Anchor Trust

The Firs Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

The Firs Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. This service does not provide nursing care. The Firs Residential Home accommodates up to 40 older people, some living with dementia. There are four units in the service over two floors, Willow, Cedar, Pine and Holly. Each of the units held bedrooms, and communal kitchenette/dining and lounge areas. People could move freely between these units. There was a main kitchen where meals were prepared, laundry and communal areas that people could use.

On the day of our comprehensive unannounced inspection on 9 August 2018, there were 33 people living in the service.

At our previous inspection of 17 October 2017, this service was rated requires improvement overall. The key questions for effective, caring and well-led were rated good and the key questions for safe and responsive were rated requires improvement. Improvements were needed in how the service ensured people received their medicines for external application, including creams and how people's care records identified how their needs were planned for and met. There were no breaches of Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had brought this inspection forward because of concerns received. At this inspection of 9 August 2018, improvements had been made and the service was now rated good overall. However, the key question for safe was rated requires improvement, this was because improvements were needed in how the service ensured that there were enough staff to meet people's needs safely. The registered manager and district manager took immediate action to put additional staff on duty and we were assured that a staffing review would be taking place.

There was a registered manager in place. The last registered manager had left the service in November 2017 and the current manager was registered with the Care Quality Commission in April 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were provided with their medicines when they needed them. There were systems in place to manage people's medicines safely. Improvements had been made in how the staff recorded that people were provided with medicines administered externally, including creams. The risks to people were assessed and staff were guided on how to reduce these risks. Staff were trained in safeguarding people from abuse and where incidents had happened the service learned from these and used the learning to drive improvement. Staff recruitment processes reduced the risks of staff being employed in the service who were not suitable.

There were infection control systems in place to reduce the risk of cross contamination. The environment

was well maintained and designed to meet the needs of the people using the service.

People were supported by staff who were trained to meet their needs. People shared positive relationships with staff. People's privacy, independence and dignity was respected. People had access to health professionals when needed. Staff worked with other professionals involved in people's care. People's nutritional needs were assessed and met.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. People were listened to in relation to their choices, and they and their relatives, where appropriate, were involved in their care planning. Improvements had been made in how people's care was assessed, planned for and met. People's choices were documented about how they wanted to be cared for at the end of their life. People's had access to social activities to reduce the risks of isolation and boredom.

There was a complaints procedure in place and people's complaints were addressed in line with the service's policy. The registered manager had a programme of audits which they used to assess and monitor the quality of service provided. Where shortfalls were identified actions were taken to improve. People were asked for their views about the service and these were valued and listened to. As a result, the service continued to improve.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The staffing levels were assessed to provide people with the care and support they needed. However, these were not always robust. The registered manager and district manager took immediate action and were going to review the staffing arrangements. Recruitment of staff was done safely.

Risks to people were assessed and mitigated. This included risks in the environment, in their daily living and protection from the risk of potential abuse.

There were systems in place to manage people's medicines safely.

The service had infection control policies and procedures which reduced risks to people living at the service.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and supported to meet their needs.

People's nutritional needs were assessed and met. People were supported to maintain good health and had access to appropriate services which ensured they received ongoing healthcare support.

Deprivation of Liberty Safeguards (DoLS) referrals had been made appropriately. People's capacity to make their own decisions was assessed.

The environment was designed to meet the needs of the people who used the service.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was respected.

Staff treated people with kindness and they knew people well. Staff and people shared positive relationships.

People's choices were respected and listened to.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed, planned for and met. People's end of life decisions were documented.

There were systems in place to support people to participate in meaningful activities.

There was a system in place to manage people's complaints.

Is the service well-led?

Good

The service was well-led.

The service had quality assurance systems to identify shortfalls, address and learn from them.

The service provided an open culture. People were asked for their views about the service and these were used to improve the service.

The Firs Residential 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 unannounced comprehensive inspection took place on 9 August 2018 and was undertaken by one inspector, an inspection manager 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 ask that service's complete and send to us their Provider Information Return (PIR), which we received. 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 make.

We reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also reviewed all other information sent to us from other stakeholders for example the local authority and members of the public.

We spoke with 12 people who used the service and six relatives. We observed the interaction between people who used the service and the staff throughout our inspection.

We looked at records in relation to five people's care. We spoke with the registered manager, the district manager and nine members of staff, including one of the two deputy managers, senior care staff, care staff, an administrator, catering and domestic staff. We also spoke with a visiting health professional. We looked at records relating to the management of the service, three recruitment files, training records, and systems for monitoring the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection of 17 October 2017, the rating for this key question was rated requires improvement. This was because improvements were needed in how the service recorded that people received their medicines for external use, such as creams. At this inspection, improvements had been made in the areas identified as needing improvement at our last inspection. However, we found that improvements were needed in how the service was staffed to ensure that people were safe. This key question remained rated as requires improvement.

We received varied comments from people who used the service and their relatives about if they felt that there were enough staff on shift to support them. Some people and relatives said that they felt that the staffing was sufficient, others said that it was not. One person said, "Usually staff have not got time to talk. Got a bell sometimes they answer sometimes not." One person's relative said, "Weekends they need a bit more staff, they always seem to not have many staff, week days not so bad." Another relative commented, "They don't have enough staff, one on each unit and a floater. Sometimes there is none on the unit, [family member] is a double up and they need two on each unit. They used to have time to sit and talk to them and do their nails."

Staff's views about staffing levels varied, with some saying they felt there were enough staff and others saying there were not. One staff member told us that they felt that there was a high dependency level on one of the units and there was not always enough staff. Another staff member said, "There is not enough [staff], run ragged on the floors, strive to do the best they can and really care."

As well as supporting people, care staff had additional duties which they were required to do. In the morning hot breakfasts were provided in the units in a hot trolley from the main kitchen. Care staff served breakfast, made hot drinks and toast and cleaned up. This was in addition to assisting people to get up and answering call bells. During lunch care staff served meals and assisted people with them, where required.

A staff member told us how some people required the support of two staff with their personal care needs. There was a person waiting to get out of bed until there was another staff member available. We observed that there were times when the communal areas were left with no staff in them, considering recent notifications we had received of incidents between people using the service, staff should be available to reduce the potential of incidents happening.

We reviewed falls audits which identified that, for example, in July 2018 nine unwitnessed falls had been in the communal areas, in June 2018 there were seven. This indicated that, whilst falls may not be prevented when staff were present, there was a high number of unwitnessed falls in the communal areas. Where people were at risk of falls actions were taken to reduce future risks. This included referrals to health professionals to obtain guidance and the use of equipment to alert staff if a person was attempting to stand without assistance. People's care records identified that when falls had happened, there were 72 hour observations in place to monitor their wellbeing. One person's relative told us, "[Family member] had a fall last night, they rang and told me, rang again when the paramedics came, [family member] is on warfarin so

had to go to the hospital and brought her back at 1am, was kept updated throughout."

The registered manager told us how the service was staffed, recently there had been less staff on shift because there were less people living in the service. As more people moved in then the staffing levels would be increased. The district manager told us that the service used a tool which assisted with the calculation of the staff numbers needed to meet people's dependency needs, this considered the layout of the service. They reviewed this tool regularly and spoke with staff about if they felt staffing levels were sufficient. The management team were not made aware of any concerns from staff about the staffing levels. There had been some concerns received from staff about long day shifts, so consultation had taken place and they were changing shift patterns to shorter shifts. However, the current use of the staffing tool was not sufficient to assess a safe number of staff to reduce the risks to people receiving unsafe care and incidents between people and falls.

We spoke with the district manager and the registered manager about the staffing levels in the service and what we had found, including unwitnessed falls and the tasks care staff were required to complete. They agreed that a full review of the staffing levels in the service would be completed, until this was undertaken additional staff would be put on each shift. We were advised the following day that the additional staff were in place. We were satisfied that this immediate action reduced the risks to people living in the service.

