Barchester Healthcare Homes Limited

Cherry Blossom Manor

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 5 and 10 March 2015 and was unannounced. Cherry Blossom Manor provides residential care for up to 77 older people, including people living with dementia. At the time of our inspection 61 people were living in the home.

The home consisted of two floors. The top floor, known as Memory Lane, cared for people living with dementia. The ground floor accommodated people with personal care needs and people living with the earlier stages of dementia. Some people were on short term re-ablement and respite placements to support them to regain the skills and independence required to return to their own homes.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like

Summary of findings

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.

During this inspection we checked whether the provider had taken action to address the three regulatory breaches we found during our inspection in August 2014. The provider told us they would complete the actions required by the end of November 2014, and we found the home was no longer in breach of the regulations.

Not all staff had completed training in the required subjects identified by the provider to ensure they could carry out their roles effectively. Staff had not always been supported through regular supervisions. However, there was evidence that staff were appropriately supported through the registered manager's open door policy and other opportunities to discuss concerns. Plans shared by the registered manager demonstrated that training and supervisory meetings would be up to date by the end of March 2015.

People's care records demonstrated that staff received appropriate guidance to meet people's specific health needs effectively. Robust recruitment checks ensured new staff were suitable to support people safely.

People and relatives did not always feel there were sufficient staff available to meet people's needs promptly. Staff told us unplanned absences affected their workload, although they ensured the impact of this did not affect people's care. The registered manager demonstrated that staffing levels were planned to meet people's identified needs. When short notice absences reduced staffing levels below the required minimum, measures had been taken to ensure the busiest times of each shift were covered. Where agency staff were used to cover staff absence, the registered manager promoted continuity of care by using agency staff on long term contracts when possible. Agency staff we spoke with had a good understanding of people's needs, and knew each of them individually.

People told us they felt safe in the home. Staff understood and followed the provider's policy to safeguard people from the risk of abuse, and were confident of reporting procedures should they have concerns.

People confirmed that they received their medicines on time. Medicines were administered, stored and disposed of safely. Equipment was checked and serviced in accordance with manufacturers' guidance to ensure people, staff and others were not placed at risk of harm. Guidance was in place to ensure staff understood their roles and responsibilities in the event of incidents and emergencies.

People's rights and wishes were promoted through effective implementation of the Mental Capacity Act 2005. Staff understood the actions to take if a person was assessed as lacking the mental capacity to make an informed decision. The registered manager understood and followed the requirements of the Deprivation of Liberty Safeguards when people had been identified as needing restrictions to protect them.

People told us they enjoyed the food provided, and were offered alternatives if they did not like the choices available. Staff were aware of those at risk of malnutrition and dehydration, and effectively supported people to maintain a healthy dietary intake.

Communication within the home effectively ensured people were supported through a network of health professionals as required. People on short term placements were enabled to return to their own homes, as staff supported them to build their confidence and independence.

People described staff as caring and polite. We observed staff treated people with respect. They took care to promote people's dignity and privacy. They listened to people's wishes, and supported them as they wished. Where people were unable to verbally communicate their wishes, staff used aids, such as plated meals or other objects of reference, to help people indicate their preferences.

People's needs were reviewed with them on a monthly basis. Assessment tools ensured people's changing needs were documented and addressed. Risks to people's health and wellbeing were identified and assessed to ensure people and others were protected from potential harm.

People and those important to them had opportunities to influence the service through comments books and quarterly residents and relatives meetings. There was evidence that the registered manager considered

Summary of findings

comments raised and took actions to address people's concerns. Formal complaints were managed in accordance with the provider's policy to reach resolution, and the findings from these were shared with the complainant.

People told us they thought the home was well managed. Staff recognised improvements made within the home, but did not always experience support and appreciation. They did not unanimously consider that issues and concerns they had raised had been addressed or resolved effectively.

Audits of the quality of care people experienced demonstrated that improvements had been made, but further improvements were required to meet the provider's policies and procedures, such as the completion rate of training and supervisory meetings.

