Minster Haverhill Limited

The Meadows Care Home

Inspection report

Brybank Road
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Tel: 01440712498

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 17 February 2016 and was unannounced.

The service is registered to provide accommodation for up to 55 older people with or without dementia. At the time of our inspection there were 53 people using the service.

There was 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.

This service was last inspected on the 24 November 2014 and was found to be requires improvement in three areas: Safe, responsive and well led. At the last inspection we had concerns about staffing levels and the support staff received which we felt sometimes resulted in people not getting the care that they received. We identified one breach around inadequate staffing levels.

At our most recent inspection we identified a number of improvements to the service and felt the home was well managed and staff reported that there was high morale and staff vacancies have been filled, which means continuity of care for people. The home had the staffing levels it had calculated it required and a generous allocation of activity hours to support people's emotional well-being. However, a number of relatives had raised concerns about the care provided, specifically on the ground floor where several relatives told us people's personal hygiene was not always met and people were not sufficiently stimulated.

On the day of our inspection there were lots of social activities being provided upstairs. But on the ground floor the majority of people were in their bedrooms, which was not the case on the first floor. Staff said this was because people were not in as good a health as those upstairs, but we felt more could be done to help people stay connected to others and take part in day to day activities.

There was a good range of activities for those offered them, which meant those people were sufficiently stimulated throughout the day. But we felt that not everyone was being included and that more could be done by care staff to engage people in activities around their routines and things that were meaningful to them.

Risks to people's safety were monitored and clearly documented and staff knew people's needs well. Staff received training in safeguarding vulnerable adults and knew who to report concerns to.

People received their medicines safely, but there were a number of things we identified which needed addressing to improve medication practices.

The homes recruitment processes were sufficiently robust. New staff were supported through an adequate

induction processes and received training and support for their job role. We did identify gaps in staff's knowledge and gaps in training but these were being rectified (by the manager?).

Staff had a good understanding of legislation relating to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberties Safeguards (DoLS). The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People's health care needs met were met and the manager had good relationships with other health care professionals.

People were supported to eat and drink but we were concerned about the accuracy of the records.

Staff were caring and regularly engaged with people. However, some of the interactions/language were not appropriate for the needs of people using the service.

People's independence and safety were promoted as far as possible.

Staff were responsive to people's needs but we did identify gaps in records which meant we were not always confident that people needs were responded to appropriately.

There was a complaints procedure but we found people's concerns were not always recorded so we could not see if actions taken were appropriate.

The service was well managed and the manager spent time supporting her staff and listening to relatives to try and improve the care. We felt that sometimes the care provided was reactive rather than proactive and a more robust way of reviewing people's needs would help identify things earlier.

There was a good quality assurance system but increased opportunities for relatives to participate in meetings would be beneficial. Perhaps improved communication between them and the home would help.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Medicines were administered safely but some necessary improvements were identified.

Risks to people's safety were well managed.

Staff had a good understanding of safeguarding people in their care and knew how to report concerns.

Staff recruitment processes were sufficiently robust to help ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff had sufficient support for their role, including robust induction, training and supervision.

People were supported to eat and drink enough for their needs but we were not sure that records accurately reflected people's fluid intake.

Staff promoted people's choices and understood how to support people lawfully.

People's health care needs/conditions were monitored and met by the relevant health care professionals.

Is the service caring?

Good

The service was mostly caring.

Staff were observed to be kind and interacted often with people, but some of the observed interactions were not appropriate to need. People's independence was promoted and people were consulted about their care.

Is the service responsive?

Requires Improvement

The home was not always responsive.

Staff were familiar with people's care needs, but care plans did not always reflect people's needs or changes that had occurred.

Some people were given opportunities for social activity and stimulation around their individual needs, but others were not included or offer suitable activities.

There was a well- established complaints procedure and the manager was responsive to feedback. However their actions were not always recorded.

Is the service well-led?

Good

The service was well led.

The manager provided clear leadership and direction to staff. Staff were supported in their role.

There were audits around the well- being and safety of people using the service. This helped them identify and improve the service. However we felt some of the staff needed more direction.