Records showed that checks were made on new staff before they were employed by the service. These checks included if prospective staff members were of good character and suitable to work with the people who used the service, from previous employers and checks with the Disclosure and Barring Service (DBS). DBS checks identify if an individual has any convictions in their history.

Despite our concerns about the staffing levels the majority of people told us that they felt safe living in the service. One person said, "I think I am well looked after, I feel safe." One person's relative commented, "[Family member] is safe here, got an alarm on the wall and they clip it to [their] shirt so if [family member] goes forward it goes off and they rush to [family member]." Another relative told us, "[Family member] is safe, staff are caring, I trust them all, I visit every day and any concerns I can ask questions and things get sorted." However, one person's relative told us about incidents relating to their family member and another person which affected their family member's wellbeing. We discussed these issues with the registered manager and deputy manager and were assured that the service was doing as much as they could to reduce associated risks to all of the people involved, including seeking the support and guidance from other professionals.

Staff told us that they had received safeguarding training and this was confirmed in training records. Staff understood their roles and responsibilities in reporting safeguarding. There were notices posted in the service advising of how to report safeguarding and whistleblowing, which is the reporting of concerning practice. Where safeguarding concerns had been reported, we saw that the service had acted to drive improvement and reduce the risks of similar incidents happening in the future. This included internal investigations and where it was identified things had gone wrong actions including, disciplinary action, training, workshops and increased checks on report writing were undertaken.

People told us that they were satisfied with the arrangements for their medicines administration. One person's relative said, "They are on the ball with medication." We observed part of the administration rounds during the morning and lunchtime, this was done safely.

Improvements had been made since our last inspection, in how the staff recorded when people had received their medicines to be administered externally, such as creams. The completion of medicines

administration records (MAR) for these medicines had improved and demonstrated that people had received their medicines as prescribed. The MAR for medicines to be taken orally, identified that people received their medicines when they needed them. Some people were prescribed medicines to be taken as required (PRN). There were protocols in place for all of these medicines to guide staff on when they should be considered to be given to people. It had been assessed that some people required their medicines to be administered covertly, such as hidden in food. The records in place identified that the appropriate actions had been taken to ensure that this method of administration was safe and appropriate.

Records showed that staff who were responsible for administering medicines had received training and had their competency checked by the management team. Medicines were stored safely in the service and there were systems in place for the ordering and disposal of medicines. Regular checks were undertaken, these included temperatures, stock balance and audits.

Care records included risk assessments which provided staff with guidance on how the risks to people were minimised. This included risks associated with mobility, pressure ulcers and falls. Where people were at risk of developing pressure ulcers systems were in place to reduce these, this included seeking support from health professionals and the use of pressure relieving equipment. Some people were at risk of developing pressure ulcers, there were records in place which identified when they were supported to reposition to reduce this. However, we spoke with a staff member about gaps in these records for during the day. They explained that this was when the person was out of bed and in a chair, but they were still assisted to move at periods during the day. They showed us daily records which evidenced this. The staff member and the registered manager agreed that they would look at how they could improve recording this and refer to the two records to give clear details of the support provided. The registered manager told us that there were no people in the service who had pressure ulcers at the time of the inspection.

Risks to people injuring themselves or others were limited because equipment, including hoists, and fire safety equipment, had been serviced and checked so they were fit for purpose and safe to use. Portable electrical equipment had been checked to ensure they were safe. There was guidance in the service to tell people, visitors and staff how they should evacuate the service in the event of a fire. Fire safety checks were undertaken and there were personal evacuation plans in place for each person to ensure that staff were aware of the support that people needed should the service need evacuating. However, there were some safety risks in the service which needed attention. This included a television in Willow, which was plugged into a multi socket which was hanging from the television wires. The registered manager and district manager assured us this would be addressed.

