Wraysbury House Limited

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Inspection report

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Date of inspection visit:
26 June 2018

Date of publication:
14 September 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Wraysbury House Limited on 26 June 2018. Wraysbury House Limited is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Wraysbury House Limited is registered to provide care for up to 27 people, with a range of health conditions and some who were living with dementia. On the day of our inspection there were 22 people living at the service, who required varying levels of support. We previously inspected Wraysbury House Limited on 27 October and 1 November 2017 and found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and further areas of improvement were required. We asked the provider to take action to make improvements and these actions have been completed.

Medicines were managed safely and in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. However, we identified some issues in respect to recording. This had already been recognised by the registered manager and did not place people at risk.

We have made a recommendation in respect to compliance with the Accessible Information Standards (AIS).

Risks associated with people's care, the environment and equipment had been identified and managed. Emergency procedures were in place in the event of fire and people knew what to do, as did the staff.

People were cared for in a clean and hygienic environment and appropriate procedures for infection control were in place.

When staff were recruited, their employment history was checked and references obtained. Checks were also undertaken to ensure new staff were safe to work within the care sector. Staff had received essential training and there were opportunities for additional training specific to the needs of the service, such as the care of people living with dementia.

People felt well looked after and supported. We observed friendly relationships had developed between people and staff. Care plans described people's preferences and needs, including communication, and they were encouraged to be as independent as possible. People's end of life care was discussed and planned and their wishes had been respected.

The provider undertook quality assurance reviews to measure and monitor the standard of the service and drive improvement. Notifiable events and actions had been reported to the CQC in a timely manner.

A registered manager was 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 and associated Regulations about how the service is run.

People were being supported to make decisions in their best interests. The registered manager and staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Accidents and incidents were recorded appropriately and steps taken to minimise the risk of similar events happening in the future.

Staff were knowledgeable and trained in safeguarding adults and knew what action they should take if they suspected abuse was taking place. Staff had a good understanding of equality, diversity and human rights. People's care was enhanced by adaptations made to the service.

People were happy and relaxed with staff. They said they felt safe and there were sufficient staff to support them. Staff had received supervision meetings with their manager, and formal personal development plans, such as annual appraisals.

People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank. Health care was accessible for people and appointments were made for regular check-ups as needed.

People chose how to spend their day and they took part in activities. They enjoyed the activities, which included, arts and crafts and visits from external entertainers. There were visits from local churches, so that people could observe their faith. People were also encouraged to stay in touch with their families and receive visitors.

People were encouraged to express their views. People said they felt listened to and any concerns or issues they raised were addressed. Staff were asked for their opinions on the service and whether they were happy in their work. They felt supported within their roles, describing an 'open door' management approach, where the registered manager was always available to discuss suggestions and address problems or concerns.

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.

Medicines were managed and administered safely.

Staff understood their responsibilities in relation to protecting people from harm and abuse.

Potential risks were identified, appropriately assessed and planned for. The service was clean and infection control protocols were followed.

The provider used safe recruitment practices and there were enough skilled and experienced staff to ensure people were safe and cared for.

Is the service effective?

Good

The service was effective.

People spoke highly of members of staff and were supported by staff who received appropriate training and supervision.

People were supported to maintain their hydration and nutritional needs. Their health was monitored and staff responded when health needs changed. People's individual needs were met by the adaptation of the premises.

Staff had a firm understanding of the Mental Capacity Act 2005 and the service was meeting the requirements of the Deprivation of Liberty Safeguards.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were involved in the planning of their care and offered choices in relation to their care and treatment.

People's privacy and dignity were respected and their

independence was promoted.

Is the service responsive?

Good

The service was responsive.

The service had arrangements in place to meet people's social and recreational needs. Comments and compliments were monitored and complaints acted upon in a timely manner.

Care plans accurately recorded people's likes, dislikes and preferences. Staff had information that enabled them to provide support in line with people's wishes, including on the best way to communicate with people.

People's end of life care was discussed and planned and their wishes had been respected.

