Surrey Rest Homes Limited

Heath Lodge 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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection of Heath Lodge took place on 28 March 2017 and was unannounced. This inspection was to follow up on actions we had asked the provider to take to improve the service people received.

Heath Lodge is registered to provide accommodation with nursing care for up to 24 people. At the time of our visit, there were 21 older people living at the home. The majority of the people who lived at the home were living with dementia, some have complex needs. The home also provides end of life care. The accommodation is provided over two floors that are accessible by stairs and a stair lift. The service is a detached house with communal lounges, dining room, kitchen and bathroom facilities.

The service had a registered manager in place. 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.

At our previous inspection on 12 April 2016 we found a breach of one of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to take action in relation to the systems in place to assess and monitor the quality of the service provided. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by 30 August 2016. We also made three recommendations to the provider in regard to infection control, risk management and deployment of staff.

During this inspection we found that improvements had been made and breaches of the regulation were now met.

There had been some improvements to the environment with new carpets and flooring fitted and further improvements were planned. The were arrangements for managing good hygiene and infection control in place. This reduced the risk of cross infections and maintained a clean environment.

Risks to people's safety had been assessed and staff knew what actions to take to minimise these risks.

People received their medicines as prescribed and on time and the storage of topical creams had improved.

Recruitment systems had improved and new staff would all have the necessary checks in place prior to them starting work, which minimises the risk of unsuitable staff being employed.

There were enough staff effectively deployed to meet people's needs which meant people were assisted with their care in a reasonable time.

People made positive comments about their care, how good the staff were and how much they liked living

in the home.

Staff had clear understanding of their responsibilities regarding the Mental Capacity Act or Deprivation of Liberty Safeguards. Where people lacked capacity they were assessed and best interest meetings had taken place when specific decisions needed to be made.

Staff were trained and supervised. A new supervision system was in place to ensure all staff received regular support and supervision, which included clinical supervision for the nurses.

Care plans had improved and although there were further on-going improvements to make the staff could see from these plans what care they needed to give to each person. Staff understood peoples needs and they could describe how people preferred to be helped with their personal and healthcare needs.

People told us that the activities that were provided could be improved. Although activities took place we have recommended that more emphasis is placed in personalising activity and occupation, especially for people living with dementia.

There were quality assurance systems in place, to review and monitor the quality of the service provided. Audits had been carried out and this had led to an action plan to continue to improve the service.

People had enough to eat and drink throughout the day and they were offered choices.Where people needed support with eating; they were supported by a member of staff.

People were supported to have access to healthcare services and healthcare professionals were involved in the regular monitoring of their well-being. The provider worked effectively with healthcare professionals and was pro-active in referring people for assessment or treatment.

Staff treated people with compassion, kindness, dignity and respect when providing care. Staff told us they always made sure they respected people's privacy and dignity before personal care tasks were performed. People were able to personalise their room with their own furniture and personal items so that they were surrounded by things that were familiar to them. People's relatives and friends were able to visit.

People knew how to make a complaint. People told us if they had any issues they would speak to the manager. People told us the staff were friendly, supportive and management were always approachable.

During this inspection we have made one recommendation.

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 providing safe care.

People were protected from the risk of infection.

Following the inspection we saw that peoples' medicines were stored safely. People received their medicines as prescribed by trained staff.

Safe recruitment practices were followed.

There were effective safeguarding procedures in place to protect people from potential abuse. Staff were aware of their roles and responsibilities.

There was a contingency plan in place in the event of an emergency.

Is the service effective?

Good

The service was effective.

The Mental capacity Act 2005 procedures were improved and capacity and best interest decisions were taking place as needed. Staff sought people's consent prior to delivering care.

Staff including the nurses started to receive supervision regularly shortly following the inspection.

People had enough to eat and drink. People were supported to have their nutrition and hydration needs met.

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

Is the service caring?

Good

The service was caring.

The staff were caring, kind and compassionate towards people.

Staff understood people's needs and how they liked things to be done. People's likes and dislikes had been taken into consideration.

People's relatives and friends were able to visit.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's activity and need for stimulation was not always based on individual's care needs, preferences or hobbies and interests.

Activities were on offer for those that could and choose to participate.

People were able to express their views and were given information how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The registered manager was caring and able to lead a staff team who knew people well and had their best interests at heart.