People were consulted about the service provided to them and their feedback helped shape improvements. However communication with relatives could be improved upon.

The Meadows Care Home

Detailed findings

Background to this inspection

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

This inspection took place on the 17 February 2016 and was unannounced. The inspection was carried out by three inspectors.

As part of this inspection we looked at the previous inspection report, we looked at notifications. These are important events that affect the service and they are required to tell us about. We spoke with the manager, care manager, a team leader, head housekeeper, the activities coordinator, the chef, domestic and four care staff.

We looked at five people's care records including the records in their rooms. We carried out an audit of the medicines. We spoke with fifteen people who lived at The Meadows, four relatives and one health care professional. We looked at records to do with the running of the service including staff records. We also 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 easily or chose not to.

Good

Is the service safe?

Our findings

Staff we spoke with had received training in safeguarding vulnerable adults. They had a good understanding of what constituted poor care practices or potential abuse. They were able to give a number of examples of the type of poor care that would need to be reported. They were confident about reporting poor care to senior staff within the home and about whistle blowing to an external authority if it became necessary.

We had been notified of one incident that had been reported to the local authority safeguarding team. We saw that the manager had been proactive in managing this and recording actions taken, including contacting all the relevant health care professionals and family members.

There were enough staff on duty to meet the needs of people on the day of our inspection. We spoke with staff, one told us that the staff were familiar with people's needs and tended to work on the same floor, which helped with continuity of care. They said there was good team work but said the shift was very busy right up until after lunch time. They said they were now fully staffed and this had improved things. Some staff spoken with were working long hours which could mean they were not as effective as they could be.

Staffing rotas showed that the home was staffed at a consistent level. The manager told us that the home had a full complement of staff. They were interviewing an additional senior carer in order to give them more flexibility to cover staff training, annual leave and sickness. One member of staff described the home as, "adequately staffed" and said that they usually had sufficient time to meet people's individual needs and preferences. The provider used a dependency tool that was reviewed weekly to calculate its staffing levels. For the current week it showed that the actual care hours funded were in line with what the provider would expect. Staff present on the day of our inspection corresponded to those shown on the rota. Staffing for the last two weeks was mostly scheduled as described to us; and it was also scheduled as described for the next two weeks.

Medicines management was safe but some improvements were needed in order to reduce potential risks and inconsistencies in staff practices The two treatment rooms were in need of refurbishment. The walls were in a poor condition with peeling paint, bare plaster and damage to the walls from the trolleys. The basins had lime scale build-up and did not look clean; lime scale is a good habitat for the legionella disease to develop in. One of the basins had a large hole in it. It would be difficult to keep the rooms in a hygienic condition. Since the inspection the manager has confirmed work on the treatment room had begun.

Medicines management was safe but some improvements were needed in order to reduce potential risks and inconsistencies in staff practices. The medicine administration records (MAR) we sampled on both floors were well completed. Staff making transcriptions or amendments to the medicine administration record (MAR) always had this countersigned by another member of staff. This was good practice. Staff recorded the amount left in boxed medicines after each dose had been given. This helped them to keep track of medicines that were not in monitored dosage systems.

Staff who administered medicines had received training and an assessment from the dispensing

pharmacist. Their competence was then assessed by one of the senior management team. However, the training did not assess their knowledge of the common types of medicines and their side effects. There was some information on the types of medicines in people's care plans and on the protocols but none on the potential side effects that staff should look out for. This meant that it would take staff a long time to acquire sufficient knowledge to administer medicines effectively. For example, Alendronic acid is a medicine taken to build up bone density in people who have osteoporosis, it is required to be given at a specific time in a particular way or it may become ineffective or harm the person taking it. Staff knew how to administer it, but not why they needed to give it in that very specific way. This could mean that if a person was reluctant to take their medicine correctly staff would not be able to tell them the reasons why this was so important.