Is the service well-led?

Good

The service was well-led.

People, relatives and staff spoke highly of the service. The provider promoted an inclusive and open culture and recognised the importance of effective communication.

There were effective systems in place to assure quality and identify any potential improvements to the service being provided. Staff had a good understanding of equality, diversity and human rights.

Systems were in place to gain feedback from staff and people. Feedback was regularly used to drive improvement.

Wraysbury House Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 June 2018 and was unannounced. The inspection team consisted of one inspector, a medicines inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what they do well and improvements they plan to make. We looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about.

During the inspection we observed the support that people received in the communal lounges and dining areas of the service. Some people could not communicate with us because of their condition and others did not wish to talk with us. However, we spoke with five people, two visitors, a visiting healthcare professional, three care staff, the provider, the chef, the deputy manager and the registered manager. We spent time observing how people were cared for and their interactions with staff and visitors, in order to understand their experience. We also took time to observe how people and staff interacted at lunch time.

We spent time observing care and used the short observational framework for inspection (SOFI), which is a way of observing care to help us understand the experience of people who could not talk with us. We spent time looking at records, including four people's care records, four staff files and other records relating to the management of the service, such as policies and procedures, training records and audit documentation. We also 'pathway tracked' the care for two people living at the service. This is where we check that the care detailed in individual plans matches the experience of the person receiving care. It was an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

Good

Is the service safe?

Our findings

At the last inspection on 27 October and 1 November 2017, the provider was in breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not receiving safe support with their medicines, risks associated with people's safety, safety of the environment and equipment were not identified and managed appropriately and emergency evacuation procedures were not detailed enough to ensure people's safety. We also found areas of practice that needed improvement. Parts of the service were unclean and required recruitment processes had not always been followed. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Significant improvements had been made, and the provider is now meeting the legal requirements.

At our last inspection we found that medicines were not always managed safely and our medicines inspector advised that urgent action was needed. During this inspection we found significant improvements had been made to ensure people could receive the best outcome from their medicines.

Medicines were stored in a new temperature controlled, secure room. Staff recorded temperatures of the room and the medicines fridge daily. The service monitored the minimum and maximum fridge temperature, to be assured that medicines were stored within the manufacturer's recommended ranges. People's dignity was maintained if they required a medicine to be applied to them. For example, a cream or patch. Body maps were used to show where creams should be applied. However, although staff did know to rotate the site of application to prevent irritation to the skin, staff did not record where on a person's body their patch was placed. Some people were given their medicines covertly (disguised in food or drink). We saw that staff were responsive to people's needs and had contacted the GP for advice if any medicines could not be given, or if the person refused. However, one new medicine that had been prescribed for someone had not been updated on their documentation. People were not placed at risk and the provider was already aware of, and taking action to, rectify these issues.

Decisions to administer medicines covertly were made in the person's best interests and involved their families. Advice had also been sought from the pharmacist about how medicines could be given covertly in a safe way. Deprivation of Liberty Safeguards applications had been made where required, for example if a medicine may be used to restrict a person's behaviour and it was in their best interest to do so.

We observed two senior carers carrying out the morning medicines round safely. Staff followed methodical processes for preparing, administering and recording people's medicines. Staff understood people's needs and supported them to take their medicines in a caring manner. Staff followed guidance about when people would need medicines that were prescribed on a 'when required' basis, for example pain relief. Staff offered medicines regularly and asked if people were in pain. We looked at medicines administration records (MARs) and care plans for six people. On the whole they were accurate, however, one person's allergies were not listed consistently throughout. Staff subsequently contacted the GP for clarity and updated the notes accordingly. Staff undertook weekly and monthly medicines audits. The pharmacist had also carried out an audit in November 2017. We saw that the pharmacist had revisited the home in January

2018 and noted that all actions required were met. People expressed no concerns around their medicines. One person said, "I do have medication and staff watch me take it". A relative added, "He does get his medication, they have to give it covertly, with agreement".

