Aden House Limited

Aden 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 Aden Lodge Care Home (known to people who live at the home, relatives and staff as Aden Lodge) took place on 24 and 25 January 2018 and was unannounced on the first day. This meant the home did not know we were coming.

Aden Lodge is registered to provide accommodation and personal care for up to 40 people, some of whom are living with dementia. It is a purpose built home and provides single room accommodation with en-suite facilities. At the time of our inspection 26 people were living at Aden Lodge.

Aden Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home had previously been inspected during December 2016 and was found to require improvement at that time. The previous inspection found breaches of regulations in relation to safe care and treatment and good governance. During this inspection, we checked and found improvements had been made in both these areas and we did not identify any breaches of regulations during this inspection.

The home had a registered manager in post. 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 told us they felt safe living at Aden Lodge. The registered manager and staff were aware of relevant procedures to help keep people safe and staff could describe signs that may indicate someone was at risk of abuse or harm. Staff had received safeguarding training.

Staff were recruited safely and there were sufficient numbers of staff deployed to meet people's needs. Staff told us they felt supported and we saw evidence staff had received appropriate induction, training and ongoing supervision.

Risks to people had been assessed and measures were in place to reduce risk. The building was well maintained and regular safety checks took place.

Medicines were managed, stored and administered safely and appropriately, by staff who had been trained, and assessed as competent, to do so.

People were supported to have choice and control of their lives and we observed staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice.

People received appropriate support in order to have their nutritional and hydration needs met.

People told us staff were caring and we observed staff to be kind and considerate. We observed people's privacy and dignity was respected. There was a pleasant, relaxed atmosphere in the home.

Care records were person centred and reviewed regularly. A 'resident of the day' system helped to ensure people's care needs and assessments were regularly updated. People told us they could make their own choices in relation to their daily lives.

However, the registered provider was not always responsive to people's needs and requests. Actions from a, 'You Said, We Did,' notice had not consistently been implemented. Appropriate information was shared between staff to enable continuity of care.

There was a complaints policy in place and we found complaints were responded to appropriately and in line with policy.

People received support in order to meet their wider health care needs.

Staff told us they felt supported and people and their relatives spoke positively about the registered manager. Meetings such as staff meetings and residents' and relatives' meetings were held regularly. Regular audits and quality assurance checks took place, to help improvements to continue at 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?

Good

The service was safe.

People told us they felt safe and relatives agreed.

Risks to people were assessed and measures were in place to reduce risks.

Medicines were managed and administered safely.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act 2005 were applied.

Staff had received induction and ongoing training and supervision.

People received support to meet their nutrition and hydration needs and to have their wider health care needs met.

Is the service caring?

Good

The service was caring.

People and relatives spoke highly of staff and told us staff were caring.

Staff were skilled at communicating with people and we observed positive interactions between staff and people who lived at the home.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The registered provider had not always been responsive to people's needs.

Personalised care plans reflected people's needs, preferences, choices and personal histories.

We observed people making their own choices relating to how they wanted their care to be provided.

People knew how to complain if the need arose and complaints were well managed.

Is the service well-led?

Good

The service was well-led.

Staff told us they felt supported by the registered manager and they thought the service was well-led.

Regular meetings had been held with people who lived at the home, relatives and with staff.

Audits and quality assurance checks regularly took place to help drive improvements at the home.

Aden 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.

The inspection took place on 24 and 25 January 2018 and was unannounced on the first day. The inspection was carried out by three adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection we reviewed the information we held about the home and we gathered information from the local authority and from Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used this information to help inform our inspection.

We used a number of different methods to help us understand the experiences of people who lived in the home, including observations and speaking with people. We spoke with 10 people who lived at the home, four relatives of people who lived at the home, the registered manager, the quality support manager, three care workers, the cook and the activities coordinator.

We looked at five people's care records, four staff files and training information, as well as records relating to the management of the service. We looked around the building including people's bedrooms, bathrooms and other communal areas.

