvements had been made. There was an effective system in place to assess, monitor and mitigate the risks relating the health, safety and welfare of people. Incidents were consistently reported and effectively investigated. Incident monitoring was undertaken by the management team to look for similarities and themes and to make sure any lessons were learned in order to prevent recurrences.

In most houses the nurses worked alongside the care staff and demonstrated where the priorities of the shift laid. Staff were confident and comfortable in approaching the nursing staff with any queries and passing on any changes in people's needs. However, there was an agency nurse on duty in one house, and we saw that there was more limited communication between them and the care staff.

The provider had ensured that each person at the service had an accurate, complete and contemporaneous record of their care. We saw that Care plan audits were undertaken and any shortfalls identified and addressed. However we did see some inconsistency in the way people's written records were stored, to protect their confidentiality. For instance, people's care plans were locked in the nurses' office in house one. The care plans were stored in a cupboard in house three, and we noted on the day of the inspection that there were occasions when this was not kept locked, when not in use. We spoke with the registered manager who said they would address this as a matter of priority.

There was a system in place which ensured there were sufficient numbers of competent, skilled and experienced staff. There was also a system in place was effective in ensuring staff received mandatory training, and other specialised training to meet the needs of the people who used the service.

Most staff commented about the improvements at the home. One nurse had started working in the home at the time of the last inspection and commented, "It's improved a lot since then." Another staff member said the staff team had worked hard and were making real improvements. Staff said that they could raise concerns with the management team without fear of reprisals, and they that they would be listened to. Most staff said that they received the support they needed from the management team, although there were a small number who told us they did not feel valued and only saw the senior managers, "When something goes wrong."

It was clear that action had been taken to make sure people's views were sought and acted upon since the last inspection. For instance, a planner had been introduced for residents' and relatives' meetings, to make sure meetings took place on a regular basis. People and their relatives had been invited to meetings, although the registered manager told us they were disappointed at the low attendance, and was trying

different ways to encourage people to attend and be involved, such as trying different meeting times.

We saw the notes from the meetings for each house, for November 2015 and March 2016. The main areas of discussion were the care people received, the food, issues with the laundry and the activities people wanted to be involved in. There was, generally a positive feeling from the feedback and people had made some suggestions, which had been followed up by the staff.

The registered manager told us that the 2016 questionnaires had just been sent out, to gain the feedback of stakeholders, including people's relatives and external professionals involved in people's care. We saw the feedback from the questionnaire in 2015 and overall, these were positive. The results had been made available to people and were available in the reception area.