The registered manager was supported by a deputy when they were attending to their duties in another service. The staff felt supported. Quality assurance systems were in place and the registered manager had worked with other agencies to identify shortfalls and areas for improvement and action was being taken to improve.

Care records were accurate and up to date. although the registered manager had recognised that staff needed further guidance and training to maintain meaningful records about people's daily lives and care. The provider sought, encouraged and supported people's involvement in the improvement of the service.

People told us the staff were friendly, supportive and management were always visible and approachable.

Heath Lodge 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 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.

This inspection took place on 28 March 2017 and was unannounced. The inspection was conducted by two inspectors, a nurse specialist 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.

Before the inspection we reviewed the provider's action plan which they had supplied to tell us how they had met or intended to meet their legal requirements in relation to the breaches of regulations we found at our last inspection. We asked the provider to take action in relation systems in place to assessing and monitoring the quality of the service provided.

Prior to the inspection we reviewed the previous inspection report. We gathered information about the home by contacting the local authority safeguarding and quality assurance teams. We also reviewed records held by the Care Quality Commission which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke to eight people, three relatives, the registered manager, the deputy manager, and seven members of staff. We observed care and support in communal areas and looked in two bedrooms with the agreement from the relevant people. We looked at six care records, risk assessments, medicines records, accident and incident records, minutes of meetings, four staff records, complaints records, policies and procedures and external and internal audits.

We last inspected this home on 12 April 2016 when we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the systems in place to assess risk. This had been improved at this inspection.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe. One person told us, "I feel safe, I can lock my door if I wanted to but I don't have to, it's very safe." Another person told us, "Oh I feel quite safe really." Relatives told us they felt their family members were safe at the home. One relative told us, "I don't think there are any problems regarding safety. If they notice that one of the residents who has poor mobility is trying to get out of their chair, usually somebody will come straight away."

At our last inspection on 12 April 2016, we identified concerns relating to infection control and we had made a recommendation to the provider to ensure the safe disposal and laundering of soiled items.

At this inspection we found people and staff were protected from the risk of infection. There was a cleaning schedule for the home and domestic staff had daily lists of cleaning tasks. These detailed the different tasks that needed to be carried out and checked. Staff signed when tasks had been completed. Safe and effective laundry practices were followed.

Since the last inspection the provider had developed an action plan to improve the environment. This included replacing carpets and flooring. By the time of this inspection those actions had not yet been fully completed. The carpets in the lounge was worn and flooring in a number of bedrooms required replacement. There was damaged grouting that was marked on the floor of the shower and on the shower mat in one of the communal shower rooms. There was a cracked toilet basin in one of the communal bathrooms. These were areas that could harbour germs and bacteria. Although the provider had identified in their refurbishment plan that these areas required repair or replacement this was yet to be done. However since this inspection the provider confirmed all of these areas have been completed. We saw evidence of this during a recent meeting.

In the PIR the provider told us they followed safe recruitment processes. However we found this not to be the case. However since the inspection new recruitment check lists had been put in place and all recruitment information had been include din staff files.

We had concerns about fire safety because an independent fire assessment had been carried out in January 2017 and the report received in March 2017. This had identified a number of recommendations. Before the report was received the registered manager was in communication with the assessor and it was agreed that these were not major or urgent safety factors and could be completed over a time period to August 2017. These actions are being worked through. Staff have been trained and fire door closures are being replaced.

At our last inspection on 12 April 2016 we found that when people were at risk of diabetes or at risk due to smoking they did not have risk assessments carried out to identify, or manage the risks. At this inspection we found improvements had been made. Risk assessments were in place for diabetes, smoking, using the stair lift, skin integrity, moving and handling, the use of bed rails and skin integrity.

Peoples' medicines were not always stored safely. Creams and ointment were not stored in line with the

current NICE guidelines in regard to the management of medicines, and not all creams and ointments were labelled when they were opened. We found prescribed creams were stored in locked cupboards, however the temperature of the environment in which the medicines were stored in was not monitored or controlled. This meant that people were at risk as their ointments or creams were not kept in conditions which made sure they were fit for use. Since the inspection we have seen evidence that the system has changed and the temperature is now monitored and opening dates had been added to ensure safe storage.

