Life Style Care (2011) plc

Green Acres Nursing Home

Inspection Report

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Overall summary

Green Acres Nursing Home is a purpose built home located about a mile and a half from Leeds City Centre. The home provides care for up to 62 people, including 26 NHS Intermediate Care beds. Intermediate care is a collection of services aimed at helping people stay in their own home, or care home instead of going into hospital, or that help people get home after a hospital stay.

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

On the day of our inspection we met most of the people who used the service and talked with twenty people, including visiting some people in their rooms. We were not able to speak with some people as they were too ill to speak with us. We spoke with nine visiting relatives and friends. The people we spoke with told us they felt well cared for and safe at Green Acres. We saw that staff treated people with respect and were mindful of their rights and dignity.

We found the service was meeting the requirements of the Deprivation of Liberty Safeguards. These safeguards make sure that people who lack capacity to make decisions are not deprived of their liberty unlawfully and are protected. People's human rights were therefore properly recognised, respected and promoted.

People's plans included risk assessments. These told the staff about the risks for each person and how to manage and minimise the risks to help keep people safe. People's needs had been assessed and their care given in a way that suited their needs, without placing unnecessary restrictions on them.

The arrangements for handling medicines were safe and people received their medicines as prescribed.

People who used the service and people who mattered to them, such as a close family member, had been encouraged to make their views known about their care. They had contributed to their assessments and care plans, about how they should be given care. People's care plans had a good level of information about how each person should be cared for; to make sure their needs were met.

The staff were well trained, skilled and experienced. They had caring attitudes and we saw they encouraged people to be as independent as they could be, and chose to be. People told us the staff were kind. We saw people had the privacy they needed.

People were encouraged to share any concerns and complaints they had. They said they told the staff if they had any worries. People didn't have any complaints to tell us about and were very happy with the care they received at Green Acres.

People had a chance to say what they thought about the service and the service learned from its mistakes, using complaints and incidents as an opportunity for learning and improvement. There was good leadership at all levels and the registered manager and her deputy promoted a positive culture that was person centred, open, inclusive and caring.

The environment was clean, safe and well maintained. We saw an example of good practice where each person had the name and photograph of their key worker and the name of their nurse printed on a colourful poster attached to the wardrobe, in a prominent position in each room. This helped people with recognition.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People told us they felt safe at Green Acres. Staff understood how to safeguard the people they provided care to. This was because they had training and there were clear safeguarding procedures for them to follow. People told us they felt their rights, privacy and dignity were respected.

The home was clean and safe and people told us it was a pleasant place to stay.

People were kept safe because the service had an effective system to manage accidents and incidents and to learn from them, so they were less likely to happen again. This helped the service to continually improve and develop, and reduced any risks to people.

If the risk was identified that people had behaviour that challenged others, or was a risk to themselves, there was clear guidance to help staff to deal with any incidents.

We asked whether anyone was subject to a Mental Capacity Act Deprivation of Liberty Safeguard authorisation (DoLS). These safeguards make sure that people who lack capacity are not deprived of their liberty unlawfully and are protected. The registered manager was aware of the process and an application had been submitted in the past, but none had been needed in recent months. There were policies and procedures in place and senior staff had been trained. This meant that people were safeguarded from excessive or unnecessary restrictions being place on them.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

Staff had properly followed relevant application processes and any conditions made by a Supervisory Body.

While no recent applications have been submitted, proper policies and procedures are in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one. People's human rights were therefore properly recognised, respected and promoted.

The arrangements for handling medicines were safe. All medicines were administered by suitably trained staff. People wishing to self-administer medicines were supported to do so.

Summary of findings

Are services effective?

People who used the service and those who mattered to them were involved in the assessment about their nursing and care needs and involved in producing their care plans and reviews. Some people had received support from independent advocates, who could speak up on their behalf.

We saw people's nursing and care plans had been updated regularly and when there were any changes in their needs.

