Handsale Limited

Handsale Limited - Silver Trees

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

This inspection was unannounced and took place on 6 and 7 October 2016. Silver Trees is a purpose built home which provides accommodation and nursing care for up to 62 older people over two floors. There are communal areas on each, including lounge areas, bathrooms and dining areas. There were communal areas for people and their guests to use.

We last visited Silver Trees 18 and 19 February 2016. A number of breaches of legal requirements were found. After the inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Regulations that were breached were Regulation 11, Need for consent; Regulation 9, Person-centred care; Regulation 12, Safe care and treatment; Regulation 17, Good governance and Regulation 18, Staffing.

There was a registered manager in post. 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. People told us that they felt safe living at the home.

Staff were knowledgeable about the procedures to ensure that people were protected from harm.

Staff were also aware of whistleblowing procedures and would have no hesitation in reporting any concerns.

People received their medication as prescribed.

There were sufficient numbers of suitably qualified staff employed at the home.

The provider's recruitment process ensured that only staff who had been deemed suitable to work with people at the home were employed.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We found that the senior management team were knowledgeable about when a request for a DoLS application would be required. The registered manager told us that there were applications which had been submitted to the relevant local authorities and they were awaiting the outcome.

Staff respected and maintained people's privacy.

People were provided with care and support as required and people did not have to wait for long periods of

time before having their care needs met. This meant that people's dignity was respected and that their care needs were met in a timely manner.

People's assessed care and support needs were planned and met by staff who had a good understanding of how and when to provide people's care whilst respecting their independence.

Care records were detailed and up to date so that staff were provided with guidelines to care for people in the right way.

People were supported to access a range of health care professionals. Examples included appointments with their GP and a chiropodist.

Risk assessments were in place to ensure that people could be safely supported at all times.

People were provided with a varied menu and had a range of meals and healthy options to choose from. There was a sufficient quantity of food and drinks and snacks made available to people.

People's care was provided by staff in a respectful, caring, kind and compassionate way.

People's hobbies and interests had been identified and staff supported people to take part in their chosen hobbies and or interests to prevent them from becoming socially isolated.

The home had a complaints procedure available for people and their relatives to use and staff were aware of the procedure. Prompt action was taken to address people's concerns and prevent any potential for recurrence.

There was an open culture within the home and people were freely able to talk and raise any issues with the registered manager and staff team.

People, their relatives, staff and stakeholders were provided with ways that they could comment on the quality of care provided. This included regular contact with the registered manager, staff and completing annual quality assurance surveys.

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.

People had comprehensive risk assessments in place in order to help staff to support them in the most appropriate way.

People were supported by staff who had been assessed during recruitment as to their suitability to work with vulnerable people and they knew how to keep them safe.

People were supported by sufficient number of staff to meet their needs.

People's medicines were managed in a safe and effective manner.

Is the service effective?

Good

The service was effective.

People were supported by staff who had a good knowledge of them.

People were given effective care by staff who received ongoing training and development so they had the right level of skills and knowledge.

People received care in a way, which respected their rights.

People were helped to eat and drink enough and they had their healthcare needs met in a timely manner.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion by motivated staff.

People were listened to by staff and supported them to make their own decisions as far as possible.

People's privacy and dignity was respected and promoted.

Is the service responsive?

Good

The service was responsive.

People's likes, dislikes and preferences were accurately recorded in care plans.

Staff had information that enabled them to provide support in line with people's wishes.

People were supported to take part in meaningful activities.

People were supported to maintain relationships with people important to them.

People felt able to make a complaint and were confident they would be listened to and acted on.

Is the service well-led?

Good

The service was well led.

There was a registered manager.

Quality assurance systems were in place to monitor the service.

People were provided with the opportunity to meet with the management of the service to express their concerns and make suggestions for improving the service.

Improvements had been made concerning providing people with a well-led service. However, the provider must ensure the improvements continue to provide stability and good leadership and for the benefit of people who use the service.

Handsale Limited - Silver Trees

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 was 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.

