Care Quality Commission

Bupa Care Homes (GL) Limited

Lindley Grange Nursing Home

Inspection report

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Ratings

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

Overall summary

The inspection of Lindley Grange Nursing Home took place on 24 February 2015 and was unannounced. We previously inspected the service on 8 April 2014 and, at that time we found the provider was not meeting the regulation relating to supporting workers. We asked the provider to make improvements. The provider sent us an action plan telling us what they were going to do to make sure they were meeting the regulations. On this visit we checked to see if improvements had been made.

Lindley Grange Nursing Home is registered to provide accommodation and personal care for up to 40 older people. On the day of our inspection there were 39 residents. The home is purpose built and provides accommodation over two floors. There is also a garden that is accessible for people who live at the home.

There was a registered manager who had been registered since October 2010. A registered manager is a person who

Summary of findings

has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

On the day of our inspection we saw that there were enough staff who were well trained and knowledgeable regarding safeguarding procedures and policy. We saw risk assessments that were up-to-date and reflected the needs of the people being cared for.

We found that peoples' medicines were administered safely and records kept in accordance with the NICE Guidance: Managing Medicines in Care Homes. There were effective links with GPs and other health professionals to ensure that people were receiving the input of external healthcare professionals.

We spoke with staff who informed us of the training and supervision they had received; this was reflected in the records we saw. We observed positive care of people who were living with a diagnosis of dementia which sought to enable people to maintain their independence whenever possible. Staff demonstrated a commitment to supporting people to be individuals through their interactions and communication.

Staff supported people with eating and drinking, and measures were in place to identify and action any concerns for people with a poor nutritional intake. We observed people were given choices around their food and drink, and were supported to make these choices as much as possible. The registered manager had a good understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLs). These safeguards make sure that people who lack capacity are not deprived of their liberty unlawfully and are protected.

Throughout the day we observed examples of care staff having a positive rapport with people and relatives. Relatives we spoke with said they 'were happy' and 'staff were good'. The atmosphere in the service was very relaxed and people appeared happy and calm. Staff were observed throughout the day interacting often with people, and making comments to people which evidenced they knew them well.

Our analysis of the care records and activity files showed that various activities were arranged, appropriate to the people taking part. These were flexible and accommodating, people were able to join in as they wished and we observed people clearly enjoying undertaking them. However, we saw that a film being shown to people could not be heard by those who were watching it.

The leadership of the service was robust We spoke with the registered manager who was knowledgeable about the service and the people who lived there. We observed a good rapport between staff and the registered manager. Staff were very complimentary about working in the home.

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?
The service was safe.

Staff we spoke with were aware of their responsibilities in regards to safeguarding people and had knowledge of how to report concerns.

We saw evidence of thorough risk assessments in peoples care records.

We saw peoples medicines were administered safely.

There were enough staff to keep people safe and relevant checks had been made before staff commenced employment.

Good

Is the service effective?
The service was effective.

Staff had received training and supervision which supported them in their roles

The registered manager demonstrated an understanding of the Deprivation of Liberty requirements.

We observed people receiving appropriate support to eat and drink.

We saw evidence people were enabled to access external healthcare support.

Good

Is the service caring?
The service was caring.

We observed good examples of caring interactions between staff members and people who lived at the home.

The service had a calm and relaxed atmosphere, and staff demonstrated patience and understanding. Staff were very aware of people's individual needs.

We saw staff provided support in an empathetic manner and were always respectful.

Good

Is the service responsive?
The service was responsive.

People were treated as individuals with their own preferences and strengths which were understood by the staff.

Staff knew people well and reacted quickly and favourably to all people to support them when required.

We saw evidence the complaints system was managed effectively, and the opportunity for suggestions on how to improve the service was facilitated through regular residents' meetings.

Good

Is the service well-led?
The service was well led.

Good

Summary of findings

We observed positive and effective communication between people who lived at the home and members of staff. We also saw the registered manager involved in the daily activities within the home.

We received positive comments from staff and relatives regarding the running of the home.

Lindley Grange Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

The inspection took place on 24 February 2015 and was unannounced. The inspection team comprised of two adult social care inspectors.

