Tanglewood (Lincolnshire) Limited

Hunters Creek Care Home with Nursing

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 inspection took place on 10 October 2016 and was unannounced.

The home provides residential and nursing care for up to 91 people. Some of the people at the home were living with a dementia. The home was purpose built and is set over two floors with the upstairs being a secure dementia area. There is a main lounge and dining area on each floor as well as smaller areas with comfortable seating. There were 85 people living at the home when we inspected.

There was a registered manager for the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

The registered manager had implemented new care plans to improve the recording of person centred care. These had not been fully completed and therefore people's risks and care needs were not fully documented. However, staff's knowledge of people's needs meant that the care provided met people's needs and kept them safe from most harm. Though a number of people were left sitting in their hoist slings which was not good practice and increased risks.

Staff were kind, caring and compassionate and supported people's dignity and independence.
There was a monthly programme of activities and people were able to choose what activities they wanted to undertake. People were also supported to continue to enjoy hobbies and activities they had taken part in all their lives.

There were enough staff to ensure that people's needs were met in a timely manner. In addition staff received training and support from managers which meant that the care provided was safe and effective. Recruitment processes ensured that staff were safe to work with people living at the home. Staff had received training in keeping people safe from abuse and knew how to raise concerns. The registered manager investigated any concerns raised and took appropriate action to protect people.

Medicines were safely administered to people. However, delays in receiving medicines meant they were not always available for people when needed. The registered manager was working to resolve this issue. Mealtimes were a pleasant experience for people and they were offered a choice of food and drink. Dietary needs were catered for and appropriate equipment was available for people. Staff monitored people's weight and supported them to remain at a healthy weight. People were supported to have access to healthcare professionals.

People's rights under the Mental Capacity Act 2005 were respected and where people had capacity they were supported to make decisions which may put them at risk. Where people were unable to consent to living at the home and were under constant supervision appropriate referrals had been made to the

Deprivation of Liberty Safeguards supervisory authority. People were able to make choices about their everyday lives and these were supported by staff.

People knew how to complain and the registered manager investigated complaints and took action to stop the issues reoccurring. The registered manager was approachable and supportive of staff and took account of good practice guidance to improve the care that people received. People living at the home and their relatives had their views of the home gathered and the registered manager took action to address any issues highlighted. People were supported to be involved in the running of the home.

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.

People's risks had been identified and care was planned to keep people safe. However, at times information in care plans was not up to date and people were left sitting in hoist slings.

Staff had received training in keeping people safe from abuse and the registered manager investigated concerns and took appropriate action.

Staffing levels were monitored and there were enough staff to meet people's needs. Safe recruitment practices had been followed.

Medicines were administered to people safely. However, some medicines were not always available and the registered manager was working to resolve this problem.

Is the service effective?

Good

The service was effective.

Staff received appropriate training and support which supported them to provide safe care for people.

People's abilities to make decisions were assessed and their rights under the Mental Capacity Act 2005 were protected.

People were supported to maintain a healthy weight and to eat safely. People had regular access to hot and cold drinks.

People received regular support from healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff were caring and compassionate and knew about people's likes and dislikes.

People were able to make choices about their everyday lives.

Staff supported people to maintain their dignity.

Is the service responsive?

Good

The service was responsive.

Staff knew people's care needs and provided individual are for people.

There was a full programme of activities available. People were supported to engage in activities to enable then to lead a full life.

People told us that they knew how to complain and that the provider responded to complaints appropriately.

Is the service well-led?

Good

The service was well led.

People had been asked for their views on the care they received and were encouraged to be involved in the running of the home.

People living at the home and staff told us the registered manager was approachable and supportive.

The provider and registered manager engaged with good practice guidelines to improve the quality of care people received.

Hunters Creek Care Home with Nursing

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 10 October 2016 and was unannounced. The inspection team consisted of an inspector, a specialist advisor, who was a nurse, 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 home.