The inspection took place on 6 and 7 October 2016 and was unannounced. One adult social care inspector; one specialist advisor with a nursing background and one Expert-by-Experience (ExE) carried out the inspection. An Expert-by-Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed information we held about the home, including notifications about important events, which staff had sent to us. We did not request a Provider Information Return (PIR) prior to our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. The provider therefore provided us with a range of documents, such as copies of internal audits, action plans and quality audits, which gave us key information about the service and any planned improvements.

We spoke with 19 people who used the service; they were able to tell us their experiences with the service. We spoke with other people but due to their communication needs, they were unable to provide us with detailed information about their care. We spoke with seven relatives of people who used the service to gain their feedback about the quality of care. We spoke with five visiting health professionals. We also spoke with the registered manager, deputy manager, the clinical lead, the residential floor manager and six care staff. We looked at nine people's care records, staff rosters and the quality monitoring audits. We did this to gain views about the care and to check that standards of care were being met.

Good

Is the service safe?

Our findings

The service was safe.

At the last inspection, the provider was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure that people were not protected against the unsafe use of medicines and staff did not have the qualifications, competence, skills and experience to do so safely. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

Medicines on the nursing floor were always administered by registered nurses and senior carers and the residential floor manager and senior carers on the residential floor and were stored and administered safely. A system of audits was in place to monitor the administration, storage and disposal of medicines. An audit of medicines was being completed by the deputy manager on a monthly basis which looked at general supply, administration and storage; stock control; Fridge and room temperatures had been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes; people who keep and/or administer their own medicines. This identified areas of improvement to be addressed, which had included; an up to date list of signatures for staff who administered medicines and all carers to read and sign the medication policy. We saw these actions had been completed. Medicines errors were recorded, investigated and action plans implemented. The registered manager analysed medicines errors and discussed them with staff. Staff explained what they had learned as a result of medicines errors.

People received their medicines in a safe and effective way. People said they were happy with the way their medication was given. Peoples' comments included "Staff leave my medication knowing I will take it. I do not like being treated as a child." And "All tablets are under lock and key, they make sure you take them, I am asked about the pain and whether I want the full dose, they also rub gel in." One relative stated, "I am satisfied with my loved one's pain management, they encourage them to take less."

There were no gaps in the recordings of medicines given on the medicines administration records (MAR). For medicines, which were prescribed as required (PRN), we saw staff recorded when these medicines were given. Protocols were in place for most medicines, which were prescribed PRN. For people who required medicines for pain, we saw pain assessment records were in use to monitor the use of these medicines. One person received an anticoagulant medicine. These medicines thin the blood and people who take them are at increased risk of bleeding or clotting if the medicines are not managed appropriately. Whilst this medicine was being administered safely and effectively, the risks associated with this medicine had not been clearly, provided in care plans to ensure staff were fully aware of these. Where people were prescribed creams, the nurses or care staff completed a body map with shaded areas and the name of the person, room number, what cream is put where and when.

Some people were at risk of developing pressure ulcers. Each person was assessed for pressure areas on admission, a body map completed and photographs taken of any wound. This was so staff could check that pressure areas were improving. Actions were taken to prevent pressure ulcers by using barrier creams and

providing people with pressure relieving cushions, air mattresses and profiling beds. There was clear evidence of Tissue Viability Nurse involvement. When a person declined to use pressure relieving equipment staff discussed the risks with them and recorded the person's decision. Care plans were updated to reflect this and additional preventative measures put in place. For example, more frequent checking of the areas at risk and the person's agreement to mobilise more often. The person's choice was respected and staff minimised risks of further deterioration.

When appropriate, people were proactively encouraged to take their medicines independently (self-administer). There were effective systems in place to monitor and support people who were self-administering medicines. There were no people being given their medicines without their knowledge, for example in their food or drink. However, there was a policy in place to support this practice, should it be required, which was in line with the Mental Capacity Act 2005.

At the last inspection, the provider was in breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed ensure that the service had a business continuity plan that covered all potential risks to people and their care and safety. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

A business continuity plan was in place and contained plans in the event of a major incident, such as, a gas leak or flooding. Emergency contingency arrangements were in place for people to be moved, if needed, to the nearby leisure centre, to keep people in a safe environment.

