Bupa Care Homes (BNH) Limited

Dene Place Care Home

Inspection report

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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?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Dene Place is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Dene Place Care Home is registered to provide nursing and personal care for up to 30 people. There were 16 people living at the service at the time of our inspection.

This inspection site visit took place on 13 September 2018 and was unannounced.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last comprehensive inspection on 7 November 2017 and focused inspection on the 12 February 2018, we asked the provider to take action to make improvements in relation to the deployment of staff, the delivery of safe care to people, activities available to people and the leadership and quality assurance at the service. At this inspection we found that this had improved.

There were appropriate levels of care staff to support people when they needed it. These were reviewed regularly dependant on the needs of people that lived at the service. Risks to people's personal safety had been assessed and plans were in place to minimise these risks. Staff understood risks associated with people's care. There were appropriate plans in place in the event of an emergency. Accidents and incidents were acted upon and steps taken to reduce the risks.

Steps were taken to review the care and the delivery with actions to make improvements. Methods they used included surveys, audits, resident and relative meetings and staff meetings. Where shortfalls were identified actions were taken to rectify this. People were supported to make a complaint if they needed to. Complaints were investigated and improvements made where needed.

People said that they felt safe. Staff ensured that people were protected against the risk of abuse and told us that they would not hesitate in reporting any concerns. Robust recruitment of staff took place before they started work. Staff understood how to protect people from the risk of infections.

People's medicines were managed safely and appropriately by staff. People had access to pain relief when they needed. People's nutrition and hydration were managed to ensure they received the most appropriate care. Health care professionals were involved with the care of people and people were supported to attend health care appointments. People's needs were assessed fully before they started to receive care at the service.

Training and supervision were provided to staff that ensured that the most appropriate care was being

provided to people. We saw through observations that staff were knowledgeable and effective in the care that they provided. Staff were effective in sharing information in relation to the care of people and worked in line with current guidance.

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. Staff had received training around the MCA and how they needed to put it into practice and staff were knowledgeable in this. There were people at the service that had the capacity to make decisions about their care and staff respected this. Where people were being restricted, applications were submitted to the Local Authority in line with the legal requirements.

Staff showed care and empathy towards people. It was clear that staff had good relationships with people and understood what was important to them. Staff showed patience, dignity and respect and people responded well to staff.

People received individualised care and were able to make choices around how they wanted their room to look and how they wanted their care to be delivered. People were supported to be independent and to make their own choices. Visitors were welcomed at the service.

Care plans were detailed and specific to each person. There was guidance for staff on how best to provide the support. Staff were aware of what care needed to be provided. People were supported to participate in activities that they enjoyed. Care plans were in place to people at the end of their lives. The environment suited the needs of people that lived at the service

People and staff were complimentary of the management and the support they received. Staff worked well as a team and felt supported and valued. Staff understood the values of the service. Staff worked with organisations outside of the service to improve delivery of care.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events including significant incidents and safeguarding concerns.

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.

There were appropriate numbers of staff to meet the needs of people.

Appropriate plans were in place to assess and manage risks to people. In an emergency staff understood what they needed to do.

People were protected against the risk of abuse and neglect. Staff understood what they needed to do to protect people. Staff understood good infections controls.

Medicines were stored, administered and disposed of safely.

Recruitment practices were safe and relevant checks had been completed before staff commenced work. Accidents and incidents were acted upon and measures were in place to reduce the risks.

Is the service effective?

Good

The service was effective.

Staff received training and supervision to ensure that appropriate care was delivered.

The environment suited the needs of people that lived at the service.

Assessment of people's needs was undertaken before they moved in to the service. Staff worked well across the service to ensure good delivery of care.

People were supported to access healthcare services and healthcare professionals were involved in the regular monitoring of their health.

Staff understood and knew how to apply legislation that supported people to consent to treatment. Where restrictions

were in place this was in line with appropriate guidelines.

People had enough to eat and drink and there were arrangements in place to identify and support people who were nutritionally at risk.

Is the service caring?

Good

The service was caring.

People were treated in a kind and caring way by staff. People told us they were treated in a dignified way.