Good

Is the service safe?

Our findings

All of the people we asked told us they felt safe. One person said, "I feel safe, yes. They look after me well." Another person told us they felt safe because, "They [staff] make sure I'm safe."

The registered provider had an up to date safeguarding policy and the registered manager, and all the staff we asked, were aware of safeguarding procedures and knew what constituted potential abuse. The whistleblowing policy was displayed on the noticeboard, which helped to ensure staff could share any concerns they had. This showed staff would take appropriate action if they had concerns anyone was at risk of abuse or harm.

The registered provider had recently developed an Equality and Human Rights policy which outlined staff and management duties in ensuring people were treated equally and with respect as individuals regardless of their characteristics. The policy made clear discrimination would not be tolerated and outlined the procedures in place to protect people. This helped to keep people safe from discriminatory practice because the registered provider had ensured policies and procedures were in place to educate staff and challenge any discriminatory practice.

Information was stored securely when required, such as personal and private and confidential data. A person told us they were able to store personal items in a safe in the office if they wished. This meant measures were in place to ensure the safe storage of belongings and records.

Our previous inspection of December 2016 found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because risks had not been robustly assessed and care and treatment was not provided in a safe way for people. We checked and found improvements had been made.

A range of recognised risk assessment tools were used to help assess risk and keep people safe. For example, risks associated with falls, skin integrity, choking and weight loss were assessed. Measures were put into place to reduce risks, such as sensor mats or regular assistance to reposition. Having risk assessments in place helped to ensure people could be encouraged to be as independent as possible whilst associated risks were minimised.

Moving and handling assessments had been completed. Consideration had been given to the equipment used and the method of application of equipment such as slings, to safely assist people. This helped to ensure risks were reduced and staff were given appropriate information to assist people to move safely. We observed two staff assisting a person to move. This was done in a confident and effective manner, whilst taking steps to encourage and reassure the person.

One person had been admitted to Aden Lodge with pressure sores. We saw appropriate actions had been taken by the registered manager and an appropriate plan had been put into place in order to provide effective wound care. This included monitoring wounds, regularly assisting the person to reposition and

applying prescribed creams. Records showed the creams were being applied as prescribed, the person was being assisted to reposition as required and their wound was being regularly monitored and was improving. This showed safe care and treatment was being provided.

We checked maintenance and safety records for equipment, gas and electric and fire safety and found checks had been completed on a regular basis and were up to date. An environmental risk assessment had been carried out and regular health and safety meetings were held with a regional manager. This helped to ensure the safety of premises and equipment.

There was an emergency bag located near to the office which contained personal emergency evacuation plans (PEEPs), a plan of the building and items that would be useful in an emergency such as a torch, blankets, first-aid kit and hi-visibility vests. The PEEPs detailed the level of assistance people would require in an emergency evacuation. We saw information was displayed showing what to do upon hearing the fire alarm. This information was also provided in a pictorial guide. This helped to ensure people could be evacuated and kept safe in an emergency situation.

We looked at records of accidents and incidents. We saw these were logged and records showed appropriate actions had been taken such as first aid being applied, increasing observations and making referrals to other healthcare professionals where appropriate. Monthly analysis took place to enable trends to be identified to assist the registered provider to make improvements.

During our inspection, an emergency buzzer was pressed by a person who lived at the home. We observed staff immediately attended. Although their assistance was not actually required, this showed staff responded well in what they thought could be an emergency situation.

Records showed information was shared across the homes in the provider group, in order for lessons to be learned, both at local and national level. The registered manager told us, "If I found a risk today, I would share with [the area manager] and that would be shared across the company."

We looked at staffing levels. A dependency tool was used and we saw this calculated a score based on people's dependency in relation to different areas of need such as mobility, eating, continence, pressure care and personal hygiene. This helped the registered manager to determine the numbers of staff required in order to meet people's needs.