People told us they were happy with the care they received and said their needs were met at Green Acres. Staff had a good understanding of people's nursing and care needs.

Staff were supported to deliver care safely and to a good standard. Staff had a programme of training, supervision and appraisal. Staff had received training in the core subjects needed to provide care to people. They also had training to help them meet the specific needs of the people who used the service, including training in caring for people with dementia.

The home had thought about current research and guidance and made sure the environment was suitable for people with dementia.

People told us they talked to staff if they felt unwell or were in pain. They had access to a range of specialist nursing and health care services. The records we saw showed people's health was monitored, and any changes that required additional intervention were responded to quickly.

The menus we saw offered variety and choice, and provided a well-balanced diet for people. There was evidence that the menus were put together using feedback from people who used the service about what they liked and didn't like, as well as input from a dietician.

People were assessed to identify any risks with their nutrition and hydration. Each person had a detailed care plan about their needs. These included guidance about the way their food should be prepared and any special equipment they used to help them to be as independent as they could be with eating and drinking.

Are services caring?

People told us the staff were kind and caring. We saw staff were kind and attentive to people. Staff showed patience, gave encouragement and had gentle, respectful and positive attitudes.

Summary of findings

The staff we spoke with had a good understanding of people's likes and dislikes and their nursing and care needs. They had caring attitudes and we saw that they encouraged people to be as independent as they could. When we spoke with the managers and staff it was clear they cared about people's welfare.

A member of staff approached us, unprompted, and told us, "The continuation of care from acute to non-acute is excellent. It's really good here. I wouldn't be working here if it wasn't."

People had thorough, detailed nursing and care plans about all aspects of their needs. They contained a good level of information about how each person should be cared for. Making sure people's privacy was protected was included in people's plans. People's needs, preferences and interests had been recorded and care and support was provided in accordance with their wishes.

The registered manager told us there were policies and procedures in place to make sure staff understood how to respect people's privacy, dignity and human rights in the care setting. They told us this was part of staff's induction and on-going training. Staff received training in end of life care and in caring for people with dementia

People told us they felt staff listened to them. They said they and their relatives were sometimes asked to complete satisfaction surveys. We saw that people's feedback was used to improve the service.

Are services responsive to people's needs?

Staff asked for people's views, encouraged them to make decisions and listened to and acted on them. People's capacity was considered under the Mental Capacity Act 2005. When a person did not have capacity, decisions were always made in their best interests. People also had access to independent advocates, who spoke up on their behalf.

People's needs had been assessed before they were admitted to the service. There were plans that clearly showed people's preferences, interests and diverse needs and how their care should be provided. People were provided with opportunities to be involved in activities in the home. One person who used the service was a former bingo caller and was calling the numbers for a session on the day of our visit.

The registered manager told us any complaints and concerns were fully investigated and resolved. They also explained how Life Style

Summary of findings

Care took account of complaints and comments to improve the service. The people we spoke with said they were aware of how to make a complaint and were confident they would be dealt with to their satisfaction.

Are services well-led?

We saw good leadership at all levels .The managers promoted a positive culture that was caring, person centred, open and inclusive.

Life Style Care, who ran the service, had a clear set of values. These included privacy, dignity, respect, rights, independence, choice and fulfilment for people. This was understood by staff because these values were in the service user guide, the home's policies and procedures, were part of their induction and on-going training and talked about in staff meetings.

The Life Style Care management team had systems in place to assess and monitor the quality of the service and to continually review safeguarding concerns, accidents and incidents. Where action plans were in place to make improvements, these were monitored to make sure they were delivered.

We saw that there was a policy about whistleblowing. Whistleblowing is when a worker reports suspected wrongdoing within an organisation. The staff and managers we spoke with told us they were supported to question practice and whistle blowers were protected.