People's privacy was respected and promoted. Staff were happy, cheerful and caring towards people.

People's preferences, likes and dislikes had been taken into consideration and support was provided in accordance with people's wishes.

People's relatives and friends were able to visit when they wished. People were supported to be independent.

People's religious needs were met.

Is the service responsive?

Good

The service was responsive.

Information regarding people's treatment, care and support was reviewed regularly and shared with staff. There was sufficient guidance for staff in relation to people's care.

People who were at the end of the life received appropriate care.

People had access to activities and people were protected from social isolation. There were a range of activities available within the service.

People were encouraged to voice their concerns or complaints. Complaints were investigated and responded to.

Is the service well-led?

Good

The service was well-led.

There were systems in place to regularly assess and monitor the quality of the service provided. The provider had met the breaches in regulation from the previous inspections.

The provider actively sought, encouraged and supported people's involvement in the improvement of the home.

Staff were encouraged to contribute to the improvement of the service and staff felt valued.

The management and leadership of the service were described as good and very supportive.

Staff worked in partnership with external organisations.

Appropriate notifications were sent to the CQC.

Dene Place 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 site visit took place on 13 September 2018 and was unannounced. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed the information we had about the service. This included information sent to us by the provider, about the staff and the people who used the service. We reviewed notifications sent to us about significant events at the service. A notification is information about important events which the provider is required to tell us about by law. We were also provided with feedback from three health care professionals prior to the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to This enabled us to ensure we were addressing potential areas of concern at our inspection.

During the visit we spoke with the registered manager, nine people, two relatives and nine members of staff. There were people that were unable to verbally communicate with us; instead we observed care from the staff at the service. We looked at a sample of five care records of people who used the service, medicine administration records and training, supervision and four recruitment records for staff. We reviewed records that related to the management of the service that included minutes of staff meetings, surveys and audits of the service.

Good

Is the service safe?

Our findings

At the previous inspections in November 2017 and February 2018 we found that staff were not deployed in an effective way. People were not always supported when they needed it. We found on this inspection that this had improved.

There were sufficient care staff to meet the needs of people. One person told us, "There are enough staff. They are all so good. If I want them I ring my bell and they come quickly." In response to how they had responded to staff levels the registered manager told us on the PIR, "Staffing levels are reviewed on a daily, weekly and monthly basis, also we are constantly looking to recruit into the home." We found that this was taking place on the day of the inspection. One member of staff told us there had been high use of agency staff when they started working there but that this had reduced to the point where there was only one member of agency staff now being used. Another member of staff said, "The are enough staff based on the needs of the residents." We checked the rotas and saw that there was always a safe level of staff on duty. We saw that people received care when they needed.

At the inspection in February 2018 we identified concerns that related to the safe care of people that lived at the service. This included insufficient room checks being undertaken where people were at risk of falls. Pressure sore care was not always being managed in a safe way and people at risk of choking were not always being provided with safe care. At this inspection we found that all of these concerns had been addressed.

Risks to people's personal safety had been assessed and plans were in place to minimise these risks. There were people being care for in their rooms and staff ensured that their calls bells were within reach. We saw a member of staff settling a person in the chair in the garden and making sure the call bell was in reach. One person said, "I have this bell around my neck. I'm well catered for in an emergency." Where clinical risks were identified appropriate management plans were developed to reduce the likelihood of them occurring. People were protected from developing pressure ulcers. One person's records specified they should be supported to turn over in bed to relieve pressure on their skin. They were supported to do so every three to four hours and staff had signed a chart to confirm that they had done this. Bath and shower temperature checks were taken and a recording sheet had the maximum safe temperature on it.

Staff used hoists and sliding sheets to transfer and reposition people. Each person was assessed by the physiotherapist to ensure that they had the correct slings and each person had their own slings. There were sufficient hoists and the stickers on the hoists showed that they were serviced regularly. People with the risk of falling out of bed had their beds fitted with bedrails. The bedrails were fitted with bumpers to prevent entrapment and there were bedrails assessment and risk of falls assessments in place. Action plans were in place to manage the risks identified. For example, one person was a risk of falls and a 'magic eye' had been installed in the person's room. This comprised a laser beam that, if broken, would alert staff that the person had got out of their bed. This would enable staff to respond to the person and reduce the risk of harm.