The provider's values were embedded in the home, and demonstrated by staff and managers. Feedback from people, relatives, commissioning and monitoring authorities and others was used to inform reflection and learning to improve the quality of care people experienced. A central action plan ensured progress was monitored and owned by the registered manager and regional management team. This ensured required actions were regularly reviewed until completed, and those in positions of authority were held to account for the actions required.

Summary of findings

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 always safe.

People and relatives were concerned that staffing levels were not sufficient to meet people's needs promptly. The registered manager was recruiting staff to provide additional contingency to safely manage unplanned staff absence, and had planned strategies to reduce the impact of staff shortages.

Comprehensive recruitment checks ensured staff were suitable for their roles. Medicines were administered, stored and disposed of safely.

People were not at risk of harm, as staff understood how to identify and raise concerns regarding potential abuse and other risks. Equipment within the home was checked and serviced to ensure it worked safely.

Is the service effective?

Requires improvement

The service was not always effective.

People were supported by staff who demonstrated effective care and understanding of their needs. However, a lack of regular supervisory meetings meant staff did not always have the opportunity to discuss and share good practice or concerns that could affect people's care.

Staff training had not always been completed and updated regularly. Although rotas ensured people were not placed at risk, staff had not always refreshed the skills necessary to promote people's safe and effective care.

People's rights were protected through effective implementation of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff understood the importance of gaining consent before providing care, and demonstrated this in practice when supporting people.

People were supported to maintain a healthy diet. Systems in place ensured people at risk of malnutrition or dehydration were identified, and appropriate actions taken to reduce risks to their health. Prompt referrals to health care professionals by staff ensured people received the care and treatment they required.

Is the service caring?

Good

The service was caring.

People described staff as caring and polite. We observed staff treated people respectfully, and promoted people's dignity and privacy.

People were supported to make decisions important to them, and staff listened to their comments and acted on them.

Summary of findings

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's changing needs. Personalised care plans demonstrated people's involvement in agreeing the support they required, and feedback informed staff of the activities people preferred.

People and relatives were encouraged to discuss concerns or raise issues through comments books and quarterly meetings. Complaints were investigated and resolved in accordance with the provider's policy.

Is the service well-led?

Good

The service was well-led.

People told us they thought the home was well managed. Staff mostly described the registered manager and deputy manager as supportive.

Feedback and findings from audits drove improvements to the quality of care people experienced. Actions were monitored by managers to ensure improvements were effective.

The provider's values, recognising people's rights, and celebrating people's individuality, were embedded in the home, and demonstrated by staff and managers.

Cherry Blossom Manor

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 checked 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 5 and 10 March 2015 and was unannounced. The inspection team consisted of an inspector and an expert by experience with knowledge of people living with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports, the Provider Information Review (PIR) and notifications that we had received. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. A notification is information about important events which the provider is required to tell us about by law.

Concerns had been brought to our attention about staffing levels and agency staff use through anonymous information shared with the Care Quality Commission (CQC). Prior to our inspection we spoke with a local authority officer to obtain their feedback about the care provided in the home. They noted improvements made since the CQC inspection in August 2014. This information was used to inform our inspection.

During our inspection we talked with six people, and four relatives or friends of people living in the home. Some people living with dementia were unable to tell us about their experience of the care and support they received. We observed the care and support these and other people received throughout the day to inform our views of the home. We spoke with the registered manager, deputy manager and regional director, as well as two nurses, seven care workers and other ancillary staff including those in catering and maintenance roles.

We reviewed six people's care plans and daily care records, and 13 people's charts documenting their specific care and support needs, such as maintaining hydration and re-positioning. We also reviewed four medicines administration records (MAR). We looked at eight staff recruitment files, and four staff training and supervision logs. We looked at the working staff roster for four weeks from 9 February to 8 March 2015. We reviewed policies, procedures and records relating to the management of the service. We considered how people's and staff's comments and quality assurance audits were used to drive improvements in the service.

Requires improvement

Is the service safe?

Our findings

The provider had taken actions to address the concerns regarding staff recruitment identified at our previous inspection in August 2014. Implementation of the provider's action plan, made in response to our inspection, demonstrated that the legal requirements for recruitment had been met. Criminal records checks had been completed. Where issues had been identified, the registered manager had discussed the issue with the applicant, and risk assessed the information shared to ensure people were not placed at risk of harm.