The registered manager told us, and records showed, four care workers and a senior care worker were deployed between 8am and 8pm. Between 8pm and 8am two care workers and a senior care worker were deployed. Additionally, the activities coordinator assisted people with their breakfast between the hours of 8am and 10am.

The registered manager was able to clearly outline to us how their dependency tool was used in order to determine safe staffing levels. People's needs and the tool were reviewed monthly or when people's needs changed. Records showed the numbers of staff identified as being required were deployed.

Staff were providing person centred care to people and we observed people's needs being met on the day of our inspection, although staff did appear very stretched, particularly during busy periods such as lunch-times. Most people told us they felt there were enough staff, with one person saying, "I don't have to wait for anything. I've never had to press the buzzer because I'm looked after well and asked all the time." Another person told us they were sometimes asked to wait ten minutes when they requested assistance because staff were busy.

We inspected four staff recruitment files. We found safe recruitment practices had been followed. For example, the registered manager ensured reference checks had been completed, identification had been checked and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups.

Medicines were managed and administered by staff who had received specific training to do so. The registered manager told us, and records showed, in addition to their training, staff competency was assessed in relation to the safe management and administration of medicines.

We saw the staff member administering medicines was patient and gave people the time they needed to take their medicines. The member of staff bent down to people's level and stayed with them until they had taken their medicine.

Medication administration records (MARs) included a photograph of the person, which helped to ensure medicines were administered to the correct person. Where MARs had been hand-written, such as when person was newly admitted to the home, these were counter-signed by another staff member. This was good practice in line with the National Institute for Health and Care Excellence (NICE) guidelines, and reduced the risk of errors in transcribing medicines information.

Most medicines were supplied in monitored dosage systems with a MAR. However, where medicines were in boxes, there was a count-down sheet in place which helped to ensure medicines could be accurately accounted for. We checked a random sample of medicines and found the remaining medicines reconciled with the records on each sample.

Some people were prescribed medicines to be taken as and when required, known as PRN medicines. PRN protocols were in place which helped to ensure these medicines were administered appropriately and at safe intervals.

Medicines were stored securely in trollies in a locked room. Temperature checks regularly took place to ensure medicines were being stored at correct temperatures.

We checked the controlled drugs, which are prescription medicines controlled under Misuse of Drugs legislation. These were stored securely and logged in the register as required. This showed controlled drugs were managed appropriately. We checked a random sample of controlled drugs and found the amount of medicine remaining was correct, according to the register.

Care workers demonstrated they knew how to protect people from infection and we observed protective aprons and gloves being worn at appropriate times. The head of housekeeping was an infection prevention and control lead and they had received specific training in this area. Washbasins were equipped with hand-wash soap dispensers and paper towels. The home looked and smelled clean and fresh. People told us staff wore personal protective equipment when providing personal care. This helped to prevent and control the risk of the spread of infection.

Good

Is the service effective?

Our findings

People told us they felt staff had the necessary skills to provide effective care. One person told us, "It's the best place this. I'd recommend it to anyone."

Staff received an induction prior to commencing their caring duties, which included shadowing more experienced members of care staff. The registered manager told us they had identified staff did not always complete their induction booklets, as required, and they were taking action to address this. Although the registered provider did not enrol staff on the Care Certificate, their induction was aligned to the subject areas of the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have been assessed against a specific set of standards and have demonstrated they have skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support.

Staff we spoke with told us they felt they received sufficient training to enable them to provide safe, effective care, although some commented that much of the training was done on-line and some staff felt this was not their preferred and most effective way of learning. We shared this feedback with the registered provider who acknowledged this. Staff told us they felt able to approach the registered manager if they felt they needed more training.

Records showed staff had received training in areas such as safeguarding, moving and handling, medicines management where appropriate, fire awareness, equality and diversity and basic life support. Further specific training such as dementia awareness, falls prevention and food safety were also undertaken. In addition, records showed workshops had been held in relation to the Mental Capacity Act 2005 and care documentation, to improve staff knowledge and practice.