The registered manager told us people who used the service and their relatives were invited to attend meetings, so they could say what they thought about the service, although these were not well attended and the management team were trying to find ways to encourage better attendance. The registered manager also held a 'surgery' on a certain evening each month where she made herself available to meet with people. We saw a poster advertising this in the reception area.

People were asked fill in questionnaires about the quality of the service. This showed the management team asked people to give feedback about their care to see if there were any improvements they needed to make at Green Acres.

Summary of findings

What people who use the service and those that matter to them say

When asked if people felt safe in the home people said they did.

When asked if they had access to health care services, one person told us they saw their GP occasionally, both in and outside the home.

The people who used the service and their relatives praised the staff highly. Comments included:

"They're very good. I'm extremely well looked after. It could not be better."

"The staff are kind."

"The staff are very good. I wouldn't have come back here if I didn't like it."

"Staff are kind and caring. Sometimes they are rushed off their feet, but they always have time for me."

"Staff have been very good and are most helpful."

"The carers are really good."

"I asked to come here, as I liked it so much, eight years ago."

One person we spoke with used an electric wheelchair and told us they liked the gardens but couldn't get out easily. However, they understood the reason for this and said that staff would always open the door for them. They said they felt safe in the garden as it was gated.

One person's relative told us, "The main thing is that they have involved me. They have listened to me and acted on it." He gave the example of suspecting their relative had an infection. Tests showed this was the case and appropriate treatment was given.

One person's relative told us, "I can't praise them enough here." They also said they had learnt a lot of practical things at Green Acres that would be useful to them in their carer role at home.

We spoke with seven people who were receiving intermediate care, following a stay in hospital. Four told us that they had stayed at Green Acres before and were happy to be staying again. All said they would recommend Green Acres to others.

People gave us the following examples of responsiveness to individual choices:

"I'm a funny eater. I like plain food. If I ask for cheese on toast I always get it."

"They make my lemon tea for me without a problem."

"At home I take my painkilling medication at 6am. They gave it here at 8am, which was too late for me, but when I asked they changed it to 6am."

People told us that visitors were welcome at any time. One person said the local priest came to visit them regularly.

Most we spoke with did not feel the need to complain about anything. One person told us they would speak to the manager if they had a complaint. Another said they would complain to any staff if the need arose.

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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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We visited the service on 17 April 2014. We used a number of different methods to help us understand the experiences of people who used the service. These included talking with people and their relatives and observing the care being delivered and talking with the staff. We also looked at documents and records that related to people's care and the management of the service.

Before our inspection, we reviewed all the information we held about the service and contacted a representative of the Leeds City Council commissioning team. They gave us positive feedback about the service. We also spoke with a specialist infection control nurse who had visited the home recently. They told us they had identified areas for improvement in infection prevention and control in the home recently. They said the staff in the home had been very responsive and had addressed the issues quickly and effectively.

On the day of our inspection we met most of the people who used the service and talked with twenty people, including visiting some people in their rooms. We were not able to speak with some people as they were too ill to speak with us. We spoke with nine visiting relatives and friends.

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

We spoke with the registered manager, the deputy manager and twelve members of the care team. We also met and spoke with the regional manager.

Are services safe?

Our findings

We were notified of two safeguarding concerns since the last inspection, which was in October 2013. These were notified to us by the registered manager, who had also made alerts to Leeds City Council's safeguarding team about these issues. One notification was about a visitor's inappropriate behaviour when vising a person who used the service. The second was about a person who used the service having some unexplained bruises. In both cases, there was evidence that showed Life Style Care had taken appropriate action when dealing with these issues.

The staff we spoke with had a good understanding of safeguarding people, and were confident about what they would do if there were concerns. The training records we saw showed staff had safeguarding training and this was updated regularly.

We saw that the policies about whistle blowing and safeguarding people from abuse were available and accessible to all members of staff. The registered manager told us Life Style Care's policies and procedures about safeguarding people and whistle blowing were part of the staff induction training when new staff started work.