Before the inspection we reviewed the information we held about the home. This included any incidents the provider was required to tell us about by law and concerns that had been raised with us by the public or health professionals who visited the home. We also reviewed information sent to us by the local authority who commission care for some people living at the home. 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 home, what the home does well and improvements they plan to make.

During the inspection we spoke with five people living at the home and seven relatives who visited during our inspection. We also spoke with three nurses, two care workers, a residential floor manager, the staff trainer, the deputy manager, the registered manager and the provider. We spent time observing care and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at 11 care plans and other records which recorded the care people received. In addition we examined records relating to how the home was run including staffing, training and quality assurance.

Requires Improvement

Is the service safe?

Our findings

Records showed that most people's care plans contained appropriate risk assessments. For example, we saw that people's risk of developing pressure sores had been calculated and appropriate equipment and care had been put in place help prevent this happening. Where people may display distressed reactions this was clearly documented along with advice for staff on how to support the person.

However, some people's care plans had not been recently reviewed and did not contain the latest information about people's needs. For example, one person's care plan did not reflect that they had a new wheelchair which was safe for them to spend time in. We also saw that a number of people who needed to use equipment to move were left sitting in their chairs and wheelchairs with their hoist slings still around them. We saw that some of these people were at risk of pressure sores and used pressure reliving equipment to keep them safe. The hoist sling had not been designed to be sat on all day and so might be uncomfortable for people and might increase their risk of developing a pressure sore.

While people living at the home and their relatives told us that staff used safe techniques when supporting people to move several families voiced concerns over people's safety from sitting on a sling. One relative told us, "She goes from her wheelchair into a chair with the hoist so sits in her sling all day." Another relative said, "He's sitting in his sling as he gets hoisted. But he gets agitated by the hanging straps – he wraps them round his hands. I'd prefer if he wasn't in it."

People living at the home told us that they felt safe. One person told us, "Oh yes, I feel fine. I always shut my door if I'm not in so no-one can wander in." While a relative told us said, "He's safe enough but if he was nearer the nurses' station, he could be seen and monitored much better."

Staff had received training in keeping people safe from harm and were able to tell us about the different types of abuse that people may be subjected to. Staff were clear on what action they needed to take to report abuse and stop it from happening. They also had access to the local authority safeguarding telephone number so that they could raise concerns direct to them if they felt that appropriate action had not been taken.

The registered manager had investigated all the safeguarding concerns that were raised about the home and had taken action to improve the quality of care that people receive. For example, following a recent safeguarding the registered manager identified that the nurses could have contacted a person's GP in a more timely fashion. To help nurses make more consistent decisions in the future the registered manager had introduced the National Early Warning Score system which has been introduced across the NHS. This scored people's observations, for example, their temperature, blood pressure and heart rate and identified when action should be taken. The registered manager explained how this had worked well and helped the nurses when ringing for support from the GP as it allowed them to clarify why the person needed to see the GP.

The provider and registered manager had used an appropriate staffing tool to help them identify the

number of staff needed to meet people's needs. The staffing levels were monitored on a weekly basis and compared to the national figures from the staffing tool. Records showed that for most of the time the provider was exceeding the national recommended number of staff. When the figures had fallen below this for a short period the provider had taken action and recruited more staff.

The provider had systems in place to ensure they checked if people had the appropriate skills and qualifications to care for people before offering them employment at the home. For example, we saw people had completed application forms and the registered manager had completed structured interviews. The required checks had been completed to ensure that staff were safe to work with people who lived at the home.

Some of the relatives we spoke with raised concerns that they felt the home could do with more staff, particularly at the weekends. However, when we asked about the care people received they told us that this was delivered in a timely fashion. We asked people about staff response to call bells. One person living at the home told us, "When I used to use it, they came quite quickly. I rang for another room the other night, they were calling out for help and staff came to me quickly to ask if I was OK." A relative said, "We've seen him use it and they come quite quickly." People also told us that staff completed regular room checks in line with people's care plans. One relative told us, "They always pop in to check on her." This showed that there were enough staff to meet people's needs.