The registered manager told us formal staff supervision was held six times per year for care staff. The records we inspected showed staff received regular supervision and this considered their training and development needs and feedback on their performance.

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 so that they can 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 registered provider was working within the principles of the MCA. Where people lacked capacity to make specific decisions, we saw decision specific mental capacity assessments had been completed and decisions were made in people's best interests where this was appropriate. For example,

one mental capacity assessment we inspected identified a person lacked capacity to consent to bed rails. Therefore, the least restrictive options had been considered and a decision had been made in the person's best interests, in consultation with relevant people.

The records for one person showed they were unable to retain information in order to safely use a call bell. Therefore, a decision had been made in the person's best interests for use of a sensory mat, which would alert staff to movement. This helped to keep the person safe but with consideration being given to using the least restrictive practice. This demonstrated the registered provider was applying the principles of the MCA.

Where people lacked capacity to consent to their care and treatment and where they were being deprived of their liberty, appropriate authorisations had been sought.

People told us their consent was sought and we observed staff asking people for consent before providing any care and support. This showed staff were aware of the need to obtain consent.

We looked at whether people's nutrition and hydration needs were met. A malnutrition universal screening tool (MUST) was used in order to determine the level of risk of malnutrition. People were weighed monthly and weight was monitored as necessary. One person told us, "You've no sooner finished one meal and they're offering you something else. There's no risk of me losing weight here!"

A variety of drinks and snacks were placed around the home so people could help themselves. The registered manager told us people made choices about the meals they would like but that additional meals were always prepared in case people changed their minds. Most days we were told there was a meat option and a vegetarian option. However, on the first day of our inspection we found no vegetarian option was offered on the menu, although the cook told us people could request a different choice if they wished.

The cook kept records of people's individual dietary requirements, including people who had diabetes or people who required modified diets. The cook was also aware of people's preferences and was able to explain to us how they used this information to ensure people had choices and were able to maintain a well-balanced diet.

We observed two meal-time experiences; one at breakfast and one at lunch-time. The dining area was welcoming and tables were set for dining. At breakfast people could choose from a hot or cold breakfast and two options were provided at lunch-time, although the registered manager told us in reality people could choose from a range of options because jacket potatoes and sandwiches would also be available.

The cook knew people and was visible in the dining areas and we heard people being asked whether they enjoyed their meals. People were complimentary about the food. We heard staff asking people whether they would like more food before taking plates away.

People were respectfully asked whether they would like to wear aprons, to protect their clothing and their choices were respected. Some equipment was used to help people to eat independently, such as plate guards, which help to stop food falling from a plate.

One person did not eat their meal and arrangements were made for a fresh plate to be prepared for later. Another person was very slow at eating their meal. Staff asked if the person wanted their meal warming up. This showed people received support to meet their nutritional and hydration needs.

People's own rooms were personalised to individual tastes and contained photographs, flowers and items

of sentimental value which created a homely feel.

At our last inspection, there had been a separate unit for people who were living with dementia. Since the last inspection the registered provider had made adaptations to the home and this unit was no longer a feature. Attempts had been made to give Aden Lodge a more homely feel, such as homely quotes on the walls and work was ongoing to improve the environment. On the first floor there was a quiet lounge and a small 'library' area which contained books and quiet activities.

People living with dementia can experience difficulty with orientation. Displaying information such as the day, date and time can be beneficial in reducing anxiety. We saw there were some orientation boards on display and they displayed the correct information. This showed measures had been taken to ensure the content, design and adaptation of the home was appropriate for the people who lived there.

Handovers between shifts included a written and verbal handover between care staff. Appropriate information was shared which enabled staff to provide continuity of care when care staff changed.

A nurse practitioner from a local GP surgery attended the home on a regular basis. The registered manager told us they forwarded details of any concerns to the practitioner prior to their visit, so that people who needed to access this service could do so. Referrals to other health care agencies such as opticians, district nurses and speech and language therapists were evident. One person explained to us how staff had assisted them to amend their medical appointments to suit them. This showed people received support in order to meet their wider health care needs.