If a person wished to take responsibility for their own medicines staff carried out a risk assessment and assessed their ability to continue to do so safely. There were clear records when regular changes to people's medicines, for example warfarin, were made. One person who received insulin had been able to manage their diabetes when they were admitted to the home. However, since an admission to hospital staff had gradually taken over more responsibility for monitoring the person's blood sugar levels and administration of their insulin. Staff had received some training to enable them to take blood sugars. Staff had information on the signs and symptoms of low or high blood sugars but this was confusing and unclear and needed to be expanded and made much clearer. The manager said that they would discuss this person's needs with the community nurses. They would clarify the level of training and assessments of competence that staff would need to take full responsibility for monitoring and administering the insulin or whether it was more appropriate for the nurses to provide this person's support.

Some people had a medicine delivered through a skin patch. Staff were recording the rotation of the patches on a chart. However, one chart showed the patch only being moved between two places. The risk of skin reactions would be increased if the patches were not rotated regularly to different areas. The balances of the controlled drugs (CDs) were correct. However, they were only being checked once a month. This could potentially make it very difficult to identify and resolve any issues relating to the CDs so long after an event. The temperature of the treatment rooms and the medicines fridge were at the correct temperatures for the storage of medicines. However, we could not find the records of the monitoring of the room temperatures.

Staff had protocols for administering medicines that were given when the person required them, rather than at set times (PRN). This reduced the risk that the medicines would be given in an inconsistent way by different staff. However, some of the protocols needed to be more personalised to individual people to make them more effective. There was minimal use of sedatives in the home. Staff confirmed that they were only used when a few people became very distressed or anxious and staff intervention to support them had not been effective. There were good records related to the appropriate use of sedatives given in this way.

The times of medicines were printed on the MAR and the last time was 10pm. This resulted in a few people missing their medicines at this time because they had gone to sleep. The care manager said that they would discuss the times with the pharmacist and GP and ensure that people were offered medicines at times that fitted with their sleep patterns. Staff had shifted the dose of one person's medicine, which had a sedative effect, to later in the day with the agreement of their GP. This resulted in a reduction in their falls.

We consistently found there was good information about where to apply creams and the frequency of application but the cream chart was not filled in, so we could not be sure staff were administering it.

Risks to people's safety were documented with actions staff were expected to take to minimise the risks. People had care plans in situ and room charts which included things like how often people should be checked for their safety and any special considerations such as specific equipment to maintain a person's

skin integrity, how often their position needed changing and what their risk was of falls. Staff were vigilant and supervised people regularly. Staff were observed regularly offering people drinks, but we did not see staff always ensuring the fluid was taken. Supervision at meal time was appropriate and people got the support they needed to eat and drink in sufficient quantities. One person told us they had bed rails to stop them falling out of bed. They said they were turned frequently and needed a hoist with two staff to support them with their manual handling needs. They told us staff supported them appropriately.

Where people were assessed as unable to use the call bell this was recorded and people were regularly monitored for their safety as often as every half an hour. This was evidenced by records.

One person had been having a number of falls. We could see actions staff had taken as part of the monthly review but not actions taken after each fall. This might have resulted in less falls if a possible cause was identified earlier. Records showed us that health care professionals were consulted for advice as required.

We observed a minor confrontation between two people at the service but staff were on hand to help manage the situation and did so safely.

Records showed that the provider followed a recruitment process and appropriate checks were undertaken before staff started work. We looked at three staff records. These indicated that a recruitment process was followed. This included an interview process, two references sought and identification checks being carried out. Criminal records checks were undertaken before staff started work. We also checked agency staff records and found there was appropriate information about staff before they had been offered a shift at the meadows but, there was no evidence of an induction taking place to familiarise them with policies and procedures and the building.

Good

Is the service effective?

Our findings

Staff told us that they felt very well supported by the senior management team and said that communication was good within the home. Staff told us that they had regular supervision and staff meetings. One of them said, "You can air your views and discuss any concerns or training needs at supervision. I find it helpful."

One staff told us "The Manager does my supervision about six weekly. There is a monthly Head of Department meeting." Staff also told us that new staff were supported well with a two week induction which including shadowing more experienced staff and completion of most of their mandatory training.