We spent time watching both the nurse and a senior member of the care staff administering medicines. We saw that they spoke with the people and explained what the medicine was. They supported people to take their medicine at their own speed and in their preferred way. For example, some people chose to take their medicine with water while others preferred to take it with yoghurt. People told us that staff stayed with them until they had taken all their medicines. One person explained how they were supported to self-administer their medicines as this reduced their anxiety that it would not be administered on time. A relative told us, "We've had no issues and the doctor has reviewed them. They stay with her while she takes them."

People also said that they were able to request their medicines when they needed it. One person told us, "I can ask for extra painkillers for my leg if it's bad." Where people were at risk of being in pain and were unable to verbalise this or request pain medicines we saw their care plans recorded behaviour they may use to indicate their pain. For example, we saw one person's care plan showed that their behaviour may change when in pain.

The registered manager and staff told us that they had some problems when reordering the medicines on a monthly basis and for medicines ordered following GP visits. This was because not all the medicines ordered were delivered in a timely manner. We saw that at times this delay impacted on the care that people received. For example, one person living at the home had been seen by a GP and prescribed antibiotics. However, they told us that there had been a delay of over five days between the medicines being prescribed and being available for them to take. The registered manager had spent time working with the GP and pharmacy to see if the situation could be resolved, but the problems continued to happen. The registered manager was therefore looking at other ways they could improve the reordering and delivery of medicines including the use of an electronic medicines administration system.

Good

Is the service effective?

Our findings

People living at the home and their families told us that they were happy that staff had the skills needed to care for people safely. One person told us, "They seem very good, even the new ones. Some are very, very good and have been here a long time." A relative told us "The girls are very good. But the deputy manager fills me with confidence; she's made so many good changes."

There was a new staff trainer at the home. While they worked with other trainers across the provider's organisation to standardise training their main role was to develop and implement the training for staff at Hunter's Creek. There were systems in place to monitor what training had been completed and when refresher training was due. The residential floor manager told us that the trainer updated them on the training progress of their staff and that if a member of their staff had repeatedly missed mandatory training they would take them off the rota until it was completed.

There was a structured induction in place to support new staff. This consisted of some time spent learning about the provider's policies and procedures as well as time shadowing an experienced member of staff. All new staff completed a probationary period and had their competencies checked during their probation to ensure they were learning the skills needed to care for people safely. As part of the probation staff were expected to complete the Care Certificate. This is a national set of standards that the government have defined as the basics staff need to provide appropriate care for people. One member of staff who had recently completed their induction told us that they felt it had covered all the skills they needed to care for people safely. They told us they were having their supervisions with the trainer while they worked through the Care Certificate.

Nursing staff told us that they were supported to maintain and develop their knowledge and skills. They said they could approach the registered manager and request any training which would improve the quality of care that people received. In the information the provider sent to use before our inspection they explained that they were going to train a member to staff to assess people's ability to swallow safely as the wait for NHS staff to do this was long.

Staff told us they were supported with regular individual supervisions meetings with their line manager and annual appraisals. This allowed them time to review the care they provided and if they needed any more guidance or training to meet people's needs. Staff also confirmed that they had an annual appraisal where they could discuss their future career developments and any related training needs.

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

The registered manager and staff had received training in the MCA. They were able to tell us how important it was for people who had the capacity to make individual decisions to be supported to do so, even when those choices put them at risk. We saw that where people chose to take risks their wishes were respected. For example, we saw that there was a positive risk taking agreement in place regarding one person who chose not to use bed rails when they has been assessed as being at risk of falling out of bed. However, we saw that some people had not been made aware of their ability to refuse certain aspects of their care as they complained that night checks completed by staff disturbed their sleep.