There was information for people who used the service about how to make a complaint or raise a concern. This was displayed on a notice board in the reception area and we saw copies in people's rooms, along with the service user guide.

The care plans we looked at had an assessment of the person's nursing and care needs and a plan of care. They included risk assessments specific to the needs of each person. Each person and people who mattered to them had been involved in discussions about the risks associated with their specific needs. Therefore the risk assessments were different for each person. They included areas such as the risks around moving and handling each person, the risk of falls, nutrition and hydration and the risk of pressure sores. The assessments were clear and gave guidance to staff about how the risks to people should be managed. They had been re-assessed monthly.

When we were showed around the home we noticed that one person was being barrier nursed in their room due to the risk of cross infection. It was clear that thought had been put into how this information was imparted, without compromising the person's dignity or confidentiality.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards.

While no applications have been submitted, proper policies and procedures are in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one. People's human rights were therefore properly recognised, respected and promoted.

The registered manager and other members of the home's management team had received training in the principles associated with the Mental Capacity Act 2005 (MCA). The staff we spoke with during our inspection understood the importance of the MCA in protecting people and the importance of involving people in making decisions. We were told that there were plans to provide training in the principles associated with the MCA and the Deprivation of Liberty Safeguards (DoLS) to the staff who had not yet received formal training in this area.

The staff we spoke with were clear about their role in promoting people's rights and choices. We saw that when people did not have the capacity to consent, procedures were followed to make sure decisions that were made on their behalf were in their best interests.

The care plans we saw included mental capacity assessments. They detailed whether the person had the capacity to make and communicate decisions about their care. The registered manager told us mental capacity assessments were undertaken each time staff noticed changes in people's behaviour. When staff noticed behavioural changes in people they referred the person to the GP. This was to rule out any medical conditions, such as infections. If necessary, the GP also carried out mental capacity assessments. The registered manager told us that people living in the home had received support from independent advocates and they were involved where decisions were more complex. The mental capacity assessments we saw included details of advocacy services used. We also saw that one person had been supported by an independent mental capacity advocate (IMCA) when their capacity was being assessed.

We saw records in two people's files that showed best interest meetings had taken place and that decisions made on people's behalf, were made in accordance with the

Are services safe?

principles of the MCA. Meetings usually involved people who were important to the person and actively involved in their life. Sometimes an IMCA had been involved, along with staff from the home and other professionals.

We looked at records of accidents and incidents and saw evidence these were reviewed by the registered manager and reported to the senior management team. The registered manager and the deputy manager told us reports were reviewed to help prevent similar incidents in the future. The home had a policy of close observation for people who had had a fall or other accident. A separate monitoring form was used for this purpose and was kept in the person's room, with details of the fall or accident. This showed that practical action was taken to make sure the risks of recurrences were minimised.

If the risk was identified that a person might display behaviour which challenged others or was a risk to themselves, there was clear guidance for staff in people's care plans and risk assessments to help staff to deal with any incidents effectively. We saw the risk assessments and risk management strategies in people's written records. The guidance included respecting people's dignity and protecting their rights. The records of staff training showed staff had been given training in this area.

We saw the records for one person who was admitted on intermediate care with a fracture, which required them to be nursed in bed. They had other needs relating to dementia, which increased their risk of re-injury. The home had made application to the intermediate care team and extra one to one staffing hours were provided to help make sure the person was safe. This showed there were proper resources provided to meet people's needs.

We found that the arrangements for handling medicines were safe. All medicines were administered by suitably trained staff. The medicines administration records were clearly presented to show the treatment people had received. When new medicines were prescribed these were promptly started. Written individual information was in place about the use of 'when required' medicines and about any help people may need with taking their medicines, to help make sure medicines were safely administered. We found that medicines, including controlled drugs, were stored safely.