Evidence of good conduct had been sought from applicant's previous employers, and each applicant's identity had been verified. Gaps in employment history had been investigated when required, and applicants had completed a declaration to confirm their medical fitness for their role. Recruitment files had been audited by the registered manager to ensure all the required information had been completed. People and relatives raised concerns regarding staffing levels. One person told us they waited up to 30 minutes for staff to respond to their call for assistance, and others told us response times were variable but "Not as quick as I would like". A relative stated "It ends up being an age before things get done because staff are being pulled elsewhere".

Staff told us staffing levels were generally improving, and the reliance on agency care staff had greatly reduced, although there was still a reliance on agency nurses to meet rostered hours. Agency nurses were usually on long term contracts to the home to promote consistency of care. The registered manager confirmed that agency care workers were no longer used, as there were sufficient staff employed in this role. However, recruitment was ongoing to provide additional cover for leave and unplanned absences.

Three care workers did not feel that staffing was sufficient to meet people's needs promptly. They told us people's dependency needs had increased without changes to staffing levels, and there was more demand for two staff to help people to transfer safely. During our inspection call bells were usually responded to promptly, but there was one occasion when a delay of approximately 15 minutes occurred. This person had not required urgent assistance, but staff had not checked to ensure this was the case. This meant that the person could have been caused distress or discomfort by the delay experienced. The registered manager was able to review call bell times, and told us this delay had been caused as all available care workers were supporting people requiring two staff to safely mobilise. They stated that this was an unusual situation, as review of call bells did not demonstrate repetition of this occurrence.

We observed that staff were busy throughout the day, particularly at meal times, but we did not observe that this impacted on people's care. All the care workers and nurses we spoke with confirmed that people's care was not usually impacted by a lack of staff. However, the impact was felt by staff, as they informed us they were not always able to take planned breaks, and some worked late to complete paperwork.

We reviewed the staff roster for a four week period between 9 February and 8 March 2015. This indicated that on nine days staffing had not met the provider's agreed levels, due to unplanned absences. The registered manager explained how nursing staff had provided additional care worker cover on five of these days, as nursing staff levels were above the required minimum levels. Over the other four days, measures had been implemented to reduce the impact of reduced staffing, such as extending the end of shift time for staff on late shifts, and asking staff on early shifts to start earlier. This ensured the busiest times were covered with sufficient staffing. Staff from other disciplines, such as the activities team, provided additional support such as meal time assistance. A member of the maintenance team was trained as a care worker, and was able to provide additional rota cover at short notice when unplanned absences affected staffing levels. The impact of reduced staffing levels was therefore managed to ensure people had the care and support they required.

The regional director explained that people's dependency needs, the home's layout and staff skills were all considered when agreeing suitable staffing levels for each of the provider's homes. The registered manager and regional director were reviewing staffing levels at the time of our inspection. Planned recruitment of new staff would provide a level of contingency for short notice absences that was not yet available.

People told us they felt safe in the home, and all, with the exception of one relative, told us they felt people were safe

Requires improvement

Is the service safe?

with staff. We discussed with the registered manager the cause for one relative's concerns. This matter was being investigated, and appropriate actions had been taken to ensure people were safe.

Staff had been trained in safeguarding, and understood their responsibilities to protect people and report concerns. The provider's safeguarding and whistle blowing policy and reporting procedure, and the local authority's guidance, were displayed in staff rooms for reference. Staff told us they felt confident in managing people's anxieties. We observed staff were skilled at supporting people when they became agitated or upset. A care worker stated "We are aware of those who rub each other up the wrong way". Staff understood triggers affecting people's moods and actions, and took appropriate steps to quickly diffuse situations that may cause people or others harm.

People told us they received their medicines on time. One person explained how their medicines were time specific to ensure they were not placed at risk of harm due to their medical condition, and this need was met. We observed medicines administration. The nurse followed the Medicines Administration Records (MARs) to ensure people received their prescribed medicines. Time of administration was highlighted, and changes to medicines were colour coded, to ensure nurses administered medicines safely and on time. Some medicines, such as insulin, were dependent on the person's condition. Night staff had checked people's blood sugar levels where this was required, and this information was logged with the person's MAR chart. This ensured people received the appropriate amount of insulin to manage their diabetes safely.