At the last inspection, people were not safe as assessments of risk were not accurate, did not contain enough detail and were not being followed by staff. Additionally, equipment used to alert staff when people were at risk of falling did not work. Furthermore, appropriate emergency evacuation plans for people did not contain appropriate information and a fire risk assessment had not been carried out for the service. Improvements had been made and each person's care plan had a number of risk assessments completed which were specific to their needs, such as mobility, risk of falls and medicines. The assessments outlined the associated hazards and what measures could be taken to reduce or eliminate the risk. We saw safe care practices taking place, such as staff supporting people to mobilise around the service. Sensor mats that were used to alert staff that people were at risk of falls had been replaced and were now working. People's ability to evacuate the building in the event of a fire had been considered and where required each person had an individual personal evacuation plan (PEEP) that showed the actions staff would need to take to ensure their safety. A fire risk assessment was in place, and regular fire alarm checks had been recorded, and staff knew what action to take in the event of a fire. Health and safety checks had been undertaken to ensure safe management of utilities, food hygiene, hazardous substances, moving and handling equipment, staff safety and welfare.

At the last inspection we identified issues in relation to the cleanliness of the environment. For example, there were unpleasant smells in the service, and some areas were visibly not clean. Improvement had been made and people were cared for in a clean, hygienic environment. One person told us, "They clean my room daily". A relative said, "Usually it's clean and the new owner has made some environmental improvements, he has a programme. [My relative's] room is always clean and tidy and the toilet is cleaned, I hardly ever smell any odours". We viewed people's rooms, communal areas, bathrooms and toilets. The service and its equipment were clean and well maintained. was an infection control policy and other related policies in place. We observed that staff used PPE appropriately during our inspection and that it was available for staff to use throughout the service. Hand sanitisers and hand-washing facilities were available, and information was displayed around the service that encouraged hand washing and the correct technique to be used. Additional relevant information was displayed around the service to remind people and staff of their responsibilities in respect to cleanliness and infection control. The registered manager told us that infection control training was mandatory for staff, and records we saw supported this. The service had policies, procedures and systems in place for staff to follow, should there be an infection outbreak such as diarrhoea and vomiting. The laundry had appropriate systems and equipment to clean soiled washing, and we saw that any hazardous waste was stored securely and disposed of correctly.

At the last inspection we identified issues in relation to required recruitment processes being followed. Improvements had been made and records demonstrated staff were recruited in line with safe practice and equal opportunities protocols. For example, employment histories had been checked, suitable references obtained and appropriate checks undertaken to ensure that potential staff were safe to work within the care sector.

People said they felt safe and staff made them feel comfortable, and that they had no concerns around safety. One person told us, "I am happy here and I do feel safe". Another person said, "I do feel safe, the staff are very well behaved". A relative added, "I think he is safe from injury and accident, there's no neglect".

Staffing levels were assessed daily, or when the needs of people changed, to ensure people's safety. We were told existing staff would be contacted to cover shifts in circumstances such as sickness and annual

leave and that agency staff were rarely used. Feedback from people and staff indicated they felt the service had enough staff and our own observations supported this. One person told us, "When I call for help, staff come quickly". A relative said, "In general, staff numbers are pretty good. If you need someone, you can usually find a staff member". A member of staff added, "There are enough staff, we all have our roles". Documentation also helped demonstrate that staff had the right level of skill, experience and knowledge to meet people's individual needs.

Records confirmed all staff had received safeguarding training as part of their essential training and this had been refreshed regularly. There were policies in place to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Information relating to safeguarding and what steps should be followed if people witnessed or suspected abuse was displayed around the service for staff and people. The registered manager gave us examples of when they had liaised appropriately with the local authority in respect to safeguarding.

Staff took appropriate action following accidents and incidents to ensure people's safety. We saw specific details and any follow up action to prevent a re-occurrence was recorded, and any subsequent action was shared and analysed to look for any trends or patterns.

Good

Is the service effective?