Incidents and accidents were recorded and action taken to reduce the risks of incidents reoccurring. There

was detailed information around how the incident was followed up and what steps had been taken. For example, one person had two unobserved falls in their bedroom. Measures implemented to reduce the risk of further falls included lowering the person's bed and placing a mat nearby to reduce the risk of harm if they fell from the bed. This had reduced the person's falls. Staff understood what to do in the event of an emergency. One told us, "If an emergency occurred I wouldn't leave them by themselves. I would wait for the nurse. I would then write it in the daily notes and on an incident form."

There were appropriate plans in place in the event of an emergency such as a fire. Each person had a personal evacuation plan which was reviewed regularly by staff. These were left in the reception area and could be accessed quickly and easily if needed. Where people chose to smoke there were risk assessments in place and staff always ensured that people were offered a smoking apron. There was a business continuity plan in for event of an emergency for example, if the building needed to be evacuated or staff sickness.

People told us that they felt safe with staff. One person said, "I do feel very safe. The carers are all very good." Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. One member of staff said, "If I had concerns I would tell the nurse, or go straight to manager and she'll do anything necessary. We also have the safeguarding policy in the nurse's station." We saw that there was a policy in place and all staff had received training. There was a notice board where staff were reminded of the different types of abuse and what to do if they suspected abuse.

There were safe medication administration systems in place and people received their medicines when required. Nurses were available on each shift to ensure people received their medicines at the times they required them and the right dose. People's medicine administration records (MAR) were signed as appropriate and up to date. All MAR charts had a recent photograph to ensure the right person received their medicine. Staff completed medicine's audits weekly and monthly to ensure that people received their medicines as prescribed. Medicines were stored in a locked trolley in a locked clinic room and the keys were kept by authorised staff only.

Medicines that were required to be kept in the fridge were stored in the fridge. Daily temperature of the fridge and room were taken daily. For those people that were diabetic staff monitored people's blood sugar before the administration of insulin. Staff told us (and we confirmed) that they had medication management training annually and medicine competencies. When applying cream there were body maps to indicate where the cream should be applied. PRN protocols were used when giving 'as necessary medicines'. One relative told us, "She [their family member] got her painkillers when she needed it." When medicines were given the nurse waited for the person to swallow their medicine before walking away.

People were protected against the risk of infection as appropriate measures were in place. People and relatives felt that the service was always clean and that staff followed good infection controls practices. One member of staff told us, "It's important to follow good infection control to prevent cross contamination that could make people ill." We saw that daily room checks and cleans were being completed as seen on the check list on the cleaner's trolley. Rooms were also clean and tidy and with no malodours. The laundry room was well organised and staff ensured that soiled and non-soiled laundry were separated and washed appropriately.

People were protected from being cared for by unsuitable staff because robust recruitment was in place. We saw that there was an up-to-date record of nurse's professional registration. All staff had undertaken enhanced criminal records checks before commencing work and references had been appropriately sought from previous employers. Application forms had been fully completed; with any gaps in employment

explained. Notes from interviews with applicants was retained on file and showed that the service had set out to employ the most suitable staff for the roles. The provider had screened information about applicants' physical and mental health histories to ensure that they were fit for the positions applied for.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) is a legal framework about how decisions should be taken where people may lack capacity to do so for themselves. It applies to decisions such as medical treatment as well as day to day matters. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

We saw mental capacity assessments had been completed where people were unable to make decisions for themselves. These assessments were specific to particular decisions that needed to be made. For example, the use of a 'magic eye' to alert staff when one person got out of bed represented a restriction on the person's freedom of movement. A mental capacity assessment had been carried out to assess whether the person had capacity to consent to the equipment's use. The assessment identified that the person did not have the capacity to give informed consent to staff using the equipment. There was evidence that an appropriate process had been followed to ensure that the decision had been taken in the person's best interests, including recording the contributions of staff, relatives and healthcare professionals. We saw that DoLS applications had been submitted to the local authority where restrictions were put in place for people that were unable to consent for example, the bed rails and the locked front door.