We found the environment to be safe and well maintained. When we looked round the home we noted that the fire exits were clear and the fire extinguishers had been checked and maintained at regular intervals. The sluice rooms we looked at were appropriately equipped, clean and were kept locked. We saw the fire risk assessment, which had been completed in February 2014. Each person had a personal emergency evacuation plan (PEEP) and these were available in the reception area.

One person's relative told us that, although visitors had to ring two bells for admission and then sign a visitors' book, no-one challenged them or checked who they had come to see. They told us that, in their view, the system was not sufficiently policed. We discussed this with the management team at the time of the inspection.

Are services effective?

(for example, treatment is effective)

Our findings

We looked at the care plans for six people who used the service. There was documented evidence that people and those who mattered to them had contributed to the development of the assessments of their nursing and care needs. One person had an advanced care plan (ACP) in place. The aim of an ACP is to make clear the person's wishes and will usually take place in the context of an anticipated deterioration in the individual's condition in the future, Under 'What elements are important to you?' They had said, "I would like to stay here as long as possible."

There were a number of assessments, care plans and reviews that very clearly set out people's individual needs, choices and preferences. At the point of admission assessments had been undertaken about such things as people's appetites and fluid intake, including their dietary preferences. Assessments were undertaken of their communication and cognition and their sleep pattern. Their preferences around spirituality and dying had been sought, along with information about their history and social profile. This included their religion and spiritual activities, siblings, place of birth.

People's care plans provided detailed information to staff about what specific support they needed, what they liked and didn't like and how their support should be provided, their concerns and expectations. For instance, people had care plans for eating and drinking and assessment of how independent they were when eating. One person's desired outcomes were, 'to maintain adequate dietary and fluid intake and to maintain independence.' They had listed their special dietary requirements.

On the day of the inspection people were being asked about the food, as part of a planned 'Food Forum'. People were encouraged to attend to talk about the food and say what they would like on the menus. We saw that the cook and the activity coordinator visited people in their rooms to seek their views, if they chose not to or were not well enough to attend.

People each had a 'My life story' in their files. These talked about the relationships and things that were important to them. This included what they liked to be called, things that were important to them from their childhood and what was important to them now, including a section called 'my preferred appearance'.

Although it was not the primary reason for their admission, some people had dementia. When we were shown around the home we saw that the home had considered current research and guidance in order to provide a suitable environment for people with dementia. There were areas of the home that had been decorated and equipped for people with dementia, with pictorial signs on doors. Most people had possessions and photographs in their rooms. There was information displayed to orientate people to their location, the date, time of day and the season. The walls and carpets were not too heavily patterned. We saw that people had access to a safe, secure garden area.

The manager told us staff were undertaking training in caring for people with dementia. The staff we spoke with had a good understanding of people's care and support needs. We saw how staff members interacted with people who used the service. The staff knew people well and were respectful of their wishes and feelings.

The registered manager showed us the staff training matrix, which had been developed to show the training staff had completed and to highlight the training and updates they needed. The matrix showed the dates when training was due and when it was planned. The registered manager told us Life Style Care put a lot of emphasis on making sure staff were provided with the training they needed to meet people's needs. One staff member we spoke with said, "We are often having training. Infection control was last week and we've done hand washing."

To make sure staff were supported to deliver care safely and to a good standard there was a programme of staff training, supervision and appraisal. Staff had received training in the core subjects needed to provide care to meet people's basic needs. This included moving and handling, health and safety, food hygiene and infection control.

They also had training to help them meet the specific needs of the people who used the service. This included understanding autism, diabetes, epilepsy and preventing falls. The registered manager also told us that training in working with people with dementia was planned. This was to make sure staff could meet one person's changing needs.

People told us they would tell the staff if they felt unwell or were in pain. The registered manager described how people were observed and monitored in relation to their

Are services effective?

(for example, treatment is effective)

general well-being and health. There was emphasis on observations, especially for signs of any pain, as not everyone could effectively communicate their needs verbally. We saw that some people had pain assessment charts, to help staff monitor whether their pain was being managed effectively. People were provided with understandable information about the medicines they took and the health care and treatment options available to them.