Prior to our inspection we reviewed information from notifications, the local authority commissioners and safeguarding. We had not sent the provider a 'Provider Information Return' (PIR) form prior to the inspection. This form enables the provider to submit in advance information about their service to inform the inspection.

People at the home were not always able to verbalise their opinion due to their level of dementia. We spent time in the lounge and dining areas at various periods through the day observing the care and support people received. We also completed a Short Observational Framework for Inspection (SOFI). This is a means of helping us to understand the experience of people who could not initiate conversation with us about this.

We spoke with four relatives and one friend. We interviewed seven members of staff including three members of care staff, one member of the housekeeping team, two nurses and the registered manager. We also spoke with a visiting district nurse.

We looked at five care records and three personnel files. We also reviewed quality audits including medication, fire safety, and risk assessments.

Good

Is the service safe?

Our findings

We asked relatives their view on staffing. One person said, "Sometimes there are not enough staff but you can't staff for every circumstance as it is so variable". Another relative said when asked about staffing,: "They could always have more but they look after (person)". One relative said they were "Very happy. (Person) is safe. Staff are caring".

Staff we spoke with all told us there were enough staff on duty. One staff member said, "We all get experience of both units but tend to work on one or the other for a few months".

The registered manager advised us they had not used agency staff since September 2014, preferring to use bank staff where required. They explained the bank staff were given regular shifts to help them understand the care planning system and to enable them to build relationships with residents. The registered manager told us there was a low level of sickness for the staff. This showed that people living in the home were receiving care from staff who knew them well.

We looked at the recruitment records for two members of staff. We found that recruitment practices were safe and that relevant checks had been completed prior to staff commencing employment. This included obtaining two written references and checking their professional qualifications, where relevant. We also saw Disclosure and Barring Service (DBS) checks had been completed prior to staff commencing employment with the service. The DBS provides criminal record checking and barring functions. This helped reduce the risk of the registered provider employing a person who may be a risk to vulnerable adults.

Staff we spoke with demonstrated a sound understanding of what constituted a safeguarding concern. One staff member told us, "Report anything you feel is not right, it's best to report it". We spoke with another staff member who said a safeguarding concern 'could involve not using the hoist [where required] and not lifting someone properly'.

A further staff member told us a potential safeguarding concern could involve 'service user on service user'. This showed that staff were aware of the possibility of harm occurring between people within the home due to their varying levels of capacity. They advised us they 'would tell the nurse'. They were also aware of the local authority safeguarding procedures and policy on how to respond to suspected abuse. This meant staff understood the urgency and significance of prompt action to ensure someone's safety at the home.

There was also evidence in care records that the registered manager had reported safeguarding concerns appropriately to the required bodies. This demonstrated their awareness of what may constitute abuse and where further action may be necessary, either in relation to staff conduct or another person living within the home who may need further support.

We looked at care records which contained defined and personalised risk assessments for people living within the home. These included falls, skin integrity and nutrition. These were reviewed on a monthly basis. We observed people being monitored for their food intake where they were deemed to be at nutritional risk and daily record sheets showed what people had consumed that day. This information was then analysed and advice sought from health professionals if concerns became evident.

One person, who was finding it hard to settle, was being supported by one-to-one care in hourly shifts by each of the staff on duty under direction of the nurse. This was because they were prone to falling and needed constant support.

Staff were aware of the importance of giving people choice. One staff member said, "Taking risks may not be the best choice, but let them have freedom but limit the risk of serious harm. We don't want to restrict people of their liberties". This showed staff were keen to ensure people were supported as much as possible to make choices while at the same time minimising risks to their safety.

We witnessed a number of good examples of support skills from staff when they helped people to mobilise. For example, staff walked backwards while holding a person's hands and moved at the person's own pace. Staff also helped assess the risks for those people unable to do so themselves, for example one person was carrying a ball around but was encouraged to sit down with it rather than kick as this would have presented a hazard for other people in the lounge.

We observed the medicines round which began in the lounge. The nurse administering medicines told us people remaining in bed had their medicines later in the morning. This meant that some people were still receiving their

medicines as late as 11am. We checked the record of one person receiving medicine at 11am to ascertain if the medication had been prescribed for a certain time but this was not the case. If medicines are not administered at the correct time there may be a risk these medicines might not be effective which could affect a person's health and wellbeing .