People told us that the service was regularly cleaned. One person said, "It is always clean, they do a good job." One person's relative told us that their family member's, "Room is always spotless whenever we come."

The service was visibly clean throughout. Infection control and hand hygiene audits were carried out. However, there were some areas of the service which needed attention, including unclean plug holes and overflows in sinks. The audits did not include checks on these areas. The registered manager and district manager said they would address this.

We checked equipment including wheelchairs which were clean. Records identified that cleaning of the service was completed, including mattresses and equipment. Staff had received training in infection control and food hygiene. The service had achieved the highest rating in their recent food hygiene inspection by the local authority. There were disposable gloves and aprons that staff could use, such as when supporting people with their personal care needs, to reduce the risks of cross contamination. These were available throughout the service to allow access. There was hand sanitiser around the service and notices around the

service with directions for effective hand washing methods. In addition bathrooms provided disposable paper towels and hand wash to use to reduce the risks of cross contamination.

Good

Is the service effective?

Our findings

At our previous inspection of 17 October 2017, the rating for this key question was rated good. At this inspection the service had maintained the good rating in effective.

People's care needs were assessed, planned for and delivered holistically. This included their physical, mental and social care needs. A staff member told us about the assessment process which was completed prior to the person moving into the service. This included visiting them at their own home, other care service or in hospital to discuss their needs. This assisted a smooth transition between services. Discussions with staff showed that the service worked with other professionals involved in people's care to ensure they received a consistent service. This included the commissioners for services and health care professionals.

People and relatives said that the staff were skilled to meet their needs. One person said, "They are all very good, they know what they are doing."

Staff told us and training records showed that staff received the training that they needed to meet people's needs and the requirements of their role. This included training in safeguarding, moving and handling, fire safety, health and safety, falls and medicines. In addition, staff received training in equality and diversity, nutrition and hydration, and dementia to meet the needs of people with specific needs. The registered manager told us that they had arranged additional training for staff in falls prevention, and dementia friends.

New staff received an induction course which included training and shadowing more experienced colleagues. Where new staff had not completed a recognised qualification in health and social care, they were supported to complete the Care Certificate. This is a recognised set of standards that staff should be working to.

Staff told us that they were supported in their role and received supervisions. These provided staff with a forum to discuss the ways that they worked, receive feedback, identify ways to improve their practice and any training needs they had.

People's told us that they were provided with a choice of meals and that they got enough to eat. One person said, "Breakfasts are good here and we sit down and talk. Lunch is a cooked meal and they know what we like and bring the stuff we like." Another person commented, "Food some days are better than others, on the whole alright, get a choice, don't get a lot of fruit, maybe I would like more." Another person said, "Food is very nice." After lunch one person said, "Very nice, I enjoyed that it was very nice, lovely."

During meals we saw that people were offered choices of what to eat. This was done by staff showing people the two choices from the menu on plated up meals, to allow them to make their choice. Staff offered encouragement to eat and staff were available to assist those that needed help. During lunch we observed that there were no napkins available for people to use. This had been identified in the service's own meal time experience audits, and records of these showed that napkins had been ordered.

During the morning of our inspection after breakfast and before lunch people were offered snacks. A staff member looked in the cupboard and said to a person, "I've got some jaffa cakes here, do you want some?" the person agreed and were provided with them, these and other biscuits were also offered to the other people present.

People told us that they got plenty to drink to reduce the risks of dehydration. One person said to us when they asked the staff to top up their cold drinks, "I get plenty." We saw people were regularly offered choices of hot and cold drinks. There were jugs of cold drinks around the service that people could help themselves to.

People's records included information about how their dietary needs had been assessed and how their specific needs were met. This included people who were at risk of choking or malnutrition. Where people were at risk of not eating and drinking enough, this was monitored and people were encouraged with their nutritional requirements. Other professionals were contacted for guidance and support to meet people's needs, such as a dietician or the speech and language therapy (SALT) team. One person's relative told us, "[Family member] lost a huge amount of weight before they came and we were very concerned, they had the GP and were weighing [family member], very caring they were…They initiated a staff to sit and eat a meal with [family member] otherwise they will not eat, they stabilised [family member's] weight, was 30 kilos and probably 45 now, they picked up on the weight loss."