Medicines were handled safely. MARs were not signed until the nurse had observed the person taking their medicine. Where people declined, the nurse had a system to ensure medicines were offered again. We observed this was effective in ensuring people received their prescribed medicines. People's records and MARs ensured staff were informed of allergies. Medicines were stored securely.

Appropriate actions were taken to check prescribed medicines were ordered and received, and spoiled and unwanted medicines were disposed of weekly through the pharmacy.

Risks affecting people's safety and welfare had been identified, assessed and reviewed. For example, risk assessments had been completed to ensure people and others were protected from risks associated with the laundry and chemicals stored at the home. Storage areas and the laundry were kept locked to protect people from harm. Risks specific to individuals, such as smoking, had also been assessed, and actions put into place to ensure these risks were safely managed.

The home had a fire evacuation plan, which had been reviewed and updated in February 2015. This considered the requirements to support each person to escape, such as whether they required staff support to safely mobilise. Staff roles and responsibilities had been allocated, and fire drills ensured staff were trained in these. The provider's business continuity plan documented how the home would be managed in the event of emergencies such as severe weather and utility failure. These measures guided staff to protect people from events that may affect their safety.

The maintenance team ensured equipment was checked and serviced regularly to protect people, staff and visitors from harm. Staff used a log book to record any maintenance issues, and this was checked by the maintenance team daily. Actions were prioritised according to risk and impact, and repairs and replacements were completed promptly. Certificates demonstrated that safety tests, such as lift servicing, legionella water sampling and gas safety, had been carried out in accordance with the manufacturers' guidance by competent professionals. Where issues had been identified, such as failure of emergency lighting, actions had been taken to complete the actions required. This ensured that people and others were not placed at risk of harm due to faulty equipment.

Requires improvement

Is the service effective?

Our findings

The provider had taken some actions to address the concerns regarding staff training and supervision identified at our previous inspection in August 2014. Implementation of the provider's action plan, made in response to our inspection, demonstrated that the legal requirements for staff support had been met. Training completion had improved, and actions were in hand to ensure all required training was refreshed regularly. The provider's trainer told us training had "Really turned around since the registered manager has been in post". However, we were not assured that these actions ensured all staff had the skills required to support people safely, as some staff had not yet completed or refreshed all their required training.

The provider required an 85% completion rate for staff in all training subjects relevant to their role. Not all training at Cherry Blossom Manor had met this level. For example, 77% of all staff had completed fire safety drills, and 75% had completed or updated emergency resuscitation training. The trainer explained that additional training was planned to ensure that staff had the required skills to safely meet people's needs, and showed us dates planned in March 2015 for training delivery to meet the required completion rate. Sufficient trained staff were on duty each shift to ensure people would be supported safely in an emergency. Rotas were managed to ensure staff were available to attend planned training. This demonstrated that the provider was aware of the need to update training, and had taken steps to ensure people were protected from identified risks.

Staff described training as "Really good". Training and guidance specific to people's needs, such as dementia study days, palliative care and resources to support people with Parkinson's, were made available to staff. Trained senior staff assessed staff competency to ensure they had the skills required to support people safely, for example through safe support to mobilise, or to support people with dementia. This ensured people were supported by staff with the skills and knowledge to meet their individual needs.

All staff had attended a supervision meeting in November or December 2014. Half of the care staff had attended at least one supervision meeting in January or February 2015, and the others had these planned for March 2015. At the time of our inspection, it was not clear that staff received sufficient guidance or support through regular planned supervisory meetings. The registered manager told us they aimed to complete supervision meetings with staff every two months, in accordance with the provider's policy, from April 2015. Senior staff were attending training to provide them with the skills to support the registered manager and deputy manager to deliver these.

Supervisory meetings, due to be held every two months, provided an opportunity for staff and managers to review concerns, skills and learning. This guided staff to support people effectively and safely. Group supervisory meetings shared learning and discussed good practice. For example, a nutritional meeting held on 25 February 2015 identified people at risk of malnutrition, and agreed measures to reduce these risks such as adding cream to people's soup. We observed this in practice at lunch time. This demonstrated that supervisory meetings were productive in agreeing and implementing actions to support people's needs.