There were aspects of the medicine management that were safe. People had their medicines on time and as prescribed. One person told us, "Oh yes they are given to me at the right time. They give me them in a little cup and I put them in my mouth." Only staff who had attended training in the safe management of medicines were authorised to give medicines. We saw staff administer medicines to people; they explained the medicine and waited patiently until the person had taken it. Any changes to people's medicines were prescribed by the person's GP. All medicines coming into and out of the home were recorded. Staff training is continuing and we have evidence that staff are attending courses in medication.

Arrangements were in place to record medicines. The medicines administration records (MARs) were accurate and contained no gaps or errors. A medicines profile had been completed for each person and any allergies to medicines recorded so that staff knew which medicines people could safely receive and which to avoid. A photograph of each person was present to ensure that staff were giving medicines to the correct person. There was guidance for staff to use when people were on PRN (as needed) medicines. Where people had topical creams (medicines in cream form) charts were completed to show that this had been administered and where.

There were sufficient staff to meet people's needs. We asked people and relatives whether there were enough staff at the service. One person told us, "I think there is plenty of staff around." One relative told us, "I think so, there is another sister home down the road, if there are any absences they swap staff. But it would be very rare to have somebody on that we don't see regularly. They've never been short of staff." Staff told us there were enough staff and the registered manager assessed how many staff were needed. We saw that people were helped with their needs in reasonable time and did not have to wait too long for assistance. This was confirmed by the staff rotas which showed that consistent levels of staff were in duty.

There was a contingency plan in place should an emergency have an impact on the delivery of care. The provider had identified alternative locations which would be used if the home was unliveable. This would minimise the impact to people's care if emergencies occurred. Staff knew what to do in the event of an emergency such as fire, adverse weather conditions, power cuts and flooding. We observed information displayed regarding the Fire Evacuation plan. There was information about how to support each person living at the home in the event of an emergency and staff knew where to access the information.

People were provided with the necessary equipment to assist with their care and support needs and to help keep them safe such as wheelchairs, walking frames and hoists. Specialist equipment such as wheelchairs were checked on a weekly or monthly basis to ensure they were safe and in working order. Handrails were placed throughout the home to support and aid people's mobility. Fire, electrical, and safety equipment such as fire extinguishers was inspected on a regular basis.

People benefited from a service where staff understood their safeguarding responsibilities. Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. Staff had access to a safeguarding policy which gave information about how to raise concerns to the local authority if necessary. Staff were knowledgeable about the types of abuse and the reporting procedures to follow if they suspected or witnessed abuse. A member of staff told us, "If I had any concerns I would speak

to the manager."

Good

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "They are very good at their job", "I've never been worried about the knowledge and skills of staff." and "I'm sure they are because I think they would have had training to use equipment, how to get people downstairs from upstairs."

We found that the nursing staff were able to describe the nursing care they needed to give people. There were plans in place to manage pressure sores. This is important because four people did have pressure sores at the time of the inspection. Three out of the five carers were also able to provide information about the interventions for preventing pressure ulcers (this was due to their previous experience as a nurse, they were working as carers rather than nurses at this time). They were able to talk about pressure relieving equipment and use of sliding sheets, repositioning and keeping the skin clean. After the inspection we received confirmation that training in pressure area management had been arranged and provided to the nursing staff.

The provider's records confirmed that all staff had received mandatory training such as: administration of medicines, safeguarding, moving and handling, fire awareness, food hygiene, health and safety, infection control. Training was delivered in different formats such as online learning, and training courses. Nursing staff had received training in catheterisation (a procedure used to drain the bladder and collect urine, through a flexible tube called a catheter) and venepuncture (the procedure of inserting a needle into a vein).

The care plans were up to date. We saw a summary sheet which is available to staff which includes all the needs and some people's preferences. They are reviewed monthly or when there is a change. In staff meetings individual staff are asked what they know about individual people to test they have an up to date knowledge of the needs they need to meet.

The deputy manager a senior carer and a nurse monitor how less experienced staff are delivering care in line with the care plans. For instance recently senior staff noted someone wasn't using the correct moving and handling technique so they demonstrated how to do this effectively.
We saw that staff assisted people to stand up from chairs using their walking frames and further observation of transfer techniques confirmed that staff had sufficient knowledge to enable them to carry out this task safely and effectively. Staff confirmed that an induction programme was in place and all new staff attended induction training and shadowed an experienced member of staff until they were competent to carry out their role. The registered manager informed us that she had arranged for a local teacher to attend the home to provide English lessons for staff that needed assistance with the language.