Staff told us that they had regular training and updates in safe working practices. However, we could not see that all staff had received sufficient training on topics related to people's medical conditions. One member of staff we spoke with did not understand the link between a person's Parkinson's disease medication and their ability to move. Staff told us they had training on dementia care but this was not evidenced through all staff practices. Some staff had not had training around diabetic care. However, the manager confirmed that additional training was available to staff at request and according to staffs identified training needs. Examples included diabetes training, end of life care training, Parkinson's training and funeral care days. They told us further training was being sourced for dementia awareness and Parkinson's with the Parkinson's nurse. They said dignity training had been booked for an additional 30 staff by the end of March 2016.

The manager told us that staff were encouraged to develop their careers and gain further qualifications. One of them said, "The management are very supportive. They encourage you to develop." The role of team leader was used to give care staff additional responsibilities before they took on the full responsibility of senior carer roles. Staff led roles for topics such as nutrition and dignity had been identified in the home. However, staff could not describe what this meant for their day to day practice and the manager told us the role would be developed.

The training matrix identified only the mandatory training. During feedback it was suggested that additional training was also recorded. Five out of 43 staff had not completed the three year mandatory training in infection control, food hygiene and safeguarding. There were also gaps with the annual refresher training, most notably, 23 staff had not completed the safeguarding training. The care manager told us seven more staff would complete this over the next two weeks. Seventeen staff had not received refresher training in first aid and 16 staff had not completed refresher training in Control of Substances Hazardous to Health (COSHH). Staff we spoke with said they felt they had access to the training they required.

The manager stated that the provider's standard was to undertake supervision every four to six weeks. A supervision matrix was not in place but the three records checked showed that staff had received supervision within the last few weeks and staff spoken with confirmed this.

Staff we spoke with had an understanding of people's mental capacity and how this could vary from day to

day. They supported people to make as many decisions as they could. They told us that they would make 'best interests' decisions on their behalf, in consultation with their relatives, if their condition deteriorated or they had a period of ill health.

During the day we observed that staff offered people choices and treated them with care and respect. People had signed their care records to confirm their consent to care.

Decisions made in people's best interests had been recorded and it was documented that family had been involved when this was appropriate.

We saw that one Deprivation of Liberty Safeguards (DoLS) application had been approved and a further nine applications had been made. The manager told us that she needed to make another 22 applications. Staff demonstrated an awareness of their responsibilities under the Mental Capacity Act 2005.

Staff we spoke with considered that the standard of food provided was good. They told us that they always offered two different plates of food to people living with dementia so they could make a genuine choice on the day. Eight out of 24 people living in the service ate in the dining room downstairs. The rest chose to eat in their bedrooms. People were supported to access the dining room downstairs from 12.15pm and the food was served from 12.30pm. People were supported in their rooms shortly after this. However, upstairs some people were already at the table before lunch time, other people were supported to the table by 12.00pm and lunch was not served until 12.30pm. Some people went to a second dining room for what staff said an 'enhanced dining experience.'

Drinks and snacks were offered to people throughout the day. One relative said drinks tended to be squash and not often tea or coffee which they said their relative preferred. We also noted people with diminished appetites were not routinely offered biscuits and snack plates for. On the dementia unit some people continuously moved around so would require increased calories.

Both care staff and kitchen staff demonstrated an understanding of how to meet people's nutritional needs and systems were in place to monitor changes in people's dietary needs. The kitchen had a food hygiene rating level five and appropriate routine checks were undertaken.

There was evidence that people were weighed at least monthly and a food and fluid charts were instigated when there were concerns about people's nutritional intake. Fluid intake seemed to be high for some people and the Manager agreed to check this was being recorded correctly.

People were encouraged to comment daily on the food and staff recorded feedback in a comments book just outside the kitchen. Kitchen staff told us they read this through daily and took any feedback on board (in addition to direct feedback from people and staff.)

Staff considered that they knew people very well so were very good at monitoring their health and responding promptly to changes in their physical or mental wellbeing. One relative spoken with told us, "They [my relative] are safe here; they weren't before they moved here. They have put on weight." And they said that staff were quick to pick up any changes in their relative's needs and kept them informed.