Where people needed to use equipment which may be deemed as a restraint, for example, bedrails, the use of the equipment was assessed to ensure that it would be safe for people. People were meant to sign their care plans, but these were in the process of being updated so written consent was still to be obtained.

We saw that one person had chosen to sit in their wheelchair and had a belt across their lap to keep them safe. We looked at this person's care plan and could not see that the use of the lap belt had been identified in the care plan. This lady was living with dementia but there was no capacity assessment in place to see if she was able to consent to the use of a lap belt and no best interest decision to show that she needed it had been taken. We discussed this with the registered manager who arranged for the person's named nurse to review and update their care plan. This was completed during the inspection.

We saw that where people had been assessed as unable to make the decision about living at the home and were subject to constant supervision the registered manager had submitted an application to have them assessed for a DoLS authorisation. While a number of applications had been submitted the DoLS supervisory authority had not yet completed any assessments.

People living at the home and their relatives told us that the food was good and that choices and alternatives were offered at mealtimes and special diets were catered for by the kitchen. One person said, "It's alright. We get two choices, I'm having omelette and salad today instead [of the set items on the menu]. They'll do you anything. For tea it is usually soup, something on toast, sandwiches and cake. I always have a bag of crisps with my sandwich."

We saw that people were offered a choice of hot and cold drinks on a regular basis and that staff encouraged people to drink and supported them when necessary. People told us that they had access to drinks. One person told us, "I have a pot of lemon tea in my room. I'm always drinking." While a relative said, "They're always telling her to drink up. They make her smoothies in the afternoon."

People who were at risk of being unable to maintain a healthy weight had been identified and appropriate support from healthcare professionals had been sought. Where necessary people had been supported with prescribed high calorie supplements. There was one person living at the home who had, when younger, lived with the condition of anorexia. Staff told us how concerned they were that they had noticed the person had stopped eating so well recently and were considering if their dementia had taken them back to the time they had the condition. Staff were monitoring how much the person was eating and drinking so that they could support the person to stay healthy.

People were given the right adaptive equipment they needed at mealtimes in order to eat independently.

For example, one person was given a plate guard to enable him to eat his lunch. Where people needed support to eat and drink care workers were encouraging and took their time to ensure the person had enough. However, we saw at times this could be inconsistent. For example, we saw one person who chose to eat their meal with their dessert spoon was not given a clean spoon for their pudding and they used their fork to eat the sponge and custard. We saw another person was engaged in an activity at the table and did not eat independently and although encouraged by staff only ate a small amount of their meal. However, the deputy manager brought them their dessert of rice pudding and sat next to them, feeding them spoonfuls whilst chatting. This interaction and distraction worked well and the person ate all their dessert.

The registered manager and chef had reviewed the menus and were moving away from the terminology soft diet to use the national texture descriptions of thin pureed, thick pureed, pre mashed and fork mashable. This supported people to get the correct consistency of food which they could safely eat. They also told us in information they submitted before the inspection that they were looking at introducing a tray systems with different colour trays dependent on the level of support that people needed. This would help staff to ensure that they were supporting people appropriately.

People told us they were supported to access healthcare professionals when needed. One relative told us, "They've been quite quick to get the doctor out. He sees the optician once a year." Another relative said, "She has the MacMillan nurse coming in every two weeks and she sees the chiropodist regularly. I take her out to the dentist and for her hearing."

Individual care plans included all the information needed to support people's day-to-day health needs. Additionally, we saw people had been supported to arrange and attend for eye tests and their prescriptions had been updated where necessary. Records showed other health professionals such as GP's and the community mental health team had been included in people's care when needed.

Good

Is the service caring?