Staff we spoke with told us they had regular meetings with their line manager to discuss their work and performance, whilst others were still waiting. After the inspection we received confirmation that regular and clinical supervision had been arranged for care and nursing staff. We also saw evidence that senior staff have taken on responsibility for supervising other staff. The deputy manager from another home also comes in to complete clinical nurse supervisions. Supervisors now use the skills for care supervision guidance, which is a

standard of good practice. .

People's rights were protected because staff acted in accordance with the Mental Capacity Act 2005. Although some people had general assessments from before they moved in which does not meet the principles of the Act since then new assessments were only being done when a specific decision needed to be made. Each person must be assumed to have capacity until someone who knows them well assesses that a specific decision needs to be made and there is reason to believe that despite being given all relevant information the person may be unable to fully understand or make a decision in their best interests. 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. We saw emails between the registered manager and a GP discussing a decision needing to be made for medical treatment for one person. This shows that staff do understand their responsibilities to protect rights.

Staff ensured they obtained people's verbal consent before providing care and support in accordance with their wishes. We observed that staff sought people's agreement before supporting them and then waited for a response before acting on their wishes. Staff ensured that people understood the questions asked of them. They repeated questions if necessary in order to be satisfied that the person understood the options available. Where people declined assistance or choices offered, staff respected these decisions.

People's care plans contained forms which detailed that consent had been obtained in certain aspects of people's care for those who had capacity to make that decision. For example, in relation to administering medicines or for people who did not want to be resuscitated in the event of a medical emergency.

Staff supported people who could become anxious and exhibited behaviours which may challenge others. During the inspection we observed people's behaviour and how staff responded to help them calm down. Care plans provided guidelines for staff on how to best support people as well as knowing what triggers their anxiety or behaviour.

People told us about the food at the home. One person told us, "Sometimes it's very good, sometimes not so much. It depends really. They only have fish and chips on a Friday but if you wanted something else you just ask." Another person said, "It's quite good, I eat anything I'm given really I'm not fussy. They change it up a bit, the menu, it's not bad. We don't have any trouble with food, the food is a bit too soft though." A relative told us, "They do try a hundred different things to feed (their family member). They'll offer her one thing and the next minute she'll ask for something else. They are very accommodating."

There was one lunchtime meal choice displayed on the menu board, this was meatballs, however staff knew some people would prefer the fish curry with mashed potatoes. There was also a pictorial menu which staff showed people to choose from. Staff also knew people well enough to know which they may prefer. We saw a list of people's preferences displayed neat the kitchen so the chef could refer to this as needed.

Lunchtime was observed as a lively occasion. People were able to choose who they sat with and some people enjoyed their lunch together in the dining room, whilst others were in the communal lounges. People were provided with pureed meals, in accordance with their care plan, to reduce the risk of choking. We observed the meals were well presented. Staff confirmed that a dietician was involved with people who had special dietary requirements. Dietary needs and preferences were documented and known by the cook and staff.

People were supported to have their nutrition and hydration needs met. One relative told us about a family member, "It's their mobility that's changed and their eating habits have got worse. I think it has been mentioned in the care plan, that's why the doctor was worried about their weight and wanted to get energy drinks into her. They're very aware of that. They've talked to us about her eating and what they're doing to help her that's for sure." Where people needed support with eating, they were supported by a member of staff at a slow and steady pace. People who were able to eat independently were prompted and encouraged to do so. Throughout the day people were encouraged to take regular drinks to ensure that they kept hydrated. Where people's care plan stated their appetite was very poor and would refuse every meal, food and fluid charts were in place and people's weight was monitored on a monthly basis to reduce the risk of malnutrition.

People had access to health and social care professionals. One person told us, "I've never seen a doctor in here, I haven't had to. The opticians are very good and the chiropodist comes and she's very good." Another person told us, "If I want to see the doctor I can see one."
All people living at the home had access to the GP, dentist, opticians and mental health team.
Appointments were made with other healthcare professionals as and when required. Any visits made by healthcare professionals were documented and any guidance was acted upon.

Good

Is the service caring?

Our findings

Staff were kind and showed they cared by appropriate touch and reassurance. One person told us, "They're so nice. They all very lovely, I'm not just saying it. There is some nice people here, you couldn't ask for better girls." Another person told us, "(Staff) looks after me very well. They're all very helpful. We're very lucky here." A relative told us, "They are very kind. I don't think we could fault the staff, it's a difficult job but they do the job well."