Our findings

At the last inspection on 27 October and 1 November 2017, we identified areas of practice that required improvement. This was because training identified by the provider as mandatory for staff was not up to date. We saw that improvements had been made.

Staff had received training in looking after people, including safeguarding, food hygiene, health and safety, equality and diversity. They also received training specific to peoples' needs, such as caring for people living with dementia. Staff told us that training was encouraged and was of good quality. They also told us they were able to complete further training specific to the needs of their role, and were kept up to date with best practice guidelines. One member of staff told us, "My training is up to date". Another said, "The manager is always identifying training and when she does, we all do it". The registered manager added, "We have a training matrix in place now and we are fully up to date". We saw documentation that supported this. Staff completed an induction when they started working at the service and 'shadowed' experienced members of staff until they were assessed as competent to work unsupervised. Feedback from staff and the registered manager confirmed that formal systems of staff development were in place, including one to one supervision meetings and annual appraisals. Supervision is a system that ensures staff have the necessary support and opportunity to discuss any issues or concerns they may have.

People told us they received effective care and their individual needs were met. One person told us, "Staff seem to do a good job". A visiting healthcare professional said, "They have a really good understanding of dementia here. They meet their client's needs". A relative added, "I would think staff have good understanding of dementia as they handle residents well. They do respond to situations".

Assessment of people's care and support needs were undertaken by staff before people began using the service. This meant that staff could be certain that their needs could be met. The pre-admission assessments were used to develop a more detailed care plan for each person. These plans detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork confirmed people were involved where possible in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

People had an initial nutritional assessment completed on admission, and their dietary needs and preferences were recorded. This was to obtain information around any special diets that may be required, and to establish preferences around food. There was a varied menu and people could eat at their preferred times and were offered alternative food choices depending on their preference. Everybody we asked was aware of the menu choices available. We observed lunch, it was relaxed and people were supported to move to the dining areas or could choose to eat in their bedroom. People ate at their own pace and came and went as they pleased. Staff were checking that people liked their food and offered alternatives if they wished. People were complimentary about the meals served. One person told us, "The food's fantastic". Another person said, "I do like the food". A relative added, "[My relative] likes the meals and they will give him extra, if he wants it". We saw people were offered drinks and snacks throughout the day, they could

have a drink at any time and staff always made them a drink on request. People's weight was regularly monitored, with their permission, and staff stated that any specific diet would be accommodated, should it be required.

Staff liaised effectively with other organisations and teams and people received support from specialised healthcare professionals when required, such as GP's and social workers. One person told us, "Without question they would call the doctor if I was not well, and someone has been in and cut my toenails". A relative said, "[My relative] does see the doctor when needed, and they do check with the doctor with any signs and respond to his medical needs. He does see the chiropodist and the hairdresser, and they do his nails from time to time". Access was also provided to more specialist services, such as opticians if required. Staff kept records about the healthcare appointments people had attended and implemented the guidance provided by healthcare professionals. Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support. Staff ensured, when people were referred for treatment, they were aware of what the treatment was and the possible outcomes. This ensured they were involved in deciding the best course of action for them. We saw that if people needed to visit a health professional, for example at hospital, then a member of staff would support them.

Staff had a good understanding of equality and diversity, which was reinforced through training. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected. A member of staff told us, "I have no concerns around discrimination in this home".

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. We checked whether the provider was working within the principles of the MCA. Staff had a good understanding of the MCA and the importance of enabling people to make decisions. A relative told us, "I have seen staff gain consent from [my relative] and others".

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty these have been authorised by the local authority as being required to protect the person from harm. DoLS applications had been sent to the local authority. Staff understood when an application should be made and the process of submitting one. Care plans reflected people who were under a DoLS with information and guidance for staff to follow. DoLS applications and updates were also discussed at staff meetings to ensure staff were up to date with current information. The sensors to alert staff to people who were at risk of falls identified at the previous inspection as being broken had been fixed, and records and conversations with the registered manager confirmed that any conditions placed on people's DoLS were being complied with.