Good

Is the service caring?

Our findings

Everyone we spoke with told us they thought staff were caring. A person who had been recently moved into Aden Lodge told us, "The girls are jovial. It's really nice. I can do what I want." Another person told us, "All the staff are great. Including the night staff." A further person, who was residing at the home on a temporary basis, said, "I don't want to leave, the girls are so good at looking after us."

Many 'thank you' cards were displayed within the home. One card from January 2018 stated, 'Thank you. For all your care and support.' Another card from November 2017 stated, 'I will be recommending Aden Lodge and singing your praises forever'. A recent communication to the home, from a relative, stated, 'We're all very appreciative of the warmth and generous care you all give [name of person].'

In conjunction with the registered provider's newly developed Equality and Human Rights policy, some posters had been devised which welcomed everyone to the 'New Century Care Family.' These highlighted people would be respected regardless of their characteristics, for example, age, disability, sexual orientation, race, gender or religious beliefs. Records showed people's diverse needs were considered as part of the care planning process. This showed the registered provider embraced diversity.

The care records we inspected indicated people's preferences and choices were taken into account and accommodated. We saw some care records indicated where a person had a preferred gender of carer. People and staff we spoke with told us this was respected.

People were encouraged to maintain contact with other people who were important to them. One person told us their visitors and relatives could, "Come and go as they like." We observed visitors being welcomed into the home during our inspection.

All of the people we spoke with told us staff treated them with dignity and respect. Staff were able to outline to us the actions they took to protect people's privacy and dignity. People's care records indicated their preferences about whether they would prefer to have their bedroom doors open or closed through the day and night. The people we spoke with confirmed they could choose and we were told staff knocked on doors. We observed this in practice.

We observed two staff assisting a person to move and a staff member placed a blanket over the person's legs whilst they were being assisted, to help promote the person's dignity.

Throughout our inspection we observed staff prompted people's needs and staff could be heard saying, "Can you manage with that?" and "Would you like some help?" On one occasion a member of staff had identified a person required assistance with their continence needs. Staff respectfully and discreetly suggested to the person that they support them. This showed staff respected people and were aware of people's needs.

People were encouraged to retain their independence. We saw two staff assisting a person attempting to

stand and move. The staff appropriately encouraged the person to stand, with the use of a stand-aid. However, the person was finding this difficult. Only once staff had encouraged the person to stand by themselves did they then use the hoist because, on that particular occasion, the person was not able to stand. However, staff reassured the person and told them they would try again and not to be disheartened. We looked at this person's care plan and found staff had followed the directions given in the care plan. This demonstrated staff followed plans to ensure people retained their independence, whilst maintaining their safety.

Advocacy was available to people living at Aden Lodge. An advocate is a person who is able to speak on another person's behalf when they may not be able to do, or may need assistance in doing so, for themselves.

Requires Improvement

Is the service responsive?

Our findings

Most people told us staff were responsive to their needs. One person told us, "I can choose what I want, when I want." Another person told us, "They know how I like things and yes, they do accommodate me." A further person said, "I think I'm probably quite demanding really but they don't seem to mind. They still always try to please." One person, however, told us, "It's boring. Care workers have their own routine."

Care plans contained a photograph of the person to whom they related. Care records were reviewed monthly and all of the records we inspected had been reviewed within the last month. Care records included details of the support people required, in relation to different aspects of care such as the environment, mobility, activities, medication, continence care and personal hygiene. Personalised information was included in care plans. For example, one record we sampled stated, '[Name] likes to wear trousers and a blouse.]' We observed the person was wearing their favoured attire. Other individual preferences were included in care records such as the person's preference of a bath or shower and preferred gender of carer. People told us they could make choices in this respect.

Records showed some family members had been contacted regarding reviews of people's care. However, there was limited information in care records to show people living at Aden Lodge had been involved in developing and regularly reviewing their care plans and records, although it was clear their choices and preferences had been considered. We shared this with the registered manager and registered provider and they advised they would consider ways they could develop this further.