We observed that individual staff cared about the people living at the home. People were well groomed, clean, they had access to sufficient food and drink and staff supported them with their personal care. Staff knew people's care and support needs.

A number of people on different floors preferred to stay in their rooms all day. Staff encouraged them to come downstairs to reduce their social isolation.

People lived in a homely family atmosphere. One relative told us, "One of the carers in particular is very good, if there is music going on and mum wanders off out there, she'll hold onto her and they'll have a little dance. I've never seen my mum dance before, which was rather nice. They get her by the hand, or cuddle her, or walk along with her a bit, they know how to support her." We observed a member of staff gently supporting a person to walk. This was conducted at the person's own pace and the member of staff talked and encouraged the person throughout the walk.

People made choices about when to get up in the morning, what to eat, what to wear and activities they would like to participate in, so they could maintain their independence. A person told us, "I can look after myself but they do my washing for me. I can choose what I wear." Another person told us, "I tell them what I want to do and they will listen to that, like I tell them what I want to wear in the mornings and they get it out for me." People personalised their room with their own furniture and personal items so that they are surrounded by things that were familiar to them

People were supported by staff that knew them. Staff were able to talk about people, their likes, dislikes and interests and the care and support they needed. Information was recorded in people's plans about the way they would like to be spoken to and how they would react to questions or situations. Staff knew people's personal and social needs and preferences from reading their care records and getting to know them.

People told us they were happy with the support they received. Staff approached people with kindness and compassion. One person told us, "Everybody's very good to me. Very caring." One relative told us, "They (staff) talk to her, she asks them the same questions a hundred million times a day and they're very patient with her. She's not a nameless face, or just a number, they are very kind." Staff called people by their preferred names. Staff interacted with people throughout the day, for example when supporting them throughout the home, attending activities in the home, listening to music and watching television. At each stage they checked that the person was happy with what was being done. Staff spoke to people in a respectful and friendly manner.

Privacy and dignity was respected and people received care and support in the way they wished. Staff understood the importance of respecting people's privacy and dignity and treating people with respect. One person told us, "They are very good; they help me get washed in the morning. They never leave me alone in there, but they do respect my dignity. They help me get changed but also give me my privacy when I want it when I'm in my room. I go up to my room to watch television, I've got my privacy in there and they let me go up early." One relative told us, "They usually help her to the toilet, they respect her dignity."

Relatives and friends were encouraged to visit and maintain relationships with people. Staff supported people to visit their relative's homes. Each person had detailed information about people who were important in their lives.

People confirmed that they were able to practice their religious beliefs. One person told us, "I'm a Catholic; someone comes on a Sunday who gives us Holy Communion." Another person told us, "I'm Church of England, I can't get there but they have a service here once a week." We saw that religious services were held in the home and these were open to those who wished to attend.

Requires Improvement

Is the service responsive?

Our findings

We observed that staff responded to people's needs. Where needed people were provided with the necessary equipment to assist with their care and support.

We saw that on another occasion staff responded positively to a person who appeared to be unwell. The registered manager noticed that one person was not drinking a lot and was only drinking coffee and subsequently they had become unwell, so the registered manager called the doctor. During the inspection the doctor visited the home to examine the person and throughout our visit the person was encouraged to drink, which he did.

In the PIR the provider told us they regularly review residents' needs and update their care plans accordingly. We found there was enough information to enable staff to deliver responsive care, although this may have been in different places rather than all in the care plan. For example one person required warfarin and the plan to safely respond to this need was kept separate to their care plan, although staff did have access to the information. They did receive their care from staff who knew how to administer warfarin and look out for side effects.

Staff told us that they completed a handover sheet after each shift which relayed changes to people's needs. We looked at these sheets and saw, for example, information related to any changes in medication, healthcare appointments and messages to staff. Daily records were completed to record support provided to each person. The registered manager had recognised that further improvements were needed to make sure these notes reflected a person centred approach and enabled staff to monitor how people were each day.

People had mixed views about whether the activities met their expectations and needs. One person told us, "Just the usual stuff. Yes we all join in together but not everybody is that interested. We go for a walk occasionally, except the garden is not very good for going up and down. I used to be an artist so I like to paint now and then." Another person told us, "We do so much sitting down and we really need to go on more walks and I can't anyway. They might take you in the summer but not so much in the winter. You can't blame them." A third told us, "There is nothing I can do really." Activities included sing along, arts and crafts, board and ball games and jigsaw puzzles. Some people's capabilities were limited due to living with dementia and this needed further thought as to how they could be engaged in activity that interested them.