Staff understood and implemented the principles of the Mental Capacity Act 2005 (MCA). Training records confirmed that all staff had completed MCA training, and that this was refreshed annually. One care worker told us "Different things work for different people. It's about knowing your residents. We have a duty of care, but it's also about their choice", and another stated "We assume everyone has capacity".

We observed staff asked people for permission before supporting them with personal care or other care needs, and listened and followed their response. Staff understood people's communication methods, and explained actions in a way that the individual understood. For example, some people with dementia were able to respond to simple questions, whilst others were able to carry out conversations with staff.

Guidance supported staff to complete an effective mental capacity assessment where this was required, and documents recorded the process of assessment and best interest decision-making, including input from health professionals and family as appropriate. Where people had varying mental capacity, it was evident that they had been consulted and decisions discussed with them, to ensure their views were documented and informed their care provision.

Requires improvement

Is the service effective?

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive a person of their liberty where this a necessity to promote their safety. The DoLS are part of the MCA and are designed to protect the interests of people living in a care home to ensure they receive the care they need in the least restrictive way. Staff had been trained to ensure they understood the implementation of the DoLS. Where people had been deprived of their liberty to ensure their safety, for example through the use of door keypads, applications for DoLS had been submitted by the provider to ensure these restrictions were lawful. The registered manager had submitted applications to the local authority, and at the time of inspection five of these had been granted.

People told us they enjoyed the meals provided, and could choose alternatives and additional snacks as they wished. One person confirmed "There is a choice of food and I like it, if I prefer a sandwich I can have it. It's nice in the restaurant and nice to have a natter to other residents." People were encouraged to socialise at meal times, but people's preferences for where they dined were respected. We observed staff offering drinks and snacks throughout the day to people in communal areas and those remaining in their bedrooms.

Assessments identified people at risk of malnutrition or dehydration, and records documented that staff ensured these people were supported to eat and drink sufficiently to maintain their health. Both the chef and care workers were aware of individual dietary needs, and ensured people received diets to support their needs. Reviews of people's weight and other indicators of health ensured actions taken to promote weight gain or support hydration were effective.

People told us they were supported to see health professionals such as the GP and chiropodist promptly when needed. Staff stated that communication between teams, disciplines, management and health professionals was effective. One nurse described liaison with the GPs as a "Good working relationship", and a care worker told us there was "A good network of health support".

Records documented that when people had been identified with health concerns, there was prompt referral to health professionals, including GPs, and specialists such as Speech and Language Therapists, Occupational Therapists (OTs) and Tissue Viability nurses. Health appointments were planned and attended. People's care plans demonstrated that advice from health professionals was documented and followed, such as continence care and exercise regimes. Evidence confirmed people aiming to regain skills to support them to return to their own homes were supported through effective liaison with OTs, social services and others. The registered manager described this as a "Holistic approach" to address their needs. People requiring re-ablement respite care were provided with the skills and confidence to develop their independence and abilities before leaving Cherry Blossom Manor to return to their own home.

Good

Is the service caring?

Our findings

People told us staff were mostly very caring and polite, although one staff member's attitude when serving meals was described as " brusque", and the attitude of a care worker caused a relative to discuss their concerns with us. The registered manager was able to explain the actions taken to address this. Relatives told us staff were welcoming, and respectful of their loved ones. One relative said "I have only seen the staff be absolutely delightful, they are always trying to cheer him up".

Throughout our inspection interactions between staff and people were caring and good humoured. We observed staff were respectful of people's privacy, knocking on people's doors before waiting to be invited in, and closing doors and curtains when providing personal care. People's care plans and other documentation in the home reminded staff to promote people's dignity and privacy, and we observed staff followed this. Staff took care to ensure they supported and treated people as they wished, and listened to their responses when discussing care preferences. One care worker explained "It's a home from home. If it's not good enough for me or my family, it's not good enough for them. It's the little things that make the difference to their day".