At the last inspection, the provider was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider did not employ enough staff to meet the needs of people living at Silver Trees. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

There were sufficient staff available to meet the needs of people. The registered manager told us they had a pretty stable group of staff who worked at the home and staff rotas showed there were consistent numbers of staff available each day to meet the needs of people. The registered manager told us how they worked closely with the registered provider to support any staff absence. When a staff member was absent from work through sickness, rotas showed these duties had been supported by other members of staff or specific named staff from a preferred agency.

The registered provider had a dependency tool which they would request information for should the home require additional staffing to meet the needs of people. Relatives and staff told us there were always sufficient members of staff on duty at any time to meet needs of people and our observations confirmed this. Call bells were answered in a timely manner and during mealtimes, we saw sufficient staff available to support people in the main dining area and to support those who chose to remain in their rooms. Staff carried out their duties in an unhurried and calm way and had opportunities to provide support for people without being hurried.

People told us they felt safe in the home, "I am happy enough here and feel quite safe" and "I feel safe because there is someone here throughout the night if I need them." People were supported by staff who knew them very well and understood how to support them to maintain their own safety. Relatives told us their loved ones were safe and were supported by staff who had a very good understanding of their needs and how to ensure their safety. Health and social care professionals said they felt people were safe and well looked after at the home.

Staff had a good understanding of the safeguarding policies and procedures which were in place to protect people from abuse and avoidable harm. All staff had received training on safeguarding and knew the types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC. The registered manager had worked closely with the local authority to address a recent concern which had been identified in the home. Records showed how the registered manager had reported the concern to the local authority and information on the investigation and learning from these was clearly recorded and shared in the service. Staff were confident any concerns they raised would be dealt with swiftly by the registered manager and they were aware of the registered provider's whistleblowing policy.

Risks associated with people's nursing and care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for maintenance of skin integrity, nutrition and mobility. For people who were at risk of falls, risk assessments had been completed and used to inform care plans about their mobility and how to avoid the risks of falling around the home. This included the identification of medicines which may have a significant impact on people's risk of falls. A log of falls had been recorded in each person's care records and was used to monitor and identify any patterns in their falls.

Most risks associated with people's health conditions had been identified and appropriate plans of care were in place to mitigate these risks. For example, for people who lived with diabetes or special dietary needs, clear risk assessments and plans of care gave staff information on how these risks should be managed. We spoke with the registered manager and deputy manager who told us this work had been identified following an audit and review of records and was being completed at the time of our inspection.

We saw care plans and risk assessments were being updated. For people who displayed behaviours that might present a risk to the person or others, the behaviours and triggers to these had been identified. Staff had a very good understanding of people's needs and the risks associated with these behaviours. They told us how they supported people to remain calm, access other areas of the home and express their concerns whilst maintaining people's safety. The actions they discussed reflected the risk assessments and care plans for people. For example, one person became agitated if there were too many unknown people in a room and the room was noisy. We saw staff spoke calmly with this person and supported them to move to a quieter area of the home during a busy time in the morning. The registered manager had ensured that there was information available to staff to help them support the person. We found the information was quite generic and the residential floor manager told us that as they knew the person really well, they would devise an individual support plan for them.

The registered manager reviewed, logged and investigated any incidents and then these were forwarded to the registered provider's head office. The registered manager monitored and reviewed these incidents for patterns and trends and supported the registered manager to investigate these.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, an application form and employment history for people. Two references were sought before people commenced work at the home. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff told us that they did not start work until all recruitment checks had been completed and the registered manager and staff rotas confirmed this. Staff files were stored securely, were well organised and included health questionnaires, proof of identity and a photograph. Nurses PIN numbers were checked to make sure they were registered with the Nursing and Midwifery Council (NMC) and a note of the expiry date was kept to prompt the registered manager to check the PIN was kept in date. A disciplinary procedure was in place and

was followed by the registered manager.

Standards of hygiene and cleanliness were appropriate. Protective personal equipment, such as, gloves and aprons were available and staff wore these as necessary. Alcohol gel dispensers were located throughout the service including at the entrance to each unit. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use. Bathrooms that had moving and handling equipment in them were maintained so that they remained safe and the equipment was clean. Clinical waste was disposed of using the correct yellow bags and placed in a clinical bin

Good

Is the service effective?