Staff told us that they had good support from the local GP practices and community nurses, including out of hours support. The nurses provided pressure relieving equipment if people were assessed to be at risk of developing pressure sores. People were referred to dieticians and speech therapists if there were concerns about their weight or any swallowing problems. People received support from the local mental health team

when necessary.

We spoke with a health care professional who felt things had improved in the last four months in terms of the care people received. They said staff made appropriate referrals in a timely way. The said staff knew people's needs well and had information to hand. They said health care professional wrote directly into people's notes which they felt helped and there was improved communication with the home.

The home had one unit for people living with dementia. The other unit was for older people with physical disabilities, some of whom had a degree of short term memory loss. However, there were no objects or photos that would be meaningful to the person on their bedroom door, which could help them recognise their own rooms and help them orientate themselves in the home and promote their independence. The pictures on the walls did not provide focal points of interest that could stimulate conversations or reminiscence. Neither were they suitable for people with a visual impairment.

Good

Is the service caring?

Our findings

There was a friendly and caring atmosphere in the home. Staff told us that it was a happy atmosphere and felt that people living in the home were very content once they settled in to the home.

We spoke with relatives. One told us their family member was settled. They said they were always well presented and always seemed well and content. They felt staff were good and encouraged their family member to join in different things.

People who lived at The Meadows commented positively about the staff. Interactions between staff and people who used the service were caring and appropriate to the situation. All staff took time to chat with people during the day as they went about their work.

Three people were enjoying each other's company in the lounge. They were well presented and happy to speak with us. Staff offered them conversation and drinks, taking time to have a chat with them.

During our observations upstairs we saw that staff did regularly interact with people and pay them compliments. Staff tried to include people in the planned activities and where people did not want to be included this was respected. Staff supported people to ensure they were safe. Not all staffs interactions with people were appropriate. Some staff referred to people as ladies and gentlemen where other staff referred to people as 'mate,' 'darling' and gave people 'high fives'. This did not show people respect or take into account people's cognitive impairment. Communication with people was sometimes quite lengthy and confusing whereas people's care plans talked about using simple language and giving people time to process information.

Also, one person said they wanted to go home, staff replied, "You are at home." Thus increasing the person's distress. This was done, according to the manager, at the request of their family. However, this was not an appropriate response for a person living with dementia whose reality was different from someone without it. We looked at a number of people's care plans and these clearly told staff how to provide person centred care, which we could not be sure staff were always following.

The environment upstairs was quite noisy; we felt this might have contributed to people's needs not always being acknowledged. For example, one person repeated several times they felt dizzy; the staff member did not acknowledge them although we heard the person from a distance away.

We felt staff were well meaning but lacked guidance, we discussed these issues with the manager. Some sensitive information was seen outside people's room, including information about resuscitation. We spoke with the manager who was concerned this had happened and said they would ensure this did not happen again. They told us they were going to introduce a more discreet way to help staff identify quickly those people who had chosen to be resuscitated and who had not.

Staff gave us good examples of how they promoted people's privacy and dignity. They told us how they

promoted people's physical independence. For example, by encouraging them to take regular walks in order to maintain their mobility. We noted upstairs that people had freedom to walk around at will and some people had keys to their room which they kept locked to protect their personal possessions.

Requires Improvement

Is the service responsive?

Our findings

Staff were responsive to people's needs but this was not always accurately reflected in people's records.

We spoke with one person who told us how much they liked the home. They said they looked round several but this was their preferred home. They said, "I like the staff, they are all very nice."

Staff we spoke with considered that they gave care that was personalised to the individual person and took account of their wishes and preferences. These were recorded in people's care plans. We found people's life history information could be improved.

Room charts were in place for staff to record people's daily care needs such as food and fluid charts, if required as well as cream and repositioning charts and mattress checks.