The records we saw showed people's health was monitored, and any changes that required additional intervention were responded to. In people's files there were records of contact with specialists who had been involved in their care and treatment. These included a range of health care professionals such as specialist nurses, speech and language and occupational therapists. They showed that referrals were quickly made to health services when people's needs changed. The registered manager told us the health care professionals involved were helpful, and made referrals to more specialist services, when necessary. This was confirmed by the records we saw in people's files.

People's needs and preferences around spirituality and dying had been sought and included in their care plans. One person was recorded as saying, "I would like to be visited by a Priest."

We saw that staff encouraged people to have a healthy diet. There was guidance for staff on how to meet people's particular needs in their risk assessments and care plans. We saw the advice available for staff from a speech and language therapist about what foods were appropriate for people on a soft diet.

We saw menus offered variety and choice, which provided a well-balanced diet for people. There was evidence the menus were put together using feedback from people who used the service about what they liked and didn't like.

People's weight was checked at very regular intervals and written in their records. This was to help the nurses to make sure people maintained a healthy weight. Where people were assessed as at risk, records were seen detailing what they had eaten and drank. Where necessary, contact had been made with people's GP and other health care professionals for advice and treatment. People's diets and menus had been put together with input from relevant professionals, such as dieticians.

Some people needed to eat a texture modified diet because of Dysphagia and other health issues. Dysphagia is the medical term for swallowing difficulties. People had a detailed risk assessment and care plan about their specific needs. These included guidance about the way their food should be prepared and any special equipment they used to help them to be as independent as they could be with eating and drinking. This included things like slip mats, plate guards and adapted spoons and cups. We saw that the speech therapists had been involved in assessing some people to see if they needed texture modified diet.

One person whose file we looked at was being fed by percutaneous endoscopic gastrostomy (PEG). This is when a tube is passed into a patient's stomach to provide a means of feeding when a person's oral intake is not adequate. They had a gastrostomy care plan and risk assessment in place, and their records showed the equipment and PEG site had been checked at regular intervals.

One of the audits undertaken by the management team to look at the quality and safety of the service was an annual mealtime audit. This included whether people were assisted appropriately by staff and sitting at the right level. It included an audit of whether trained staff were present in the dining room. The deputy manager also told us staff were encouraged to sit and eat with people, as it is regarded as a social activity.

Are services caring?

Our findings

People told us the staff were kind and respected them. They said they liked the staff and they were caring. They said this about all of the staff who looked after them. They said they were happy with their care and made decisions about how they were looked after. They told us they had a named nurse, who got to know them particularly well and made sure they had everything they needed. People told us they made lots of choices every day. This included what activities they wanted to do, what and where they wanted to eat and what clothes they wanted to wear.

People said the staff were very respectful of their religious and spiritual beliefs and we saw there was information about different church services that people could attend. Staff told us that one person they were caring for was Muslim. They were aware of the person's specific needs and preferences. We looked at the care plan for this person and saw that their needs and preferences were very clearly recorded in their assessments and care plan. We were also told that there were staff members who were Muslim and they were given time for religious observance throughout the working day.

We saw staff and people who used the service interacting. Staff were respectful and friendly. We saw people being offered choices and staff often asked people if they were OK and if they wanted or needed anything.

The registered manager and staff we spoke with showed real concern for people's wellbeing.

The staff knew people well, including their preferences and personal histories. They had formed good relationships and staff understood the way people communicated. This helped them to meet people's individual needs.

There was clear guidance for staff about the principles of the service. This helped to make sure staff understood how they should respect people's privacy, dignity and human rights in the care setting. The staff we spoke with were aware of the principles and policies and were able to give us examples of how they maintained people's dignity, privacy and independence. We also saw illustrated cards fixed to people's doors which read, 'Help in Hand – please respect my dignity.' This was a simple, but effective way to show that staff were assisting the person in their room, and preventing unwanted intrusions.