The adaptation of the premises assisted people to receive effective care. Signage was used to orientate people around the service and people's doors showed pictures and details of what they were interested in. There were adapted bathrooms and toilets with hand rails to support people.

Good

Is the service caring?

Our findings

At the last inspection on 27 October and 1 November 2017, we identified areas of practice that required improvement. This was because people's dignity was not upheld at all times. We saw that improvements had been made.

At the previous inspection we saw examples of people being cared for in an undignified manner, for example waiting quite some time to be assisted. At this inspection we saw that people were attended to within a timely manner and were supported with kindness and compassion. We saw good interaction between people and staff. People told us caring relationships had developed with the staff who supported them. Everyone we spoke with thought they were well cared for and treated with respect and dignity, and had their independence promoted. Comments included, "All the staff are very kind and helpful", "Staff do treat me well" and "Staff are very nice". Throughout the day, staff spoke to people in a friendly and respectful manner, responding promptly to any requests for assistance. We observed staff being caring, attentive and responsive and saw positive interactions and appropriate communication. Staff appeared to enjoy delivering care to people. A member of staff told us, "We give good care". Another member of staff added, "I look after every one of these residents as if they were my own family".

Staff recognised that dignity in care also involved providing people with choice and control. Throughout the inspection, we observed people being given a variety of choices of what they would like to do and where they would like to spend time. People were empowered to make their own decisions. People told us they that they were free to do what they wanted throughout the day. They said they could choose what time they got up and went to bed and how and where they spent their day. One person told us, "I use a walker but I move about as I wish". Another person said, "Staff are kind. This is the quiet lounge and I like it in here, I believe if I wanted to go into the garden, I could". A relative added, "Staff are always responding to residents' needs". Staff were committed to ensuring people remained in control and received support that centred on them as an individual. One member of staff told us, "It's up to them, we always offer choice. We would never say 'we're going to' we would always say 'would you like to'". Another added, "I always offer choice, the residents always come first".

Staff demonstrated a strong commitment to providing compassionate care. From talking with people and staff, it was clear that they knew people well and had a good understanding of how best to support them. Staff gave us examples of people's individual personalities and character traits. They were able to talk about the people they cared for, what time they liked to get up, whether they liked to join in activities and their preferences in respect of food and drink. One member of staff told us, "We get enough time to get to know people".

Peoples' equality and diversity was respected. Staff adapted their approach to meet peoples' individualised needs and preferences. There were individual person-centred care plans that documented peoples' preferences and support needs, enabling staff to support people in a personalised way. Staff told us how they adapted their approach to sharing information with people with communication difficulties. One member of staff told us, "We get to know how people communicate. Some cannot speak to us, but we

recognise what they want". Staff also recognised that people might need additional support to be involved in their care and information was available if people required the assistance of an advocate. An advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People looked comfortable and they were supported to maintain their personal and physical appearance. It was clear that people dressed in their own chosen style. We saw that staff were respectful when talking with people, calling them by their preferred names. Staff were seen to be upholding people's dignity, and we observed them speaking discreetly with people about their care needs, knocking on people's doors and waiting before entering. One person told us, "Staff are very pleasant, I feel respected". A relative said, "They are all very respectful to [my relative] and always tell him what they are going to do, like change his pad. The staff are very caring, they do their best". A member of staff added, "We respect privacy and dignity". Staff encouraged people to maintain relationships with their friends and families and visitors were able to come to the service at any reasonable time, and could stay as long as they wished. A relative told us, "They are always friendly towards me. Dogs are allowed, it's good for residents". The registered manager added, "It is their home, visitors can visit when they wish".

Staff supported people and encouraged them, where they were able, to be as independent as possible. We saw examples of people being encouraged to be independent. One person told us, "I am allowed to help in the garden". Care staff informed us that they always prompted people to carry out personal care tasks for themselves, such as brushing their teeth and hair. One member of staff said, "Some people are really independent and others aren't. I encourage people to do what they can". Another member of staff said, "I always encourage people, but if they say no, well then maybe a different carer can encourage them".