People confirmed that they were asked consent before care was delivered. We saw from one care plan that one person chose to have bed rails and bumpers, "As she feels safer with it." This had been documented fully that the person had full capacity and consented to the bed rails.

People and relatives felt the staff were competent in their role. One person told us, "The carers are all so good." Another told us, "The nurses are terrific." A third said the care provided at the service was, "Very good."

Staff were sufficiently qualified, skilled and experienced to meet people's needs. New staff attended an induction and shadowed an experienced member of staff until they were confident to work independently. One member of staff said, "I did a week of shadowing. It was important to show me the needs of the residents." Nurses were knowledgeable about the management of clinical care including diabetes and wound care. Staff were up to date with the mandatory training and regular clinical training updates were provided to nurses. We saw that staff had received recent training on dysphagia and moving and handling. One member of staff said, "The training is good. You get used to doing things in a certain way. Things change and we need to be updated." Another told us, "Training is very good. Every time you learn something new."

Staff received appropriate support that promoted their professional development. Staff received one to one supervisions with their manager. One told us, "One to ones are starting to become more regular." Another told us, "We have group and one to one supervisions. I find them useful. If I have a problem I can speak with my manager." The clinical lead told us they and the registered manager spent time observing how staff provided people's care and addressing areas of poor practice. They said that a significant number of staff

had left as a result of this drive to improve standards but that the team in place now understood and demonstrated the standards required. They said, "It's a good team now; they are working together." Clinical supervision sessions took place with nurses every two months, although the clinical lead would meet more often if a nurse needed additional support. They also carried out annual appraisals for all staff.

The environment was set up to meet the needs of people living at the service. Handrails were in place throughout the corridors to help people mobilise safely. People who used wheelchairs were able to move around the building easily, including going into the garden. One person said, "I am able to come out on my own. It makes me feel free. It means I don't have to keep ringing the bell [for staff] if I want to come out." The dining room was nicely decorated with sensory flower decorations on the wall which people had helped creating. People's rooms had their names on the doors, but no memory boxes which we would suggest as these may help people orientate themselves to their rooms should they become confused.

People told us that they enjoyed the food and were offered choices. One person told us that the food was, "Excellent." Another told us, "The food is lovely. They [staff] come round and ask you what you want for lunch. I make up my own menu." The chef showed us a list in the kitchen with information about people's dietary needs. People were asked in the morning which menu option they would prefer. If they changed their mind at lunch time the other option was always available, plus other alternatives such as sandwiches and salads. One member of staff said, "If they [people] wanted something completely off menu, I'd speak to the chef and see what they could do." One person whose first language was not English had the menu translated into their language for them so that they knew what was available.

We observed lunch in the dining room. There was a menu with the choice of meals and people were offered a choice of drinks. Staff were attentive to people and checking they were happy with the food. Whilst people were waiting for the main meal to be served they were offered pieces of fruit. Staff asked permission to put neck napkins on people. Where people required support to eat this was undertaken in a patient and attentive way. Staff used different methods to encourage people to eat more. One member of staff said to a person, "Can you do me a favour? Can you test this [meal] for me as I've ordered the same and I want to know if it's nice." This encouraged the person to try the meal which they continued to eat and enjoyed. Staff were aware of who was diabetic and would therefore require an alternative pudding. People that ate in their rooms received their meals in a timely way.

People's nutrition and hydration was managed well at the service. There was an eating and drinking care plan in place for one person who had lost a significant amount of weight in the previous three months. There was evidence that staff had contacted the GP with their concerns about this weight loss and implemented the GP's recommendations. A food and fluid chart was in place and up-to-date. Nutrition and hydration assessments were completed for people regularly and people's weights were monitored.