We found there was some physical stimulation around the home for people that provided them with something to do during the day when organised activities were not happening. The provider told us they had recently sourced a new set of dementia friendly equipment which they were going to start using. This included reminiscence materials.

We recommend that the provider continues to develop more personalised ways of stimulating and engaging people, especially for people living with dementia.

Pre-admission and admission assessments provided information about people's needs and support assessments were carried out before people moved into the home and then reviewed once the person had settled in. These meant the provider and registered manager could assure people their needs could be met before they moved in. Details of health and social care professionals, information about any medical history, medicines, allergies, physical and mental health, identified needs and any potential risks were documented.

People, their relatives and health and social care professionals were involved in the discussion about people's care and support needs. One relative told us, "I would imagine it has been documented in the care plan but I can't verify that. They consult us and we are always aware of what's going on. Any decisions that need to be made about her care go through us."

People were aware of the complaints system and told us that they knew what to do if they needed to make a complaint. One person told us, "I just go to the head and I tell her, but I don't have any complaints." A relative told us, "Overall I have no concerns, [family member] seems happy and that's what's important. If I had a complaint someone would know about it. I'd go find a nurse or the manager straight away." They went on to say, "If I didn't think they would listen to me I would go one up." People could voice their opinion about the home. For example, discussing issues with staff, or the registered manager. We looked at the provider's complaints policy and procedure which was displayed at key points around the home. We reviewed the complaints log and noted there were no complaints about the home in the last twelve months.

Good

Is the service well-led?

Our findings

People spoke positively about management at the home. One person told us about the registered manager "Yes, she's very good, we chat sometimes." One relative told us, "I think she's friendly, she comes in and says hello to everybody. I haven't had to approach her for anything."

At our last inspection on 12 April 2016, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective management systems were not in place to assess, monitor and improve the quality of service people received. The provider sent us an action plan and provided timescales by which time the regulations would be met. They stated that the actions would be completed by August 2016. The action plan stated that all records have been updated and were monitored on a monthly basis. We found that apart from on going improvements this was the case. Other improvements included some areas of the environment, staff supervisions, training and first safety.

The registered manager informed us that she manages two homes and splits her time between them. Since the last inspection a deputy manager has been employed to support the manager when they are not at the home due to their other duties. The deputy manager was knowledgeable about people's needs.

There were a number of systems in place to monitor and review the delivery of care. We saw there were various audits carried out such as care plans, medicine administration records, health and safety, room maintenance and housekeeping.

The registered manager instigated visits from the Clinical Commissioning Group care home improvement team. They have visited six times recently and made some suggestions to improve health monitoring and the way staff write in the care plans. This is due to many staff not having English as a first language so staff are offered English lessons twice a week. The registered manager is developing an action plan to ensure these additional changes take place.

The care records were up to date and accurate and changed as people's needs changed. We saw a care plan that had been reviewed and summarised for staff the care that was needed.

We saw incidents and safeguarding had been raised and dealt with and relevant notifications had been received by the Care Quality Commission. Incidents were reviewed which enabled staff to take immediate action to minimise or prevent further incidents occurring in the future.

Staff were involved in the decisions about the home. We reviewed staff meetings where staff discussed a variety of topics. These included training, English lessons, cleaning, how to serve lunch, and activities. However these discussions had not always led to improvements.

People and those important to them did have opportunities to feedback their views about the home and quality of the service they received. Emails were sent to relatives to seek their feedback as it had been found that there had been poor attendance when meetings had been arranged. Not everyone remembered being

consulted about the quality of the care. One person told us, "Sometimes they do [meaning they were asked for their opinion], about the food whether you like it, whether you like it here." One relative told us, "I've never been to a relative's meeting; I don't think they have those. I don't really know what's going on, if there are any changes happening in the home. If we ask about anything we're told." All events are advertised in the home and regular surveys are sent twice a year. The registered manager told us that questionnaires had been given to relatives and residents and an analysis had been carried out. We noted comments such as 'Friendly', 'Excellent staff can discuss anything with them' and 'I am happy here.'

People told us that the management team and staff were approachable. One person told us, "Everyone is so approachable." A relative told us about staff, "The other day I came on mother's day and they offered me a cup of tea. They are very welcoming like that."