Our findings

People were complimentary about the compassion of staff. One person told us, "They're all very good, you have your favourites." While a relative said, "She gets lots of cuddles, holding her hand and I've seen them painting her nails." Another relative told us, "Mum had a bout of shingles then a chest infection so was very poorly. [Member of Staff] has been amazing, giving her drinks by a teaspoon to keep her hydrated." People told us how staff supported their relationships by letting them know when people were ill. A member of staff explained how they kept a relative who lived abroad up to date with the person's care each month.

We also saw examples of good care. Staff cleaned the table between courses as one person had made a mess; this was sorted without referring to the person to maintain their dignity. A member of staff noticed that a person's glasses had slipped down and adjusted them for the person. Staff were discrete when asking people about going to the toilet. However, we also saw that at busy times care was occasionally task focused and did not put people at the centre. We saw examples of this at lunchtime. Staff started to set the tables for lunch at 11:15am while people were still enjoying their activities and at the end of lunch began to clear tables without checking if a person was finished with their meal.

The registered manager had introduced an 'All about me' section into people's care plans. This provided staff with information about the person, where they had lived and what their occupation was. This helped staff to relate to the person when they wandered back to past times with their dementia and supported staff to join the person in their reality. However, we saw that this was a work in progress and some of the care plans we looked at did not contain this information. We discussed this with the registered manager who told us that they were working with families to get the information completed.

We saw that people living at the home and staff spoke a number of languages as their first language. Staff told us that when people were ill their command of English deteriorated and so if at all possible they would arrange for a member of staff who could speak the person's first language to be present. This enabled the person to communicate their concerns better.

People told us that they were given choices about the daily care they received. One person told us, "They ask me about having a bath or if I need something doing, I can say yes or no." Another person said, "They're always very polite." We also heard people being asked about how they would prefer things, for example, if they wanted to wear an apron at lunchtime. People also told us they were able to make choices through the day. One person told us, "I'm able to make lots of choices day to day, bed at 9pm like I've always done; I might eat in here or go to the restaurant and choose where to do my pompom making."

People also told us that staff encouraged them to retain as much independence as possible. One relative said, "They let her get on and do as much as she can." Another relative told us, "He can choose where he wants to go, he uses his walker unaided. He's encouraged to be involved in the activities." We observed people on both floors with mobility being able to move around the floor where they wished. Access to the secure garden was also allowed. One family member told us, "She can go out in the garden. They take her down and then she stays alone with the flowers, which she loves." At the last parliamentary election the

registered manager invited all the local candidates into the home to speak with the people. This enabled people to take part in the democratic elections as is their right. It also supported people to make an informed decision when they voted.

People told us that staff respected their privacy and that they were treated in a dignified manner. One person told us, "They always knock, even if my door's open. They'll shut the curtains if the nurse comes in." A relative said, "They're polite to her and knock before going in. They close her curtain when they're changing her and we leave the room too." We saw that staff helped people to maintain their dignity, for example, we saw a member of staff helped one person rearrange the blanket over their needs to ensure they were fully covered.

Good

Is the service responsive?

Our findings

People living at the home told us that they had been involved in the planning of their care. One person told us, "My key worker filled in paperwork and asked me questions." Relatives told us that their involvement with care planning was inconsistent with a lack of involvement with from the key worker. However, all of the relatives said that they would be happy to speak with staff if there was something they particularly wanted to know about or have included in the care plan. One relative told us, "I've not had any meetings but I'll discuss things if I need to."

We listened to the handover meeting and there was a good exchange of information from staff leaving to staff coming on to shift. We saw that they discussed some of the issues we had raised with staff during the morning. They also raised concerns they had and if people needed any extra support or if people's needs had changed. Staff we spoke with showed a good understanding of people's needs. For example, they knew who enjoyed their tea and biscuits and who could always be encouraged to eat with a jam sandwich. However, people told us that new staff were not always informed of the personalisation of care that staff provided. For example, one relative told us, "The new staff don't know their special needs, like him not having a drink by his bed else he'll pour it over the sheets."