Information regarding people's life history was included in care records, including details relating to previous interests, spiritual and cultural needs and family history. This helped to provide staff with the information they required to provide person centred care and support.

One person's care plan we looked at indicated the person was hard of hearing and they could hear better in their left ear. When we observed the member of staff administering medicines, they were aware of this and told us they would approach the person from their left side. This showed the staff member was aware of the person's needs and able to provide personalised support accordingly.

Records showed a person was forgetting to use their call bell and beginning to become distressed because they sometimes needed assistance to use their bathroom. Actions had been taken to display a police notice, within the person's sight, reminding them to call staff whenever they needed to, by using their call bell. In a personalised way, this helped to ensure the person received the support they required.

On the first day of our inspection, some new flooring was being laid in the lounge area. Therefore, attempts had been made to keep people comfortable in other communal areas, for example, by placing comfy chairs within an area of the dining room. On the second day of our inspection the new flooring had been laid and we observed a game of skittles in the lounge. People were joining in enthusiastically. We observed the activities coordinator assisted a person, who had only recently begun residing at the home, join in with the game. The activities coordinator used warm tones and ensured the person felt welcome. We observed

people in the lounge area laughing and engaging together. We also observed the activities coordinator providing some quality one to one time with some people, in the communal area, whilst providing a hand massage.

An activities display board, placed in a communal area, indicated activities such as arts and crafts, floor games, baking, movies, keep fit, reminiscence and card games took place. In additional to this, external artists provided entertainment at the home, such as singing. Most people told us they were satisfied with the activities available at the home. However, one person told us they were often, "Left to sit," and it was, "Boring." Another person told us it was too tiring to go to communal areas and join in activities but that activities were not brought to the person. This meant, although a range of activities took place, some people felt these were not always person centred.

One person liked to read the newspaper and they had a paper delivered daily to the home. However, they told us they were currently unable to read the newspaper due to their glasses firstly being misplaced and then needing repairing. They had been without their glasses for three weeks. Care staff we asked were unclear as to what action had been taken, or was being taken, to rectify this. We raised this with the registered manager and arrangements were made on the second day of our inspection for the person's glasses to be mended. However, this demonstrated the service had not always been responsive to this person's needs.

People were able to make their own choices. A person told us, "I can do what I want. I like to sit with other people." We observed this person joining in activities with other people. People told us they could choose what time to rise in a morning or retire on an evening. One person told us they liked to get up early and have fresh air in their room. We noted their bedroom window was open.

We looked at how information was provided and shared with people. The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand and any communication support they need. Although the registered manager was not aware of the Accessible Information Standard, we saw information had been provided in alternative formats. For example, some information was pictorial and we saw care records contained information relating to people's specific communication needs. This showed consideration was given to people's individual needs in relation to communication methods.

Relatives were welcomed in the home. We observed some relatives arrived during a meal-time and the person was then assisted to take their meal in their own room, to be with their relatives. People told us their families could visit whenever they wished. This helped to reduce social isolation.

Details of how to make a complaint were displayed throughout the home and the registered provider had a complaints policy in place. We saw a complaint had been received and this had been managed appropriately, with an apology being given and actions taken to resolve the complaint.

Care records included a section relating to future decisions and care. Some people had indicated they did not wish to discuss this, and this was respected. For other people, there was a note in the files prompting staff they needed to speak with families regarding end of life wishes. A primary health care team had recently delivered some end of life training at the home and staff and the registered manager were able to outline what good end of life care looked like. We saw some positive feedback from a relative thanking the home for the care and kindness they provided at the end of a person's life.

Good

Is the service well-led?

Our findings

The home had a registered manager in post, who had been registered with the Care Quality Commission (CQC) to manage the home since September 2017. They had not been in post during the last inspection.

The previous inspection ratings were displayed at the home. This showed the registered manager was meeting their requirement to display the most recent performance assessment of their regulated activities.