Prior to moving into the service people's needs were assessed to ensure that the service was appropriate for them. Pre-admission assessments provided information about people's needs and support. Staff gathered information from the time of referral from different sources in planning the person's care. On the day of the inspection the registered manager was visiting a person in hospital to gain information about their needs prior to a decision being made about them moving in. Care and support was planned and delivered in line with current evidence based guidance. BUPAs 'Resident Care' standards incorporated relevant guidance that was specific to the services they delivered. For example, from the National Institute for Health and Care Excellence, British Journal of Nursing, Royal College of Nursing, Mental Capacity Act 2005 (MCA) and NHS England.

There was evidence in care plans that a range of healthcare professionals were involved in people's care.

One person said, "I have an appointment to see a specialist and they [staff] call the doctor if needed." We saw that staff supported people to access medical treatment when needed. Staff had recorded that they had contacted the person's GP if they became unwell. For example, one entry recorded, "Contacted GP as [person] is sleepy today and his food and fluid intake is minimal." Another entry demonstrated that staff had sought medical advice when the person experienced decreased appetite and subsequent weight loss. A healthcare professional had recommended supplements and these had been introduced. The clinical lead told us the tissue viability nurse was involved in one person's care and said, "She [the nurse] is happy with our dressing and how it looks." We saw that there were effective outcomes for people. One person said, "They [staff] involve me quite a lot in terms of my physio and walking again." A health care professional told us, "The staff are always welcoming and listen to my professional opinion regarding clients."

Staff worked well together across the service. One member of staff told us that staff were always available to give them advice if they needed it. They said, "There's always someone to ask." Another member of staff said of the staff team, "You need to get along. We are professionals." They said care and nursing staff now worked well together. They said, "If I have a concern about a resident I'll report it to the nurse. There is good communication [between staff] now. We try and support each other. We always have a handover." We saw that staff had a handover at the beginning of each shift that updated them with any changes in people's needs or concerns. They were also given a handover sheet, which contained a summary of each person's care needs and healthcare conditions. One member of staff said, "It's important to get updates about people's needs."

Good

Is the service caring?

Our findings

People told us that they thought staff were kind and caring. One person said, "Staff are so caring. Every morning I get a big hug and kiss. It makes me feel wonderful." Another person said, "[Staff are] very patient, very caring." One relative said, "They [staff] are so friendly and helpful."

Staff expressed how they felt about caring for people at the service. One told us, "I love working here. I love the residents. Everyone has something amazing about them. It makes my day coming here." Another told us, "I try to put myself in their shoes."

We observed that staff engaged with people in a kind and caring way. There was a relaxed and friendly atmosphere. Staff were proactive in their interactions with people, greeting them cheerfully when they entered the room and engaging them in conversation. We saw one member of staff stoop down to one person after an activity and say, "You did really well." The person smiled back at the member of staff. In the lounge another person called out to member of staff asking what the activity was going to be. The member of staff sat with them, held the person's hand and explained the activity. Another person called out that they wanted a cup of tea and staff made this for them. Blankets were placed over the knees of people by staff if they felt cold. When people sat in the garden staff offered them sun hats to wear. One lady came in late to an activity. Staff went straight over, welcomed them in and gently rubbed their arm. One member of staff told us, "We try and make it as homely as possible."

Staff spoke with people in a respectful manner and treated people with dignity. When people needed the toilet, staff approached them discreetly to speak to them about this. All personal care was delivered behind closed doors. One person said, "When they [staff] give me a wash they always close the door and shut my curtains." People were asked by staff if they wanted a serviette placed on them during lunch rather than them just being placed on them. One member of staff told us, "If were carrying a tray and can't physically knock [on a person's bedroom door] we'll say, 'knock knock'." We observed staff knocking on people's doors throughout the day. One member of staff said, "The residents' needs come first." We found evidence that the service proactively engaged with LGBT [Lesbian, Gay, Bi-Sexual and Transsexual] people considering their needs. One visitor told us, "The staff are fantastic, nothing too much trouble, smile. No problem, just do it."

We saw that family and visitors were able to visit the service whenever they wanted. During activities relatives and visitors were encouraged to take part. We saw one relative arrive in the lounge and was asked by a member of staff, "Would you like a cup of tea?" One person's relative told us they could visit at any time and were made welcome by staff. They said they had been invited to events at the service and had attended a garden party at the service the previous weekend.