We saw that care plans were in the process of being changed to a new format. In order to do this some of the old information had been reviewed. While we saw that most people's needs were accurately recorded there were some gaps in the information and it was not always recorded in the most appropriate section of the care plan. We discussed this with the registered manager who explained that they had identified that the old care plans had not reflected the person centred care that people received. Staff told us that they were working on transferring all the information into the new care plans and that they would be completed by December 2016.

Despite the gaps in the care plans staff we spoke with were knowledgeable about people's needs. When we asked they could tell us about the information missing from the care plans and how this was reflected in the care provided for people. For example, they knew about people's catheter care needs and what support people needed with wounds and dressings. This showed that the lack of recorded information had not impacted on the care people received.

People living at the home told us that the care met their needs. One person said, "I have to have help to bathe, it's usually a Monday evening on their list. My room gets cleaned every day." Two other people we spoke with also told us that they had regular help to have a bath or shower. A relative told us, "He always looks good; he has an en-suite shower and has a few a week, with help." However, there was concern amongst other relatives that people were being given bed baths instead of baths.

There were activities provided for people seven days a week. There was a monthly activity programme and each person living at the home is given a copy. The people living in the dementia unit had their activities in the morning as this was the time of day that people living with a dementia were more engaged and so will get more out of the activity programme. However, they were also invited to join in the afternoon activities in

the downstairs lounge.

During the morning in the dementia unit we saw that some people had chosen to engage in craft activities supported by the activity co-ordinator and other staff. We saw that people doing the activity were enjoying the music and one person got up to dance. A member of staff joined in with the person and we saw that the person was smiling and enjoying themselves. However, other people had chosen not to join and were sitting in a quieter area of the room; some of them were engaged with reading the daily paper and talking to other people. We saw that the activity co-ordinator had music on their side of the lounge and the television was also on with the sound up in the same room. The music and television might be too much stimulation for some people living with dementia and may increase people's agitation. We discussed this with the activity co-ordinator who told us that they had not realised this and that they normally turned the television sound off. However, this may still be confusing for people with dementia.

We saw that the activities co-ordinators wore yellow uniforms this made them look cheerful and meant they were easy to identify. They were affectionately know by the people living at the home as the yellow coats. People were happy with the activities provided to them.

In the afternoon we observed a visiting singer in the ground floor lounge. People from both floors along with family members were encouraged to join in. Percussion instruments were shared out and most people joined in with singing, clapping or shaking their instrument. One person told us, "I've made lots of friends here. We've a singer today and we do Monday bingo. We have quizzes and have grown vegetables in the garden – some worked better than others. I'm not bored as I can read to fill time. We don't go out on any trips" A family member told us, "The one thing decent here are the activities. The Yellow Coats are tremendous, they'll come and see him, but not in his room."

People we spoke with told us that they knew how to raise a concern and that they were dealt with when they did raise them. Several people had not felt the need to complain. One person told us, "No complaints at all yet." Another person said, "Once I complained about the noisy night staff, giggling or shouting in the corridor. I told [the registered manager] and it helped. The same with loud TVs left on in bedrooms after bedtime." While a relative told us, "I've raised quite a lot of things. Not adhering to what I want doing for her basic care, baths are supposed to be one a week and I know she won't always co-operate so it gets left. Now I come in to help with her. It's changed a bit now but it's not always perfect."

We saw there was a notice telling people how to complain in the main entrance. People told us they were happy to raise complaints with the registered manager or other staff. Relatives we spoke with said they knew who to go to if they had any worries or complaints. The provider had received three formal written complaints since our last inspection and these had all been investigated and resolved to the satisfaction of the person making the complaint. Informal verbal complaints were also recorded along with the action the registered manager had taken to resolve the complaint.

Good

Is the service well-led?