Staff spoken with, including catering staff, understood people's specific dietary needs and how they were met. This included people who required a softer diet and those who needed a fortified diet and drinks to boost their calories and maintain a healthy weight. A member of the catering staff said that people made choices about the menu in meetings and the chef did taster sessions where people and their relatives could sample suggestions for the menu.

People told us that they felt that their health needs were met and they were supported to see health professionals if needed. One person said, "They can call a doctor or nurse for you." One person's relative said, "If [family member] is not well they are quick on getting the doctor."

Records showed that where there had been concerns about a person's health, they were referred to health professionals and any advice and treatment was recorded. Some people demonstrated behaviours that may be challenging to others. Records and discussions with the registered manager and the staff identified that actions had been taken to seek the support of other professionals to support people.

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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's care records included if they had capacity to make their own decisions. If people lacked capacity there were systems in place to assist them. There were records of best interests decisions in place, for

example when people required to have their medicines hidden in food. Training records identified that staff had received training in the MCA and DoLS. Staff asked for people's consent, for example where they wanted to be in the service and if they needed any assistance with their meal.

People were complimentary about the environment and how it met their needs and choices. One person said, "I am comfortable here." People could move freely around the service. There was signage in the service, including on people's bedroom doors, which assisted them to mobilise independently around. Relatives spoke of liking the freedom of the service for them and their family members.

People's bedrooms included items of their personal memorabilia which reflected their choices and individuality. The environment had communal areas that people could use, including lounges and dining area. There were areas in the service where people could see their visitors in private. The facilities were designed and adapted to be accessible for the people using the service, this included, wide corridors which enabled people who used mobility equipment to mobilise freely. Bathrooms had wide doors which supported people to access them easily when using mobility equipment, and there were grab rails in the corridors and bathrooms.

There were gardens which people could use. People could access the gardens and take part in its upkeep. The gardens surrounded the service and were mainly secure. However, we had been notified that a person was able to leave the service by breaking to wooden panelling. The staff had taken action to reduce the risks to the person.

Good

Is the service caring?

Our findings

At our previous inspection of 17 October 2017, the rating for this key question was rated good. At this inspection the service had maintained the good rating in caring.

People spoken with said that the staff were caring. One person said, "Staff are so excellent, they couldn't be better." Another person commented, "I really love it here, staff all friendly. I cannot complain about any of them, they are very good, I am delighted with them, practically everyone knows me." Another person told us, "I think they are kind to me." One person's relative said, "I cannot fault the staff as they are caring as you can get, marvellous." Another relative commented, "I feel I know them [staff] and they know my [family member]. [Family member] has a good sense of humour and [staff member] often tells me things that has made them laugh." Another relative said, "Chef did the murals, the art work [around the service], it feels like a family and they do care."

We saw cards and letters sent to the service thanking the staff for the care and support provided. One card thanked staff for, "All the loving care and attention you gave to [person] during their brief stay." Another commented on the care provided which was delivered in a, "Professional and genuinely caring way."

There was a relaxed and friendly atmosphere in the service and people and staff clearly shared positive relationships. One staff member said, "We love our residents, we are a good team." Staff talked about, and with people in a caring and respectful way. This included positioning themselves at people's eye level to engage in effective communication and the use of touch to reassure people. Staff spoke about people in a compassionate way and clearly knew people well. One person had their hair styled in the morning, when they returned to the communal area in one unit, a staff member said, "Check you out." Which made the person smile and did a pose to show their hair.

People told us how they had developed friendships in the service. One person said, "Nice here, got nice friends, staff treat us well, nice friendly place, [other person] is my friend."