The medicines administration records (MARs) were personalised with a photograph of each person. We also saw information about people's allergies was recorded, where appropriate. There were four colour-coded sets of blister packs – one for morning, lunch, tea and evening. This corresponded with colours on the MAR sheet.

We observed the nurse safely administer medicines to five people. Medicines were given in a considerate manner allowing the person to take their time and ensuring that they were taken properly. Explanations were given to the person as to what was being offered. We observed liquid medication administered via a syringe to ensure the correct dosage. One person had medicine made from a sachet and we observed the number of sachets being checked before one was opened and made up. We also saw MAR charts were updated after administration and duly initialled by the nurse. This is in accordance with the NICE Guidance for Managing Medicines in Care Homes. We checked the storage of medicines and found that all were appropriately stored and the date that the medicines had been opened was recorded and they were labelled correctly. This demonstrated people were protected against the risks associated with medicines because the registered provider had appropriate arrangements in place to manage medicines.

We saw a list in the nurses' office highlighting when medication reviews were due which included three monthly reviews for those on anti-psychotic medication. A monthly medication audit also revealed no gaps in records, correct identification of people with allergies, balance of stock levels and medication being given at the specified time. This showed that the service was ensuring people were only receiving medicines that were necessary and regular checks were taking place, demonstrating that the service was administering medicines correctly.

We saw evidence in one person's records that staff had raised a query with the resident's GP regarding one of their medicines. The record detailed the response from the person's GP and the corresponding action taken by the staff. We also saw evidence another person's family had requested a review of their relative's medicines. We saw from the person's records that this review had taken place and the person's family had been consulted. This demonstrated that the service was responding well to relatives' concerns and requesting assistance where appropriate.

During our observation of the medicine round we observed the nurse tipping one tray of discarded packaging and dispensing cups into the other. A cloth was used to wipe the tray and then a syringe and other medication was put into it. The same cloth had been used to wipe down medicine bottles to prevent them being sticky. This meant that there was a risk of cross contamination of people's medicines and that basic hygiene was being compromised. This was raised at the end of the day with the registered manager who agreed to discuss appropriate use of wipes and general hygiene during the administration of medication.

We saw that when people where prescribed topical applications there was a body map in the person's care records. We looked at the records for one person who was prescribed a topical medicine. We saw the records contained a body map which detailed the name of the medicine and when it should be applied. We also saw the area where the cream was to be applied was 'shaded' on the body map. This meant staff were provided with clear guidance to ensure peoples' topical medicines were applied safely.

When observing the medication round as it went to people's own rooms we heard staff discussing safe moving and handling techniques to move a person up their bed to ensure medication was safely given. The staff used a slide sheet to do this and during the procedure closed the person's door to preserve their dignity.

We saw evidence of appropriate health and safety records. These included risk assessments for people with safety bedrails, wheelchair maintenance records and portable appliance testing. All were up to date and where issues were noted, the necessary follow up action had been taken.

Staff told us how they reported any concerns they had regarding the premises or equipment. This was evidenced when we looked at the weekly and monthly maintenance plan for the home. We saw the home had recently

Good

Is the service safe?

undergone a programme of refurbishment. This included repainting of the rooms and replacement of the carpet with easier to clean flooring. When we entered the first floor of the home there was a strong odour. The registered manager told us the flooring had not yet been replaced, however this was scheduled for the near future. This meant the provider was aware of the importance of following effective infection control measures and had as robust a cleaning method as possible in the interim.

We also saw records of recent fire drills and weekly testing of the fire alarms and equipment. There was an ongoing staff training schedule for fire evacuation. We saw the most recent one was dated 20 January 2015. Staff we spoke with were able to tell us the fire evacuation procedure. This meant staff were aware off their role in the event of the fire alarm being activated.

Good

Is the service effective?

Our findings

Our inspection on 8 April 2014 found the provider was not meeting the regulations relating to supporting workers. On this visit we checked and found improvements had been made.