We looked at care plans to ascertain how staff involved people and their families with their care as much as possible. People were able to make choices about when to get up in the morning, what to wear and activities they would like to participate in. We saw that care plans included information about people's background and things that were important to them.

Staff encouraged independence in people irrespective of their conditions and this was a feature in all the care of the people at the service. Staff encouraged people to do things rather than assume they could not do them. During lunch people were encouraged to eat independently and when people were playing games or doing arts and crafts staff supported people to move the pieces themselves. There were religious services planned for people of various dominations.

People were able to personalise their room with their own furniture and personal items and each room was homely and individual to the person who lived there. People were supported to communicate in a way that benefitted them. One person was unable to speak English. Staff were learning different words in the person's language and there was a book of words that staff could refer to when speaking to the person. Staff ensured that the television in the person's room was always on the channel from their country.

Good

Is the service responsive?

Our findings

At the previous inspection in November 2017 we found that people did not always have access to activities and people were socially isolated. At this inspection we found that this had improved significantly.

People and relatives were positive about the range of activities on offer at the service. One person said, "There are always activities going on." First thing in the morning there was a craft activity taking part in the lounge. The activities co-ordinator encouraged people to join in the activity that was taking place. Mid-morning there was an entertainer singing to people. People sang along, clapped their hands or tapped their feet clearly enjoying themselves. People were offered sherry and other drinks if they wanted. In the afternoon one person asked the activities co-ordinator for the 'daily quiz'. The person explained that the activities co-ordinator had quiz sheets available relevant to each day of the year. The activities co-ordinator brought the quiz and the person spent time completing it with their friend. One relative said, "The provision of activities here is excellent. He [their family member] goes to the garden, they ask to take him outside and give him a choice."

People in their rooms also had access to activities. One person said, "They brought the activity to me yesterday. It was food tasting. I think it's lovely that they do that." We saw that the PAT dog was also taken around to people's rooms in the afternoon. A PAT dog is a therapy dog that is trained to provide affection and comfort to people care homes. Staff gathered information about the people's interests and hobbies. For example, one person who was restricted in bed was able to watch their favourite programmes and listen to their music. Outings were also offered to people.

People had detailed care records which outlined individual's care and support. For example, personal hygiene (including oral hygiene), medicine, health, dietary needs, sleep patterns, emotional and behavioural issues and mobility. Any changes to people's care was updated in their care records to ensure that staff had up to date information. Staff always ensured that relatives were kept informed of any changes to their family member. Where people's clinical needs were identified steps were taken to manage this. For example, one person [that had a pressure sore] had pressure-relieving equipment in place as recommended, including a mattress, cushion and inflatable boot. Their wound care plan was evaluated and reviewed each week. For people that had diabetes there was a care plan in place which had been developed with input from a specialist diabetes nurse. Staff read people's care plans and contributed to their updates. One member of staff said, "I write and read the care plans. When you review care, it gives you a chance to look at other ways of looking after them."

The provider had systems in place to ensure people received appropriate end of life care. One care plan stated that the person would like to see London and [their country of origin] again. The registered manager told us that they were looking to expand on the planning of end of life but that this needed to be approached sensitively with people. We saw cards from relatives from people that were supported at the end of the lives. Comments included, "Thank you so much for caring for our lovely dad. Your kindness and friendliness to him is greatly appreciated" and, "Thank you for looking after [person's name]. He was always treated with kindness and respect. Long may your good work continue."

Complaints and concerns were taken seriously and used as an opportunity to improve the service. One member of staff told us, "If someone makes a complaint we discuss it in our daily handover so we can make sure it doesn't happen again." We reviewed the complaints received by the registered manager. Complaints had been investigated thoroughly and people and their relatives were satisfied with the response. For example, a relative had complained that their family member had not been supported to eat their breakfast. The registered managed met with the relative, offered an apology and discussed with staff the importance of supporting the person. They also introduced food and fluid charts so that they could monitor what the person was eating. A copy of the complaints policy was available in reception and in people's rooms.