Our findings

The service was effective.

At the last inspection, the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had failed to ensure all mental capacity assessments were completed and were decision specific. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

People told us that they are free to decide when they get up or go to bed, and can please themselves what they do during the day. We heard staff seeking consent before providing care and support to people and waiting for a response before proceeding.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The registered manager and staff were aware of the legal requirements of the MCA and demonstrated their understanding of how to support people who lacked capacity to make decisions for themselves. They knew about the processes for making decisions in people's best interest and how they should support people who were able to make their own decisions. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Staff had received training and demonstrated their understanding of DoLS guidelines. The registered manager had submitted applications for a DoLS to the supervisory body (local authority) and they were awaiting the outcome.

We saw capacity assessments had been completed for specific decisions, for example the use of bedrails. Where people were not able to make the decision best interest meetings had been completed involving the person's relatives and healthcare professionals.

When people did not have the capacity to make complex decisions, meetings were held with the person and their representatives to ensure that any decisions were made in people's best interest. People and their relatives or advocates were involved in making complex decisions about their care. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf. Some people had made advanced decisions, such as, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). This was documented in people's care plans so that the person's wishes could be acted on. These were reviewed to make sure they were still required.

During our inspection, people made decisions and were offered choices which staff respected and supported. When people were not able to give consent to their care and support, staff acted in people's best

interest and in accordance with the requirements of the MCA.

At the last inspection, the provider was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. The provider had failed to ensure people received care and support from staff who had the skills and knowledge to meet their needs. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

Both people and their relatives felt staff were well trained and had the experience and skills required to care for them well. One person said, "They [staff] do a great job. Staff are excellent at personal care, they are experienced at making people feel at ease and they are always around and help me do the things I can't do for myself." Another person commented that, "They made sure I saw the doctor and attended my appointments."

Staff told us they received an induction when they started to work at the home. The induction included shadowing more experienced care staff and time to read and understand the policies and procedures for the home. The registered manager confirmed and we saw that new staff were working towards the new national Care Certificate as part of the induction process. The Care Certificate sets out the key common induction standards for social care staff. Information was available about the training staff had received and the future training the registered manager had planned for staff.

The training records showed staff skills were reviewed regularly and developed in line with the needs of the people who lived at the home. One staff member said, "We keep up to date with our training and do special courses like dementia so we know how to look after people in the best way". Staff were encouraged and supported to develop their skills further. For example, staff told us they had acquired, or were working on, level 2 or 3 qualifications in social care. Nurses told us how important it was to keep their skills updated and were aware of the revalidation process. (This was a new process that nurses in the UK need to follow to maintain their registration with the Nursing and Midwifery Council). We observed staff applying their skills in the right way when they did things like helping people with their personal hygiene needs and to move around.

Staff said that they were well supported by the registered manager, deputy manager and residential floor manager. They told us that they received regular supervision sessions which gave them the opportunity to discuss their day to day work role and any personal issues. They also received a yearly appraisals and observed practices. The registered manager and staff said they also used the sessions to identify and agree any additional training or development needs for each staff member.

Peoples care needs were identified and had been reviewed. Care records showed actions taken to respond to any increase or decrease in the support given. For example, when people needed to be cared for in bed any changes to the specific timings for support to be provided had been updated in order to manage those changes. People told us how they had been part of a review of their care. One person said, "I have a care plan and I have signed it." Records showed when people had been seen by healthcare professionals such as local doctors, community nurses, dentists and opticians. The family of a resident, whose health has deteriorated, praised the care they had received, and told us how they had been kept informed by both staff and GP of their condition.