We found People's care plans were not always up to date if changes had occurred in their health or other care needs. One person had steadily lost weight over the past year, 9.3kg in all, they had lost 6.1kg in one month. However, this was not mentioned in their nutrition and hydration care plan. It only stated that their food and fluid intake was being monitored, and the care plan review stated 'no change'. There was no care plan about how staff should manage this person's insulin dependent diabetes or what they should do when they ate very little of their meals when they would be at risk because of their diabetes. There was no evidence that staff were supplementing their diet with snacks or nourishing drinks to maintain their blood sugar levels at these times, which would have also help them maintain their weight.

This person did have a diabetic foot care plan. This was good practice because nerve damage is a complication of diabetes that could lead to amputation. However, staff were writing 'no change' every month rather than commenting on the sensation and colour of the person's feet. Staff were generally not using the monthly care plan review as an evaluation of people's condition and their care needs in the previous month. This meant that there was no record of the effectiveness of care management for people.

One person had a body map completed when they returned from hospital. This showed that they had numerous marks and red areas on their skin. However, there was no subsequent record showing the progress of healing or deterioration of their wounds. Another person was receiving end of life care. Their weight was very low and they were at very high risk of developing a pressure sore due to their medical condition. Their care plan stated that they should be turned every two hours to reduce the risk of sores. However, staff were on occasions changing their position between three to five hourly and were not always recording what side they had been turned onto. This meant that it would not be possible to assess whether the person had the pressure relieved sufficiently to prevent their skin breaking down.

We looked at some charts of people's fluid intake. However, the amounts were extremely high and it was difficult to establish whether this was the amount that people had been offered or what they had actually drunk. The manager said that they would reassess the recording of fluids, discuss this with staff and ensure that the records were an accurate reflection of people's intake. Six out of the 53 people at the home

currently had a urinary tract tnfection (UTI) which could be indicative of poor fluid intake. There was scope to improve the records held in people's rooms. For example, fluid charts did not state the target intake and it was not clear that recording was accurate.

People's needs were assessed before admission to the home and again if they had spent some time in hospital. However we found the information gathered at assessment stage was quite limited and did not clearly demonstrate how the home could meet their needs. Additional information from the local authority was in place.

Most people commented favourably about the activities provided. However, one relative felt there was insufficient activities offered and that relatives were not always consulted about what was provided. There were newsletters and a list of activities around the home. The relative felt people could be more involved by staff such as helping with the daily routines and folding laundry. We took these suggestions to the manager. There were three staff providing activities in The Meadows and in the small sister home, The Hay Wain, next door. Staff told us that they felt the standard of activities was very good and that they were provided for seven days a week. There were 112 hours set aside for activities. They described numerous activities that would appeal to a range of interests. These included clothes sales, enabling people to shop for clothes from the comfort of their own home, birthday parties and teas for people and shopping trips on a one to one basis. There were also entertainment afternoons and evenings with singers as well a gardening, movement to music, cooking, arts and crafts, memory cards and viewing films.

The Salvation Army, Jehovah Witness Church and The Church in the Field also visited the service. They also had a volunteer from a local college who visited each week to spend time with people. There was limited opportunity for people to go on trips out of the home but there was some one-to-one support. The reminiscence room and pub downstairs helped to create a positive environment for people. People were encouraged to offer ideas about what they would like to do. A programme of activities was displayed on the notice board in the downstairs lounge.

On the day of our inspection a gentle exercise session took place during the morning and a singer came in the afternoon. Staff told us that people would be offered one- to- one time at least once a week and that this was documented. The quiz downstairs did not take place because an activities coordinator was off sick. However, people were encouraged to join the activities upstairs. During the day staff had time to converse with people and one to one time was offered.

Throughout our observations in the dementia care unit, staff were always present but we felt greater opportunities could be provided to people. People were mostly sat in the lounge at the table. Staff gave people magazines but there was no discussion about these. People also waited a long time at the table before lunch was served, about half an hour. Staff did frequently talk to people but there was insufficient to engage people and their environment was not particularly stimulating. The only exception to this was some flowers on the windowsill and some hearts people had made for valentine's day. The manager said they were going to do a family tree and this would be on the main wall in the lounge/dining room. There were other rooms people could use and there was a range of games people could access. There were limited sensory objects available for people with dementia.