Good

Is the service responsive?

Our findings

At the last inspection on 27 October and 1 November 2017, the provider was in breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care plans did not always reflect people's needs and preferences. This placed them at risk of receiving care that was not appropriate and did not meet their needs. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At this inspection, we saw that people's needs were assessed and care plans were developed to meet those needs, in a structured and consistent manner. The registered manager told us, "All care documents are now up to date and staff can access care plans at any time on the tablet or laptop". Our own observations supported this. Care plans contained personal information, which recorded details about people and their lives. This information had been drawn together, where possible by the person, their family and staff. A relative told us, "[My relative's] care plan review is tomorrow and I am going to be involved in it".

Staff told us they knew people well and had a good understanding of their family history, individual personality, interests and preferences, which enabled them to engage effectively and provide meaningful, person centred care. Each section of the care plan was relevant to the person and their needs. Areas covered included; mobility, nutrition, continence and personal care. Information was also clearly documented regarding people's healthcare needs and the support required to meet those needs. Care plans contained detailed information on the person's likes, dislikes and daily routine, with clear guidance for staff on how best to support that individual. One member of staff told us, "Care plans contain all their details, what they like and dislike, but it's not about routines, everything is person centred". Another said, "The care documentation is good, you get to know different information about people, their families and their life before they came here. We also watch people to learn how they talk, how they move and what they like". We saw that people were given the opportunity observe their faith and any religious or cultural requirements should they wish to.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 250 of the Health and Social Care Act 2012. Services must identify, record, flag, share and meet people's information and communication needs. Nobody at the service who received funding had specific communication needs. However, staff ensured that the communication needs of others who required it were assessed and met. We saw that where required, people's care plans contained details of the best way to communicate with them and staff were aware of these. However, staff were not aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS.

People told us they were listened to and the service responded to their needs and concerns. One person

told us, "Staff do listen when I ask for something, they are very good at that". A relative said, "Communication is good and they do ring me anytime and I come in". A visiting professional added, "I think they are very good at responding to people's needs, they are one of the better homes in that respect".

Peoples' end of life care was discussed and planned and their wishes had been respected if they had preferred not to discuss this. People were able to remain at the service and were supported until the end of their lives. Observations and documentation showed that peoples' wishes, with regard to their care at the end of their life, had been respected.

We saw a varied range of activities on offer which included, music, arts and crafts, ball games, exercise and visits from external entertainers. Representatives of churches also visited, so that people could observe their faith. People were happy with the activities on offer. One person told us, "I like the entertainment". Another person said, "Yes, I do think I am well looked after here and there seems to be a reasonable activities programme". A relative added, "They have activities like colouring, drawings for special occasions, ball games, singing, music, skittles, exercises and entertainers. They involve the residents who wish to take part". It was clear that a formal activities programme had been developed and implemented, and we saw evidence to support this.

People knew how to make a complaint and told us that they would be comfortable to do so if necessary. They were also confident that any issues raised would be addressed. One person told us, "I feel I could approach the staff if I needed to". A relative added, "If I had any concerns, I'd say". The procedure for raising and investigating complaints was available for people, and staff told us they would be happy to support people to make a complaint if required.

People had access to technology to ensure they received timely care and support. The service had a call bell system which enabled people to alert staff that they were needed. We saw that people had their call bells within reach and staff responded to them in a reasonable time. Furthermore, the service used an electronic care planning system that was easily accessible for staff.

Good

Is the service well-led?

Our findings

At the last inspection on 27 October and 1 November 2017, the provider was in breach of Regulations 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not receiving safe support with their medicines, risks associated with people's safety, the safety of the environment and equipment were not identified and managed appropriately and emergency evacuation procedures were not detailed enough to ensure people's safety. We also found areas of practice that needed improvement. Parts of the service were unclean and required recruitment processes had not always been followed. After the inspection, the provider wrote to us to say what they would do to meet legal requirements. Improvements had been made, and the provider is now meeting the legal requirements.