People told us how their independence was promoted and respected. One person said, "Staff are excellent, I mentioned I would like a shower this morning and they were straight on it, I was trying to do it myself but became too much, it was marvellous, had a bath the other day." During lunch people had equipment which assisted their independence, including bowls with raised edges. One person with sight loss was supported by staff who explained what was on their plate and where each item of food was to assist them to eat independently.

People's care plans guided staff to ensure people's privacy, independence and dignity was respected. Staff knocked on bedroom and bathroom doors before entering.

People told us that they made choices about their daily lives and the staff acted in accordance with their wishes. One person said, "I get up 8am-ish, get washed and choose my own clothes and then I come to the dining room." People's relatives told us how they contributed to planning for their relative's care. One

relative said, "I have sat down and gone through [family member's] records, six monthly and [family member's spouse] is kept updated all the time. Care plan is gone through and if we wanted to add something they would add it."

People told us that they could have visitors when they wanted them, which reduced the risks of isolation and loneliness. Records included information about the relationships that people maintained which were important to them. One person's relative said, "[Family member] likes playing pool, there are things to do for when [family member's spouse] comes here and in fine weather they sit in the garden, local groups come in and do music." Another relative said, "I like being able to go and make a cup of tea for us both, like home."

Good

Is the service responsive?

Our findings

At our previous inspection of 17 October 2017, the rating for this key question was rated requires improvement. This was because improvements were needed in how people's care was assessed, planned for and met. At this inspection, improvements had been made and responsive is now rated good.

People told us that they felt that they were cared for and their needs were met. One person said, "I am very happy." One person's relative told us, "We are very happy with [family member] here and would not move [them]."

We saw an example of how staff responded to an incident. A person was walking from having their hair done and they looked as if they were going to fall. We turned to ask staff to see to the person and they had already spotted it. They quickly went to the person and walked with them to a chair. They were reassuring and caring with the person.

People's care records had improved and demonstrated that people received care which was tailored to their individual needs. The records clearly identified how people's needs had been assessed, planned for and met. People who had conditions which may affect their wellbeing, had care plans which identified how their conditions affected their daily lives and any warning signs staff should be aware of, such as signs and indicators of becoming unwell associated with diabetes.

Guidance was in people's care plans for actions staff should take to reduce risks to themselves and others, when supporting people with behaviours that others may find challenging. One person's relative said, "[Family member] had an altercation with another resident and the staff intervened and they try and keep them apart, they handled that well, they cope well with [family member's] aggression."

People said they had opportunities to participate in meaningful activities. One person said, "Been to shows here, play cards, couple of times been in the garden, went to the beach, no cooking but don't want to." A person's relative told us that their family had been taken to the slot machines locally.

The provider had changed the way that activities were provided in their services. This included all staff had received training in how meaningful activities could be incorporated into people's daily living. This included as well as care staff, gardening, domestic and maintenance staff. There were plans to have champions in roles to support people with specific areas. A care staff member told us that they were going to be the tablet champion, which involved supporting people to use a tablet computer. The plan was for each champion to have four hours each week to spend on doing their champion role with people. Staff spoken with were positive about the training they had received; however, it was still early days to assess if this was effective. One staff member told us about the changes and said, "Not sure how it will work, but the training was good, we are going to give it a go." They said that they would be encouraging smaller one to one activities and smaller groups.

There was a music room on the first floor which was well stocked with musical instruments and a piano and

stage. People sat and listened to music and handled the instruments during our inspection. A staff member told us that the piano needed tuning, we had seen that a person played the piano in their bedroom and some people were singing along to it. The district manager told us that the communal piano would be tuned to support communal activities led by the people who used the service. There was also a pool table in the music room, we were told that a person played with their relative, in addition their relative had been allocated a part of the garden, and the person helped with planting and tending the garden.

People participated in a range of activities during our inspection. This included a person collected plates from their table after lunch and took them up to the care staff who thanked them for their help. A new large piece jigsaw and games had been delivered to the units. A person played snakes and ladders with a staff member. An impromptu sing song was started by staff and all people in the unit joined in. When the song had finished people started other songs, which were then joined in with by staff and other people. One person read the newspaper, a staff member said that daily the person had their newspaper delivered and read it all day. There was an afternoon tea activity, with singing and lots of laughter.