The atmosphere in the unit on the first floor was transformed when the activity coordinator arrived, who very quickly engaged with and motivated people. They clearly enjoyed, singing, dancing and shaking instruments and pompoms. About nine people joined in but we could see other people smiling and nodding. The activities coordinator was very inclusive. We spoke with a relative who told us there was rarely anything planned for the evening.

The home did not have access to its own transport and it was not clear how people were supported to access the community. However, no one said they were bored and we observed many positive interactions during the day.

The provider had a complaints policy and procedure. No complaints had been made in the last few months. However, it was clear that the manager had spent a great deal of time with relatives who had verbally raised concerns but had not put them in writing, neither had the manager recorded their conversations or actions they had taken. During feedback it was suggested that niggles and issues were logged so that patterns and themes could be reviewed and managed. One family said they raised concerns about laundry.

People were involved in their care. Care plans recorded if people were able to consent to their care and their involvement in day to day decisions. Resident/relative meetings were held but these were not particularly well attended or established.

Good

Is the service well-led?

Our findings

One of the staff told us, "The home is well run and well managed. If you have any concerns the manager sorts it out very quickly." Staff told us that senior staff were approachable and that training was good. People and their relatives told us they knew who the manager was and could approach senior staff with any concerns. Senior staff had a visible presence throughout the home on the day of our inspection.

Senior and team manager roles had recently been developed to help create a career structure within the home. The roles and responsibilities of each were being developed at the time of the inspection. The manager was supported by a deputy manager and a head of compliance who was there twice a week and completed audits looking at the quality and effectiveness of the service being provided. Team leaders were on each shift and we observed them managing the shifts effectively. The manager told us each staff member either had or was working towards a higher qualification unless they were new to post. Some staff also held national vocational courses qualifications in Team Leading/Leadership.

Communication with families could be improved. The manager told us there was a newsletter and information for relatives on the notice board by the entrance. However, one relative told us they did not have time to look at the notice board. We discussed this with the manager and suggested they should ask relatives what their preferred method of communication was and could email information to relatives if they preferred. Relatives meetings were held but the manager said either no one had turned out or attendance was low which might be because relatives were either unaware of these meetings or did not have sufficient notice, particularly when they did not visit the service regularly.

We looked at the quality assurance processes in place. There was an audit last year and this was done at different times throughout the year. Professionals, relatives and people using the service had been asked for their feedback. The manager said if people were not able to comment on their care and did not have family to support them they used an advocacy service, 'voice ability.'

We saw examples of feedback about food and how comments had been responded to. Similar feedback was seen about the laundry. Quality audits included direct observations of care and the manager often supported staff in providing care. They also attended daily meetings to discuss any concerns about the home or changes in the needs of people using the service.

There was evidence the manager had worked with the local authority and health care professionals to keep up to date with changes in legislation and best practice. They had also signed up to dementia friends run by the Alzheimer's Association which aimed to promoted awareness of dementia sufferers. Some staff had signed up to this and we suggested relatives might benefit from this too. The manager told us they got support from the local hospice around end of life training and support for staff and in return had done some fundraising. They also said they had good links with the funeral directors who also provided support and training for staff to help ensure people's dignity was upheld even after their death.

The manager offered staff development, this included making fluid champions on each floor who would oversee how much people were drinking and if it was enough for their needs. There were also audits for any event affecting people's well- being and, or safety. For example a log of falls were monitored to see if there were any themes or trends such as specific time of day or night which might be indicative of insufficient staff. It also identified people who fell often and helped to establish any specific reason for this. There was also a weight tracker in place so we could see at a glance who was at risk of malnutrion. The manager was able to tell us what actions had been taken to maintain and increase people's weight when necessary. They told us they had spent a great deal of time with the West Suffolk Hospital Prevention of Admission to Hospital teams and therefore had arrangements in place to avoid any unessential hospital admissions for many people using the service.

Since our inspection the manager has written to us confirming actions taken immediately following our inspection to address the concerns we raised as part of this inspection.