Staff understood the impact dementia had on people's lives. One care worker noted "When people have dementia they don't always register what you say". Staff took time with people to understand their wishes and provide reassurance. They knew people's favourite meals, preferred routines and triggers that affected their wellbeing, and ensured that people were supported to promote their health and satisfaction.

Staff greeted people cheerily in the morning. They checked where people would like to eat their breakfast, what they would like to eat, and whether they were ready to rise yet. Their responses informed the actions staff took. For example, one person told the nurse they did not want their medicine until after their breakfast, and told the nurse what they wished to eat. The nurse shared this information with the care worker assisting with breakfasts, and returned later to administer the person's medicines.

Although meal times were busy, staff took time to support people to eat when this was required, and understood each person's needs and wishes regarding their diet. People chose where to sit, and mealtimes were used as an opportunity to promote conversations, socialisation and friendships. Where people were unable to verbally make their wishes known, staff understood how to help them communicate their wishes. For example, plated meals were offered at lunch time to support people to chose their preferred meal option.

When a person appeared unwell during a meal, staff were attentive to their needs. They noted indicators of the person's discomfort and came to their aid without the person needing to call for help. A nurse checked the person's health discreetly and with compassion before advising them on actions to promote their recovery.

Staff provided people with friendship, reassurance and comfort. Hugs and compliments were evident, and people readily approached staff when they were ill at ease. Staff understood when anxieties or frustrations affected relationships between people, and took actions to distract people from triggers known to escalate behaviours that adversely affected people's welfare or wellbeing. Effective communication ensured staff shift changes did not affect the support people required when experiencing a period of increased anxiety, as staff were informed of each person's mood and support needs during handovers. This ensured people received the daily care and support they required to protect them and others from potential harm.

Good

Is the service responsive?

Our findings

At our inspection in August 2014 we did not see evidence that people's care plans reflected appropriate guidance for care staff to manage their specific health needs. Guidance to manage known health conditions, such as diabetes, was not provided. Implementation of the provider's action plan, made in response to our inspection, demonstrated that legal requirements had been met. Care plans included specific guidance for staff, such as the signs and symptoms of hypoglycaemia and hyperglycaemia. These are conditions that characterise abnormally high or low blood sugar levels, often related to a diagnosis of diabetes. Information in people's care plans ensured care workers were alerted to these symptoms, and understood the actions required to support people to return to normal blood sugar levels. Symptoms of ill health and guidance to maintain people's health ensured staff understood how to support people to manage known health conditions. Staff understood the actions required to manage people's health should symptoms indicate that known health conditions were not suitably controlled.

Relatives told us they were encouraged and welcomed to visit at times convenient to them. Records demonstrated that information about people was shared with relatives promptly when appropriate, for example following a fall or health incident. People's and relatives' views were sought through informal conversations, comments books, quarterly meetings and an annual satisfaction survey.

The satisfaction survey held in the summer of 2014, and completed by 23 respondents, noted a score for overall satisfaction of 61%, with 45% of respondents satisfied with the availability of staff, and 67% stating they were happy to live in the home. The registered manager explained that actions to address feedback from the survey were included in an overall action plan for the home. Meeting minutes from resident and relatives meetings held in December 2014 stated an overall satisfaction with care, but noted concerns over the lack of activities, and staffing at weekends. The registered manager told us the number of activities staff had been increased, and managers now worked at weekends, to address the concerns raised.

Other concerns were raised by people, relatives and staff, such as missing laundry, response to call bells and a lack of cutlery and other kitchen equipment, in meetings in December 2014 and 2 March 2015. We were informed of similar concerns during the inspection. This indicated that some concerns had not been addressed in a timely manner to the satisfaction of people and others. The registered manager told us they were working to resolve issues, such as a review of staffing levels and ordering additional kitchen equipment. Formal complaints had been dealt with in accordance with the provider's procedure, through investigation, actions and feedback as appropriate. Compliments were shared with staff and displayed in the home.

Activities were planned and delivered on both floors. These included games and quizzes, individual one to one sessions of pampering or reminiscence, and external entertainers visiting to lead music sessions. Links with the local community were being developed, such as visits to and from a local school. People were encouraged to suggest activities they would enjoy. An electronic device was being tested in the home, to support people to search areas of interest, such as historical sports events, or play memory games.