There were muffs with items on them such as buttons and things to feel and stimulate the senses of people, placed on the backs of chairs for people to use. One person had one on their lap, another person was handling one and laughed and said to staff that they were, "Messing," with the item.

People told us that they knew how to make a complaint and that they were confident that their concerns and complaints would be addressed. There was a complaints procedure in the service, which advised people and visitors how they could make a complaint and how this would be managed. Records showed that people's complaints and concerns were investigated and responded to in line with the provider's complaints procedure. This included giving a written apology where needed. Where concerns had been received the service had learnt from these and used them to drive improvement.

People's records included their decisions about the care they wanted to receive at the end of their life. For example, if they wanted to be resuscitated, where they wanted to be cared for, specific choices relating to their care at the end of their life and any arrangements they had made for their funerals. A notice board in the service advertised upcoming training for staff in dispelling the myths funeral training. Training had also been organised for staff in end of life care from a local hospice.

Good

Is the service well-led?

Our findings

At our previous inspection of 17 October 2017, the rating for this key question was rated good. At this inspection the service had sustained the good rating in well-led.

Since our last inspection there had been management changes. The previous registered manager had left the service in November 2017. The current registered manager was registered with the Care Quality Commission in April 2018. The registered manager had a good understanding of people's needs and was able to provide us with information about individuals promptly. The registered manager was visible in the service and we could see that people knew who they were and responded to them positively. We saw the registered manager speaking with a person and they held hands whilst they were interacting. The person was clearly comfortable with the registered manager. Another person went into the office to speak with the registered manager, they sat down when they entered and they chatted to each other. One person told us, "I like the people that run it, they are like my friends."

Staff were positive about the registered manager and the district manager. One staff member told us that they thought that things had improved at our last inspection but the new management team had made further improvements. Another staff member commented, "We all work together, we have a good manager and good team. I know the area and this [service] is the best."

The district manager told us that they visited the service on a monthly basis. They undertook quality assurance checks. They told us about improvements that were being made, this included replacing the carpets in the communal areas. The district manager told us how they valued the opinions of staff and had responded to their comments, including changing duration of shifts to shorter ones. Staff could be nominated for employee of the month, for going over and above their duties. Staff meetings were held where they discussed any changes in the service and in people's needs.

There was a programme of audits which were used to monitor the quality of service provided. This included audits in falls, care plans, medicines, infection control and dining experience. There were actions in place where shortfalls had been identified, to improve. This included ordering napkins for meal times and staff had been booked on training where it had been identified that people's experiences could be improved. Action plans were formulated and these were monitored to show when the improvements had been implemented. This included staff being booked on end of life care training, where gaps were identified.

People and relatives were involved in developing the service and were provided with the opportunity to share their views. This included quality assurance questionnaires. Actions taken as a result of the responses received were included the introduction of an engagement champion. People and their relatives could attend meetings to discuss the service. One person's relative said, "[Family member] goes to the resident relative meetings." Notices were posted around the service with the monthly dates of the engagement meetings. The minutes of the meetings attended by people and relatives demonstrated that they were kept updated with changes in the service such as staffing and they were asked for their views in areas such as the menu.

The registered manager and district manager took immediate action to address the issues we were concerned about relating to the staffing in the service. This was because the needs of people had increased. This demonstrated that the management team were responsive to our feedback and to provide people with safe care.

There was information for staff in the staff room, this included a policy on the new General Data Protection Regulation which was implemented in May 2018. This demonstrated that the service kept up to date with changes.

The registered manager told us how they were developing links with the community. This included working with the dementia alliance team in Felixstowe, the local hospice, they had met with a manager of a local dementia café, and were looking at ways to include members of the community in initiatives to prevent loneliness. The registered manager was also building links with local school and choir.