Our previous inspection of December 2016 found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to good governance. We issued the registered provider with a warning notice. During this inspection we found sufficient improvements had been made, such that the requirements of the warning notice had been met.

All of the people and relatives we asked told us they felt the home was well-led. One relative told us they felt communication could be improved in terms of keeping relatives informed. However, they added they felt the home had vastly improved in recent months. Another visitor we spoke with told us, "I last visited this home about ten years ago and it has very much improved since then, the cleanliness and the décor, very impressed."

Care staff told us they felt the home was well managed and had improved under the management of the new registered manager. They felt able to approach senior care workers and the registered manager. Teamwork was evident and we saw staff working well together throughout our inspection, sharing the work load and helping each other.

A noticeboard in the reception area displayed images of the different uniforms various staff would wear and how their roles could be identified by the colour of their uniform. Staff wore clear name badges with large print which helped people to identify staff.

The registered manager told us residents' and relatives' meetings were held every six weeks and the minutes from these meetings were displayed. Upon our arrival we saw a notice was displayed in the reception area, indicating a residents' and relatives' meeting was being held on 1 February 2018. Records showed, during a previous meeting, the complaints policy was shared and people were encouraged to provide feedback. Notes from meetings indicated people had been encouraged to attend.

Regular staff meetings were held. Records showed a meeting was held with staff when the registered manager was new in post and the registered manager listened to any concerns and assured staff of actions that would be taken. Staff were reminded about issues relating to safeguarding and confidentiality. A staff member told us everyone [staff] had the opportunity to speak in meetings. One staff member said to us, "It's good when we all sit down and have a think about how to improve things." Meetings are an important part of a registered manager's responsibility to ensure information is disseminated to staff appropriately and to come to informed views about the service.

Regular regional meetings took place and the registered manager attended these. They told us they felt they had access to good, effective peer support. Good practice was shared across the registered provider's group of homes. The registered manager was proactive and seeking new ideas to improve the home. They shared with us a plan for a recruitment day which they hoped would increase applications for employment at the home.

The registered manager told us they felt they had access to the resources required to run the home safely and effectively. They told us, "If we need something, I'll put a strong business case forward and, yes, funds have been agreed." This was evident through some ongoing redecoration works and a new floor was being laid in the lounge area, which showed investment was being made.

Records showed daily checks took place in relation to staff uniform, call bell times, staff interactions, activities and cleanliness for example. A 'resident of the day' system was in place, whereby a resident was identified each day and their care would be reviewed and risk assessments updated.

Most of the documentation we reviewed during our inspection was up-to-date and reflected people's needs and the care provided. One record of a person's repositioning and food intake had not been updated since the day before our inspection. We shared this with the registered manager who agreed to address this. Some workshops had been held with staff regarding record keeping and work was ongoing to ensure care documentation continued to be completed contemporaneously.

Monthly care plan audits took place and any areas identified for improvement were followed up at the next audit. Medication audits took place regularly which considered areas of practice such as training, medicines storage, records and management of controlled drugs. Records showed following an audit, senior care workers were reminded of the need to counter sign hand-written medicines administration records. We saw, from the records we reviewed, hand-written medicines administration records were counter signed. This showed the audit had been effective in improving practice.

Other audits took place regularly in relation to accidents and incidents, falls, health and safety, infection prevention and control. Where areas for improvement were identified through auditing, records showed these were actioned. This showed the registered manager had an effective system in place to improve the quality of service through auditing.

Monthly audit quality reports relating to people's dependency, weight, pressure ulcers, infections, medication errors, accidents or incidents and hospital admissions for example were submitted to the registered provider. The registered provider then used this information to support the home and taken actions if necessary to help drive improvements.

The registered provider had a range of up to date policies in place to ensure current best practice was being followed. They had developed a business continuity plan, which outlined procedures to follow in the event of certain situations such as electricity failure, gas leak, flood, loss of water supply or severe weather. This helped ensure staff knew what to do in the event of specific incidents.