We observed lunch on the residential floor. The tables were laid with drinks and condiments, the meal was served from a hot trolley, all staff were helping, and staff appeared to know each people's individual likes. The meals looked appetising, portion size was appropriate and sauce was served separately. People told us

that they enjoyed the range of food and drinks that were made available to them throughout the day. Comments from people using the service included, "On the whole the food is very good." "The food is always hot and tasty." "I always get a choice and if I don't like the choice they always get me something else." Records confirmed that the cook catered for a range of individual tastes and varied menus had been developed through asking people about their preferred meals. A number of people were on soft diets and their meals were planned and delivered in the way the people had been assessed. Care records showed where people were at risk of poor nutritional intake, their weight was checked regularly to help make sure it was maintained. Staff also told us when it was needed they understood how to make referrals to specialist services such as dieticians in order to request any additional support and advice they required. Tea and coffee with biscuits was served throughout the morning and afternoon and water jugs in residents' rooms were replenished frequently.

Good

Is the service caring?

Our findings

The service was caring.

People confirmed that they were treated with kindness and compassion. They spoke positively about the care and support they received. One person told us, "Yes, it's okay here, I'm happy and they look after me well." Another person said, "Staff are kind and caring". A third person added, "Everybody is so kind to me, I do not need much help but am always asked if there is anything they can do for me". Relatives commented, " My loved one has always been obstinate and has refused to co-operate and engage in ways to help them, staff have been so understanding and patient, they are lovely." and "Staff are caring and kind to my loved one, they understand their condition, and are encouraging".

We observed many positive interactions between staff and the people using the service throughout the inspection. Staff demonstrated a good understanding of the needs of the people they were supporting and their approach was personalised. For example, we observed one staff member interacting with people during breakfast giving them choices and talking with them about their day. We also saw that one person was upset and we saw staff comforting this person, by giving them one to one support. We also observed and overheard lots of laughter and chatter between staff and people. It was clear from the conversations we heard that staff were knowledgeable about the people they were speaking with and knew how best to engage them.

People confirmed they felt involved in making decisions about their care and day to day routines. One person commented, "I have my care my way. I am listened to by the staff." We noted that staff listened to people and provided information in a way that was appropriate for each person. We also heard them taking the time to check people were okay with the support and care provided. For example we heard comments such as, "Is that better?" and "How's that, are you comfortable?"

Regular formal reviews encouraged people and their family members to express their views about their care and be fully involved in how their support was delivered. Where people did not have relatives or family involvement we saw that advocates and other organisations could be involved to ensure their views, choices and decisions were heard. This meant that people felt listened to, respected and had their views acted upon. One staff member told us that they were trying to organise this for one person. We spoke to the person and they told us staff were actively seeking a befriender from "Silverline", a voluntary organisation that will offer them a weekly phone call.

The service had a fairly stable staff team, many of whom had worked at the service for a long time and knew the needs of the people well. The continuity of staff had led to people developing meaningful relationships with staff. A staff member told us, "It does make a difference having the same staff. We get to really know people."

People told us that staff were always respectful towards them and took every step to promote their privacy and dignity. One person told us, "They do manage to make sure everything is covered up and respect my

dignity." Another person said, "The staff show me courtesy and respect me." A relative commented, "They always knock on people's doors and they treat people with respect." Staff told us they respected people's privacy and dignity. One staff member said, "I treat people with manners. I'm never rude." A second member of staff told us, "We treat people with respect. It's just what do."

Staff told us that people received personal care in private; and chose what clothes they wished to wear and how they preferred to be addressed. We saw that people were able to exercise their right to privacy by staying in their room if they wished. Our observations on the day of the inspection showed that people wore clothing that reflected their age, gender and previous life style, and many were wearing chosen items of jewellery, nail polish and other accessories.
We also observed that if someone spilt food or drink on their clothes they were gently supported to change into clean clothes. This meant that people's personal choices were respected and their dignity maintained.

The service had systems in place to ensure that people's confidentiality and independence was upheld. We saw that staff were provided with training on confidentiality. Information about people was shared on a need to know basis. We saw that people's files were kept secure in filing cabinets and computers were password protected. Handovers took place in private and staff spoke about people in a respectful manner.

People were supported to maintain relationships with others. People's relatives and those acting on their behalf could visit at any time. One relative told us that they were able to visit their relative whenever they wanted and they were always made to feel welcome by staff and offered a drink as soon as they arrived.

Good

Is the service responsive?

Our findings

The service was responsive.