Our findings

The registered manager was trying to develop an open culture in the home and to make information more accessible for people living at the home and their relatives. They had purchased a television and used it to display information in the reception area. The information included the recent staffing levels at the home and training that had been undertaken by the staff along with information related to people's care like why having a flu vaccination was important. The registered manager told us that they had received positive feedback from people about the information. The registered manager also told us how they were trying to move the home towards a culture of using the learning gained from concerns and incidents to improve the care people received.

People told us that the registered manager was visible and usually available if they wanted to talk. One relative told us, "She gets on well with the manager and has had lunch in the office with him a few times" While a person living at the home said, "He says hello when he's around. He's very nice."

People living at the home, their relatives and visiting health care professionals had been asked for their views on the home. We saw the results from the 2015 survey which identified that people thought the home provided well led, clean and safe environment with caring staff who treated people with compassion and promoted a good quality of life. We also saw that the registered manager had identified areas for improvement and had taken action. For example, the majority of people did not know who their key worker was and so photographs and names of key workers were placed in people's rooms.

People told us that residents' and relatives' meetings took place every three months. People told us that they saw changes being implemented after meetings. One relative told us, "I always go, they're about 3 monthly. Odd things get done as a result, but not everything." We saw minutes from the latest meeting where issues with the laundry, which were discussed with us during the inspection, were raised and action was taken to improve the laundry service.

People had become involved in the running of the home. Residents' meeting minutes showed that people had been invited to participate in employing new members of staff. One person living at the home was made the community champion and would feedback to the manager issues they had seen around the home. All residents have been invited to attend any staff training they are interested in and recently the community champion attended moving and handling training. Another person liked to spend time assisting around the home and is now going to formally become the community assistant and is to be presented with a uniform and a badge.

Staff told us that both the registered manager and the deputy manager were good at their jobs and that both were supportive and helpful. They also said they were supported through their supervisions and regular staff meetings. The registered manager had introduced a new format of care plan and staff were happy with the new format and supported the registered manager with the change. However, we saw that the planned introduction of the new care plans could have been better as information to guide staff was missing from people's plans. We have reflected this throughout this report.

The provider had an effective suite of audits which monitored the quality of care people received. For example, we saw they had reviewed the number of falls they had each month and people's weight to see if any action was needed. The registered manager had taken part in a year long study with a consultant from the local hospital regarding falls and how to reduce them in care homes. The provider had also arranged for an external agency to visit and review the quality of care people received and the environment. This meant they had the view of a person external to the organisation about the care they provided for people.

The registered manager had completed the Kings Fund audit on care home environments for people living with a dementia. This looked at the environment that people lived in and how that impacted on their health and wellbeing. This recognised that the longer corridors in some of the homes were an issue for people living with dementia. The provider had supported them in making some changes and each of the corridors in the dementia unit were now themed. For example, one corridor was given a holiday feel, another had been designed around a garden theme and a third had a music theme.

In each corridor there were items for people to interact with. The registered manager told us that this had helped to orientate people and that it could be used to distract people when they were distressed. By distracting people they would often become calmer and begin to interact with the staff. This meant that there were fewer occasions where people needed additional support or medicine to help them remain calm and safe and could enjoy their day more. In addition the changes had reduced the number of falls as people stopped to look instead of continually walking around. It had also supported people's privacy, as with so much to look at in the corridors there had been a reduction in the number of people going into rooms.

The registered manager had also arranged for the local college to deliver some dementia training to relatives so that they understand more about the disease and the impact that it has on people. Following the training people were given a certificate. This supported relatives to understand that when people are distressed and angry that it is the disease and not an indication of a failure of their relationship.

They had engaged with the Boston Dementia Action Alliance. This was a local organisation which aims to make Boston into a dementia friendly town. They had reviewed the environment and were making changes where concerns were identified. For example, they had become aware that the threshold at the front door was an issue for people in wheelchairs.

Following the recent national guidance regarding the lack of vitamin D for people over 65 the registered manager had spoken to the GP practices where people living at the home were registered. They had requested that the GP review people's vitamin D Levels.