At the last inspection the provider's systems of quality monitoring and improvement were not robust and had not identified or prevented the concerns that we saw. We saw that improvements had been made. The provider undertook quality assurance audits to ensure a good level of quality was maintained. The registered manager told us that regular audits for health and safety, accidents and incidents, care planning and medication took place. Documentation we saw supported this, and the results of these audits were analysed to determine trends and introduce preventative measures. Up to date sector specific information was also made available for staff including details of managing specific infectious conditions. We saw that the service also liaised regularly with the Local Authority, Clinical Commissioning Group (CCG), a local hospice and local groups including Dementia Action Alliance, to share information and learning around local issues and best practice in care delivery.

People and staff spoke highly of the service and felt the service was well-led. Staff commented they felt supported and could approach the registered manager with any concerns or questions. One person told us, "The management seems ok". A relative said, "I do get on with all the staff and the management. The manager is very proactive, as is the owner. She is always approachable and the owner is very friendly". Another relative added, "The manager and owner are making improvements and things are getting better. Things have certainly got better in recent times". People felt happy with the care they received and were complimentary of the service. One person told us, "I am glad that I am here". Another person said, "I love it here, it's fantastic, I'm never lonely". A relative added, "I am very pleased with this place, I can't fault the place". Another relative said, "I think this home is on the up. Overall, the home is very caring and staff have a good understanding of dementia. It's a very good home and I would recommend it".

We discussed the culture and ethos of the service with people, the registered manager and staff. A relative said, "I am impressed by the ethos of the Home. [My relative] has never wanted to go home". The registered manager added, "We have instilled a caring culture with all the staff and residents, and we get on really well with the families". Staff supported this and a member of staff said, "We are providing good care. We are at the level we want to be. It's a good feeling coming to work". A further member of staff added, "We are a home, not a clinic. If people want to sing all day and have fun, that's fine. We care for our residents, but not just them, their families too". In relation to staff, one person said, "Staff do seem happy here". There was also a clear written set of values displayed in the service, so that staff and people would know what to expect from the care delivered.

Staff said they felt well supported within their roles and described an 'open door' management approach. They were encouraged to ask questions, discuss suggestions and address problems or concerns with management, including any issues in relation to equality, diversity and human rights. Management was visible within the service and the registered manager took an active approach. A member of staff told us, "Everything you want gets' sorted out. [registered manager] is so supportive, a brilliant manager". Another member of staff said, "The managers are really approachable". The service had a strong emphasis on team work and communication sharing. Handover between shifts was thorough and staff had time to discuss matters relating to the previous shift. Staff commented that they all worked together and approached concerns as a team. One member of staff told us, "We all help each other and are part of a team. The managers support us and never put us under pressure. We have a different age range of staff, so we get different perspectives, which helps us to learn". Another member of staff said, "I have been accepted here and we are all part of a good team. I love it here". This was echoed by registered manager who told us, "Staff morale is good and the residents are happy. People can see the change and staff have really helped with that".

We saw that people and staff were actively involved in developing the service. There were systems and processes followed to consult with people, relatives, staff and healthcare professionals. Meetings and satisfaction surveys were carried out, providing the registered manager with a mechanism for monitoring satisfaction with the service provided. A relative told us, "They do have monthly relatives' meetings, where they tell us about future plans. They don't prevent residents attending".

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. The registered manager was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation that all providers must adhere to. Under the Duty of Candour, providers must be open and transparent and it sets out specific guidelines providers must follow if things go wrong with care and treatment.

Staff knew about whistleblowing and said they would have no hesitation in reporting any concerns they had. They reported that managers would support them to do this in line with the provider's policy. We were told that whistle-blowers were protected and viewed in a positive rather than negative light, and staff were willing to disclose concerns about poor practice. The consequence of promoting a culture of openness and honesty provides better protection for people using health and social care services. Staff had a good understanding of Equality, diversity and human rights. Feedback from staff indicated that the protection of people's rights was embedded into practice, for both people and staff, living and working at the service.