A 'resident of the day' programme ensured each person received dedicated time on a monthly basis to review their care and welfare needs. Care plans documented each person's needs, wishes and preferences, such as routines for getting up and going to bed, likes and dislikes, and the activities they enjoyed. Each person was visited by the heads of departments, such as housekeeping, maintenance and the chef, to ensure their room was maintained and cleaned as they wished, and meals met their nutritional needs and personal preferences. Although care plans did not record how each individual, or others legally able to represent them, had been involved in their care planning, the information contained reflected personal preferences and needs that indicated their involvement. The managers carried out audits and reviews of care plans to ensure people's care was responsive to their changing needs. The deputy manager showed us new forms being introduced for care plan reviews that better documented people's involvement.

When people found decision-making difficult, staff understood actions to take to promote their ability to do so, such as offering simple alternatives. This supported people to make informed choices about their care and support. The activities team were in the process of updating people's life history records. Information from this was used to ensure staff understood what was important to

Good

Is the service responsive?

people, and how this may affect their care needs. For example, we saw that one person's employment meant that they had been used to rising early, and this influenced the time they woke each day. Staff understood that people's history affected their care and support needs, and used this to reduce anxieties and improve people's wellbeing.

Effective communication between care workers and nurses, such as handover meetings, daily diaries and communication books, ensured all staff were informed of changes to people's needs. The provider's systems to share information and document changes, such as charts to log food and fluid intake, ensured that staff were responsive to changes affecting people's care or wellbeing. Daily records demonstrated that people's planned care, such as dressing changes and health appointments, were met as planned.

When people's needs changed, staff worked together with the individual, family and health professionals to ensure their care met their needs. When people's dementia care needs increased, staff supported their move from the ground floor to the top floor through planned introductions during activities and meal times. They supported people to build relationships and familiarity to reduce the impact of anxieties related to the move. Staff were responsive to people's needs, and took care to manage and reduce the impact of changes on people's wellbeing.

Risks affecting people's health and wellbeing had been identified, and appropriate actions taken to reduce and manage risks. For example, people identified at risk of falling had been checked for ill health, such as urinary infection, that may increase the risk of falling. Their footwear had been checked to ensure this had not contributed to falls, and where necessary referral to the GP had been made. Reviews of falls in the home indicated that these measures had effectively reduced the number of falls for individuals. Incidents and accidents were reviewed by the registered manager and provider to ensure appropriate actions had been implemented to reduce the risks affecting people and others.

Care staff told us they referred to people's care plans, and these provided them with sufficient information to understand and meet people's care needs. Care plans included information on people's known health and support needs, assessments of risks such as malnutrition, falls and skin integrity, as well as information on spiritual, cultural and activity preferences. Where people's mental or physical needs impacted on their ability to use call bells to summon support, staff were reminded to visit them regularly to ensure their needs were met. Daily records indicated that staff made these visits regularly. People needs were met by staff responsive to their needs.

Good

Is the service well-led?

Our findings

People spoke positively about the management of the home. Comments included "If I am worried I can talk to the manager, it's taken all the worry away from living alone at home", and "I would recommend this home to others".

Staff acknowledged that the management team worked hard to implement changes, and commented on progress towards improvements in areas such as staffing levels. A nurse told us "I've seen changes in the home. We have developed together". Staff took responsibility for delivering good quality care, and understood their role in supporting changes implemented by the managers and provider.

Staff told us they and managers worked together to drive improvements, and told us managers were open to feedback, approachable and available out of hours. One staff member told us "We are proud to work here. We are willing to go above and beyond what is expected of us". Several staff referred to an improving morale and better retention rates for staff, but others told us they did not always feel managers responded to issues they raised.

People were treated with respect and dignity, but we did not see people's confidentiality had always been protected. On the first day of our inspection, offices containing people's care plans and other personal information about them, as well as contact details for relatives and staff, were left unattended and unlocked on both floors. This placed people's confidential documentation at risk of view by visitors unauthorised to do so. The registered manager told us keypad locks had been ordered for these doors, and we found these had been installed on the second day of our inspection. Unauthorised entry to areas containing people's personal data had therefore been addressed.