Good

Is the service well-led?

Our findings

At the previous inspections in November 2017 and February 2018 we identified that there was a lack of robust quality assurance processes in place. The registered provider sent us an action plan to advise how these actions were being addressed. On this inspection we found that improvements had been made. The registered manager had made significant changes to the culture at the service.

People and relatives were positive about the leadership of the service. One person said, "She [the registered manager] is lovely. She manages the home very well." A relative said, "I have a good relationship with [the registered manager]." Another relative said, "It's like a small family." One health care professional told us, "She [the registered manager] is very approachable and was eager to receive any advice or guidance. We have nothing but praise for X. We look forward to working with her in the future."

At the previous inspection the registered manager had only been at the service a matter of weeks and had not had time to implement the positive changes we found on this inspection. Staff told us that the support for staff from management was better now than previously. They said the manager was supportive and approachable. One told us, "If we have a problem, we can go to her." Another told us, "She's [registered manager] very good. It's definitely improved since she's been here. People are now more interested in coming here." A third said, "The manager is very supportive. She understands us staff. She tries to help when she can." We saw evidence of this during the inspection when the registered supported staff with the meals for people at lunchtime.

Staff were involved in the running of the service. Staff told us team meetings took place each month and that the registered manager attended these. They said that the registered manager encouraged contributions from staff. One told us that if a member of staff suggested something, "She doesn't always say yes, but she considers it." Another told us, "Staff meetings are very useful. It's nice to see how other departments work and see what issues they may have. Everything is about the resident. We can discuss how we can do things better."

Clinical risk meetings took place weekly with nursing staff. One nurse told us that the clinical team discussed any people at risk, such as people who had lost weight or had swallowing difficulties and people who had developed pressure ulcers or were at high risk of falls. They said they were encouraged to contribute ideas about how to manage any risks identified. The nurse said, "More heads are better than one." This meant that staff were encouraged to bring forward their ideas to achieve the best outcomes for people. One member of staff said that one of the areas they had realised needed improvement was recording of information of people's care. They said they had given a clear message to staff that accurate recording was an essential element of providing effective care. They said that standards of recording had improved as a result. One member of staff said of the registered manager, "She's strict but she's lovely."

There had been an improvement with the culture of the staff at the service and staff felt valued. One member of staff said, "We work better as a team." Another told us, "'We work well together. Teamwork is stronger and things are more organised. Everyone has worked hard to make this place better. I was about to

leave last time you were here but now I am so happy here." A third told us, "I feel valued by the residents, the staff and by the manager. I get thanked and it feels nice." A member of staff told us that they felt valued as they were made employee of the month and received some wine and a bunch of flowers.

Staff understood the ethos of the service. One member of staff said, "We are here for the residents. To give them independence. We try to make them feel like they are in a family. We are here to support them with their every need." We found this to be the case during the inspection.

People and their relatives had opportunities to feedback their views about the quality of the service they received. There were regular resident and relative's meetings and surveys where people were asked for their views on the service. People had fed back that the garden required improvement and we saw that this had been done. One person said, "We have new garden furniture since [the registered manager] is here." People asked for an increase in activities and we saw that this had taken place. Comments on the surveys from people included, "Staff are very kind and nice. They are very thoughtful."

There was a comprehensive system of audits that were being used to improve the quality of care. There were monthly 'Quality and Compliance' visits undertaken by the providers regional teams that looked at all aspects of care in line with the individual CQC Key Lines of Enquiries. Each audit included an action of things that required improvement and time scales for these improvements. Examples included the need to ensure that the daily audits of MAR charts were completed and daily notes to be checked by nursing staff each day. We saw that this was now being done. In addition to the external audits, internal audits took place to look at the clinical care being provided, reflective supervisions to look at people's skin integrity, infection control audits and health and safety audits. Each audit had an action plan to address any areas of concern.

There was evidence that the provider was working with external organisations in relation to the care provision. Local schools visited the service every week, a MacMillan coffee morning has been organised and the local community have been invited to attend the event. One professional from an external organisation told us, "We feel that we have built a good relationship with the managers at Dene Place."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events.