At the last inspection, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns that the provider had not ensured that records provided clear guidance for staff on people's individual needs. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. At this inspection, we found that the provider had made the improvements necessary to meet the requirements of the regulation.

At the last inspection, the care received by people was not personalised to the individual. We saw that care plans did not hold correct and accurate information about the needs of people living in the home. Additionally, the recording of people's care was not accurate and people's levels of need were inaccurately assessed. We saw at this inspection that people's needs were assessed and plans of care were developed to meet those needs, in a structured and consistent manner.

None of the people we spoke to could remember if they were involved in the development of their care plan, or were involved, as far as they knew, in any reviews. However, all the relatives we spoke with confirmed that they were fully involved in all aspects of their relative's care and had input into their care plan, as was their relative who was consulted in the decision making process.

The service was currently evaluating two different styles of care plans. All the care plans we looked at contained personal information, which recorded details about people and their lives. Staff told us they knew people well and had a good understanding of their family history, individual personality and interests, which enabled them to engage effectively and provide meaningful, person centred care. One member of staff told us, "The care plans and documentation have really improved; there has been a lot of work done on them". Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required meeting those needs, for example about the care of people with pressure wounds or continence needs. We looked in depth at some people's care plans and saw that staff were aware of the care that people needed and followed agreed plans of care.

Care plans also contained detailed information on the person's likes, dislikes and daily routine with clear guidance for staff on how best to support that individual. For example, one care plan stated that a person wished to have only female care workers assisting them, and that there was a specific way that they liked to wash. Another care plan stated that a person wished to have their medicines administered in a specific way, and we saw that this was done. The manager told us that staff ensured that they read people's care plans in order to know more about them. We spoke with staff who confirmed this was the case and gave us examples of people's individual personalities and character traits that were reflected in people's care plans. One member of staff said, "One resident always wanted their shower at a certain time and we had to make sure the bathroom was set up in a very specific way, so that they were happy". This meant staff were listening and responding to people's individual preferences.

The registered manager told us they encouraged people to visit the service before admission and gave them an opportunity to ask any questions they had. Before people started using the service a pre-assessment was completed so the provider could check, they were able to meet the person's needs. From this information, an individual care plan was developed to give staff the guidance and information they needed to support the person in the way they preferred.

The home provided activities seven days a week arranged by two activity co-ordinators. These activities varied from quizzes, arts and crafts, bingo, pampering sessions, exercises, visits from outside entertainers and trips to local shops and pub lunches. There were individual sessions for those people who stayed in their rooms to prevent any social isolation.

There were no organised activities on the morning of our visit though people had access to the activities room if they wished We saw one person made full use of the room to pursue their hobby of painting, and a pampering/nail painting session during the afternoon. We saw people on the nursing floor especially enjoying this. The activity co-ordinators were also completing comprehensive "All about me" documents to help them and staff organise activities that were more person centred and help staff know more about people.

People were regularly involved in activities and the service employed specific activity co-ordinators. There was a range of activities throughout the week, including weekends. Activities on offer included singing, exercises, films, arts and crafts and themed events, such as reminiscence sessions, pamper days and pub nights. One person told us, "I've had good conversations with [the activities co-ordinators]. A Church Holy Communion service was held once a month in the home and arrangements were made for those people who wished to attend services at local churches.
Several people had personal computers, tablets and personal land lines or mobile phones in their rooms. People were able to access the enclosed garden which was wheelchair friendly with wide flat paths, and could also if they wished, be escorted to the local park. The activity co-ordinator told us "There's an ethos of activities being important. [The manager] and senior staff stress it to all staff". We saw that activity logs were kept which detailed who attended the activity and what they thought of it, which enabled staff to provide activities that were meaningful and relevant to people.

Satisfaction surveys were carried out, providing the manager with a mechanism for monitoring people's satisfaction with the service provided. All people spoken with said they would feel comfortable in raising a concern if they needed to and were aware of how to make a complaint. The complaints procedure and policy were accessible and displayed in everyone's rooms. Complaints made were recorded and addressed in line with the policy with a detailed response. Most people we spoke with told us they had not needed to complain formally and that any minor issues were dealt with informally with the staff or registered manager.