We saw that staff attended to people's needs in a discreet way, which maintained their dignity. Staff also encouraged people to speak for themselves and gave people time to do so. They engaged with people in a respectful way.

We looked at care plans and reviews for people who used the service. They had their own detailed plans of care. They included what was important to people and how staff should maintain their privacy and dignity. For instance, the daily notes we saw for one person showed they liked their door closed at night to preserve their privacy.

Most people we spoke with told us staff listened to them and acted on what they said. They and the people who mattered to them were asked to complete an annual satisfaction survey. This also helped to make sure that people had chances to make their views known and be listened to.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

People told us that the staff asked their views and acted on them. We saw staff made sure people had time they need to make decisions. People who used the service were involved in their monthly reviews. The manager also wrote to people's relatives to ask how they wanted to be involved in reviews of care plans. People's capacity was considered under the Mental Capacity Act 2005. When a person did not have capacity, decisions were always made in their best interests. Advocacy support was available when needed. People had access to an independent advocacy service.

People's needs had been assessed before they moved into the service. The written records we saw clearly showed people's preferences and needs and how care should be provided. People were offered the opportunity to be involved in activities. Because of people's needs, these were mostly based in the home.

We met and spoke with an occupational therapist and physiotherapist, who were members of the Intermediate Care team (ICT). They told us the service was provided in the person's own home wherever possible. Where this was not possible the service had intermediate care beds in local residential and nursing homes. They had a base in Green Acres Nursing Home and this had been a recent development. They gave positive feedback about the care provided by the nursing and care staff in the home and said they worked well with the ICT to promote people's recovery from illness and maintain their independence.

When we looked at the information that was written about people, including their care plans and risk assessments, we saw they had been reviewed regularly and whenever people's needs had changed. We did note that two people's care plans did not include sleep care plans and we discussed this with the registered manager at the time of the inspection. They told us this was an oversight and would be addressed immediately.

Because of their health needs, a large number of the people who used the service spent a significant amount of time in their bedrooms. To help make sure people weren't isolated the activities worker the home employed spent planned time with people on a one to one basis. This was usually in the mornings. They went on to provide other, group activities in the afternoon. One person's relative told us their relative felt a bit isolated as they had a sensory impairment and would appreciate a member of staff coming in for a 10 minute chat during the day. We discussed this with the registered manager at the time of the inspection,

On the day of our visit, bingo was held. One person who used the service was a former bingo caller and was calling the numbers for a session attended by people who used the service, a cook, cleaner, carer and relatives.

We saw that information was provided to people in a good sized print and, often in easy to read formats. The care provided each day was written in each person's file and was appropriate to their age, gender, cultural background and disabilities.

People were made aware of the complaints system. There was an easy read version of how to make a complaint. We saw this was on the notice board. The registered manager told us people and those who mattered to them were also given copies. The registered manager also told us people were given support to make a comment or complaint where they needed assistance.

We saw the record of complaints kept in the home and reviewed how one complaint was dealt with. This showed when a complaint was made it was taken seriously and investigated fully. We also looked at the record of significant events and saw there was learning from these. We could see that learning from any complaints, incidents and investigations was fed back to staff at meetings and at individual staff supervision, if appropriate.

People were clear who they would talk to if they had a concern or complaint. They said they were happy to tell any of the staff. No concerns about the service had come directly to us at the Care Quality Commission.

The registered manager was aware of the principles of the Deprivation of Liberty Safeguards (DoLS) and knew their responsibilities within this. No one was subject to DoLS when we visited. Support could be accessed from an independent advocacy service when needed and we saw that people had received support from independent advocates, who could speak up on their behalf.