The provider's values and vision for the home, noting quality first, and promoting people's rights and choices, were reflected in the statement of purpose, residents' welcome booklet, and employee handbook. We saw these values were emphasised through training and staff group supervision meetings. The staff room displayed a board noting "Things I have learned about our residents", such as how named individuals liked their hair brushed, and how to provide reassurance to them when they were anxious. The small things important to each person had been valued and shared to ensure all staff understood their importance.

Regular staff meetings ensured communication worked effectively within the home. Clinical team meetings were held weekly. These reviewed each person's health needs, and ensured they received the care and treatment they required. Care provision was discussed to ensure it met people's needs effectively, and promoted the required response, such as healing, re-ablement or stabilising health conditions. Daily meetings for heads of department ensured a joined up approach to meet identified issues or planned actions, such as arrangements for new admissions to the home.

Senior care workers met weekly, and monthly meetings were held for all care staff, to provide an opportunity for staff to raise issues and discuss suggestions to improve people's quality of care. Concerns raised had been considered by the management team. For example, minutes from a meeting held on 20 February 2015 noted discussion of a new staff rota to trial different shift patterns. A care worker informed us this was being tested at the time of our inspection.

The registered manager and deputy carried out ad hoc visits to the home outside of office hours, including night visits, to ensure people were supported safely. The deputy manager reviewed records completion on a daily basis. Any errors or omissions were identified promptly, before people came to harm. We observed that the deputy manager discussed these with the staff member responsible, and ensured they updated information appropriately. This promoted learning and reduced the risk of repeated errors.

Staff described the registered manager and deputy manager as "Open and friendly", "Supportive day and night", and "Approachable", but staff did not always feel appreciated. Four of the staff we spoke with were not assured that issues they had raised had been addressed or resolved, as they had not seen changes implemented following concerns they had raised. The registered manager and deputy manager were able to explain to us the actions taken to investigate concerns raised by staff, and how these had been resolved or were still in the process of resolution. However, they acknowledged the process to provide feedback to staff could be improved. They immediately discussed with the regional director how this could be implemented during staff meetings in future.

The registered manager, deputy manager and provider carried out audits to monitor the quality of care people experienced. Findings from audits drove improvements to

Good

Is the service well-led?

people's care and record keeping. For example, reviews of MARs charts had identified an issue with labelling on medicines. This had been addressed through liaison with the GP and actions taken by nurses.

It was not always demonstrated that actions had been taken promptly when issues had been identified during internal management audits. For example, an audit dated 18 February 2015 had identified that people's personal records were not stored confidentially, because office doors and records storage cupboards had not always been kept locked. The action plan from the meeting noted that keypad locks for the doors had been ordered, but we identified the same concerns during our inspection on 5 March 2015.

The registered manager told us the provider's audits and monitoring made them "Feel safe", because it ensured the manager had implemented effective measures to drive improvements in people's care. A quarterly audit completed by the regional director on 26 February 2015 described the home as improving weekly, but acknowledged some areas required further actions, such as addressing staffing issues through recruitment, and ensuring staff training and supervision met the provider's requirements.

A centrally monitored action plan was completed and updated by the registered manager, and reviewed by the regional director and other senior staff. Improvements required that had been identified through staff meetings, and feedback from people, relatives and others, were collated into this central action plan. This ensured there was one document referencing actions required and progress towards resolving these. Quality audits by the provider reviewed progress towards resolution, and an electronic system ensured slippage in dates was highlighted to the registered manager and provider. This meant that information was escalated when actions had not been addressed satisfactorily, and there was shared managerial responsibility to monitor progress should any one individual be indisposed.

Accidents and incidents were reviewed by the registered manager and provider. This not only ensured that appropriate actions had been taken to reduce the risk of repetition or harm, but also ensured shared learning throughout the organisation. The regional director explained how learning from safeguarding and strategy meetings with the local authority drove improvements across all the provider's homes. This had led to actions such as colour-coding MARs charts, and improved training in the MCA. The provider sought to work collaboratively and openly with monitoring authorities to ensure people received high quality care.