Good

Is the service well-led?

Our findings

The service was well led.

At the last inspection, the provider was in breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had concerns that the quality and assurance systems were not sufficiently effective to ensure people's continued health, safety and wellbeing. We told the provider that improvements had to be made in relation to the quality assurance systems. At this inspection, we saw the provider had made the improvements required.

The registered manager had overseen a comprehensive improvement of practice using the internal management structure of the service. Both the residential floor manager and the deputy manager had recently completed their level five in management. These managers managed and oversaw both floors on a day to day basis. The clinical lead had responsibility for overseeing the care and support provided was consistent and reliable. They told us they had been involved with reviewing and reassessing people's risks and levels of individual support needs. The registered manager must now ensure this level of management support is maintained. Tto continue providing guidance and leadership on the floors benefiting and supporting staff and for the benefit of the people who used the service.

We saw that each person had received a review of their care and support. The registered manager told us that care and support plans were reviewed each month or when a change of need had been identified. We saw risk assessments and care plans had been reviewed and offered a current account of the level of support each person required. For example, we saw a person at high risk of falls had received a review of their care, their risk assessment and care plan had been updated with the information obtained from the specialist services. This ensured that all staff had the information available to provide the care and support appropriate for the person's current level of need.

People's medicines and MAR sheets were also continually reviewed and audited and saw evidence of action taken where medicine errors had taken place. Staff were not allowed to give medicines unless they had been re-assessed for competencies and had their practice observed by the deputy manager over an agreed period of time.

People at risk of malnutrition, dehydration or developing sore skin had their daily needs monitored. Checks had been implemented to ensure people received the care and support they needed and the monitoring documents accurately recorded all interventions. Staff offered reasonable explanations when we saw that the required targets had not been met. This corresponded with the information recorded in people's care and support plans.

Checks were made on a monthly basis of the number of incidents, accidents and falls people had experienced during the past month. Analysis was made of the incidents and action taken to reduce the risk of recurrence. For example where people had fallen, the possible reasons and causes of the accident were analysed and action plans drawn up. The action plans were revisited at regular intervals to ensure actions

had been completed within the agreed timescales.

People who were at risk of weight loss were identified and monitored through these monthly checks. The action taken to reduce further weight loss was made by referral to the doctor and dieticians in addition to providing high calorie snacks and fortified diets. Nutritional risk assessments were reviewed within the audit system to ensure they were accurate and recorded the current level of risk and the remedial actions.

People knew most of the management and staff by name. There were photographs of each member of staff displayed on the wall in the entrance to the home. All staff wore a uniform and a badge. The entrance / reception of the service was usually staffed by an administrator who greeted people when they arrived. People, their relatives and staff told us they thought the service was well-led. A relative commented, "[The manager] is great. Nothing is ever too much trouble". The leadership was visible at the service at all levels. The registered manager and other senior staff mentored and coached other staff to develop the staff team and provide a quality service. The registered manager was approachable and had an 'open door' policy. There was a clear and open dialogue between people, staff and the registered manager. The registered manager and senior management team knew people well and had a real understanding of the people they cared for.

Relatives meetings were arranged and at different times of the day to provide relatives the opportunity of attending at the most suitable time for them. At a recent meeting, staff and recruitment were discussed together with the action being taken to improve the service. Resident committee meetings took place at regular intervals which offered people the opportunity to discuss life at the service. Regular agenda items were the activities arranged for the month and any suggestions or ideas for other recreational activities and food. Regular staff meetings took place within the various departments. They discussed the care and welfare of people, any changes or improvements that were needed or had been implemented and any issues or concerns that had been identified. Additionally a head of department meeting was held on a regular basis, this was a brief meeting to discuss any changes that had taken place and any recent concerns or issues that had been identified. This meant there was an open environment where people were able to voice their views and the provided undertook improvements

The registered manager had a clear understanding of their responsibilities in recording and notifying incidents to the local authority and CQC. All services that provide health and social care to people are required to inform CQC of events that happen in the service so CQC can check appropriate action was taken to prevent people from harm. The registered manager notified CQC in line with guidance.