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Our findings

At the time of our inspection the service had a registered manager in post. The registered manager and deputy manager promoted a positive culture that was person centred, open, inclusive and caring. We felt that the managers had a detailed knowledge of the people who used the service and the aim to provide the best service possible.

Staff we spoke with told us the managers were very supportive and confirmed they would be conformable approaching the managers with any issues or concerns. One said, "If we had any worries or concerns the manager would definitely do something about it."

Life Style Care, who ran the service, had a clear set of values. These included involvement, compassion, dignity, respect, equality and independence for people. These were clearly stated in the service user guide. We spoke with several staff who said the values of Life Style Care and of the home were very clear. They demonstrated a good understanding of these values. They said they understood because these values were in their job descriptions, in the policies and procedures, were part of their induction and on-going training, and talked about in their meetings.

Staff felt well supported and valued and the general feeling was that there was an open and honest culture. For instance, where there were medication errors, these had been reported and learned from and discussed at meetings in an open way.

The management team had systems in place to assess and monitor the quality of the service and to continually review safeguarding concerns, accidents and incidents. Where action plans were in place to make improvements, these were monitored to make sure they were delivered.

The registered manager told us they completed a monthly report about the running of the service for the Life Style Care management team. This included information about safeguarding issues, complaints, activities and the environment. It was clear that when issues were identified, these were addressed immediately. We also saw evidence that risk assessments and care plans had been updated in response to any incidents which had involved people who used the service.

The manager told us monthly audits took place to measure the quality of the service; including quality systems, home presentation, care documentation, pressure ulcer care and safeguarding vulnerable adults' management. We saw in care plans we looked at, the audits had been recently completed. We saw evidence that some audits were also carried out by the regional manager on a monthly basis. The home was also audited by a company auditor every six months and then annually by an external auditor. The records we saw showed that the home had notified the Care Quality Commission of reportable incidents appropriately.

We saw satisfaction surveys for people and their relatives. We saw an action plan had been developed for areas which were identified for improvement. The action plans gave details of the actions to be taken, by whom and the timescale in which it should be completed. For instance, there were action plans about writing to every relative inviting them to attend people's reviews. Another action plan for activities stated: 'Weekly programmes to be given to all residents to ensure that they are aware of what is going on within the home.'

We also saw the home regularly sent surveys to other stakeholders. As the home had a number of NHS intermediate care beds, the NHS also conducted surveys. Overall, it was apparent that the home had effective ways to seek the opinions of the people who used the service and this helped to make sure people had a good quality service.

The home was staffed 24 hours a day. No one we spoke with raised concerns about the levels of staff available in the home. The registered manager told us they regularly reviewed the staffing with their line manager. They explained there were systems in place to assess and monitor that there were sufficient numbers of staff to meet people's needs. The registered manager told us staffing levels were assessed depending on people's need and the occupancy levels. The staffing levels were adjusted when needed. They said where there was a shortfall, for example when staff were off sick or on leave, existing staff were usually happy to work additional hours.

The home employed 13 Registered Nurses. This included two bank nurses. This ensured that there were always qualified nurses on duty, both in the day time and at night. We were told the home did not need to use agency nurses. We saw the records of the National Vocational

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qualifications in care (NVQs) the care staff had undertaken. This showed that around half of care staff had NVQ at level 2 and above. We saw that 11 care workers had achieved NVQ level 2 and four had level 3. One member of care staff had achieved NVQ level 4. The registered manager told us that staff were encouraged and supported to undertake NVQs.

We saw there were plans in place to help mangers and staff deal with emergencies. There was a management on call system in case staff needed management support outside of office hours. The manager showed us there were clear emergency plans. For example, information about how to keep the service running in extreme weather and a list of alternative emergency accommodation available.

Staff we spoke with told us staff meetings were held every eight weeks for the trained staff. We saw the minutes of these meetings, including evidence of learning from incidents and accidents. Actions were considered and taken following each meeting. Meetings also look at infection prevention and control issues, as well as general housekeeping.