We asked relatives and visiting friends about the food. One person said, "Good food, a bit plain but plenty". Another said they 'visited daily to give (person) their lunch'.

One person told us their relative had lost weight so they come in to support them to eat their lunch. They said, "People don't normally get offered drinks….There are not enough staff as so many need support to eat". When we asked if these concerns had been raised with the registered manager the person replied they 'didn't feel confident'. We raised these concerns with the registered manager to make them aware. The weight loss was documented in the care records and a dietician was involved. The person's weight is currently stable.

Later in the afternoon we observed the relative of this person being offered some cake. They were shown two choices and their hand went to one plate. The staff then gave them that one. They were observed eating and drinking independently mid-afternoon.

We saw evidence in the care records that weight loss was being monitored. Staff were recording the food and drinks which were offered to people and what the person actually consumed for those seen as nutritionally at risk. This meant the home had an effective system for ensuring people were receiving adequate nutrition and that any concerns could be followed up by health professionals involved in these people's care.

We observed breakfast and lunch in the communal areas. We were told by staff that there was also a significant number of people who had breakfast in their own rooms.

During the morning we saw a member of staff served people drinks and snacks from a drinks trolley. One person asked for a banana and we saw the member of staff give this to them, another person was offered a cup of tea but they refused as they said a cup of Bovril was being made for them. We saw another member of staff bring this for them.

We also saw mid-afternoon further drinks were offered to people, alongside birthday cake and scones. We saw the scones were already prepared with jam and cream. This meant an opportunity was missed for staff, where appropriate to support people to put their own choice of topping on their scone.

At both breakfast and lunch times we saw a choice of food and regular drinks were offered to each person. Staff explained that the decision had been taken to delay the main meal of the day until evening for most people who lived at the home. They told us this was because staff had noted that people enjoyed their breakfast and then did not have an appetite by lunchtime. However, there was plenty of choice for those who wished for more – people were offered vegetable soup followed by homemade chicken pizza and potato wedges. We saw people appearing to enjoy their lunch and there was not much wastage. The chef also came into the dining area to check with individuals their preferences and offered alternatives.

When we observed lunchtime at the home we saw people were sat at the dining table or used a table whilst remaining in their preferred seat at lunchtime. Two residents were assisted with eating their lunch by staff. Staff spoke with the person they were supporting and we observed one member of staff actively encouraged the person to feed themselves. They were offered a spoon to assist with eating their lunch. Another resident was holding the spoon alongside the carer and feeding themselves. We observed one person who did not wish to sit down but we saw staff give them a cold drink and then a sandwich to eat while walking around the lounge. This showed that staff were encouraging someone to eat and drink whilst allowing them the choice to walk freely.

We spoke with the registered manager at the end of day about our how people may be better supported to facilitate choices with their food. This was because although people were offered a choice of food, once they had made the decision it was already put on the plate for them. We felt people may be supported to choose the portion size they wished.

We spoke to three staff who told us they had received induction training. One staff member said, "I shadowed shifts for about two weeks before being put on the rota". They advised us their training included food hygiene, health and safety, and moving and handling. We saw this confirmed in the staff files where records were completed following a new starter's appointment.

Good

Is the service effective?

The staffing files were complete with details and signed copies of the new starter checklist demonstrating that the provider was ensuring people had received and understood the necessary information at the commencement of their employment.

The registered manager told us all staff received supervision regularly and we saw the supervision matrix which confirmed this. Staff we spoke with confirmed they had supervision regularly. We checked three staff members' records and saw documented evidence to corroborate this. This showed staff received regular management supervision to monitor their performance and development needs.

Supervision records covered topics such as whistleblowing, record keeping, and discussion around the significance of best interests decision-making under the Code of Practice of the Mental Capacity Act 2005. There was also detailed information about the handling of controlled drugs, reminding staff of the policy and process.

Staff were keen to tell us that the training provided was 'very good'. One member of staff explained this by giving an example of recent training they had undertaken. They said, "We had to think of ourselves as the person with dementia. You had to assist each other with yoghurt, they take away one of your senses, you may be blindfolded". This showed the registered provider was promoting effective care of people living with dementia by making the training relevant and memorable.

All the staff we spoke with told us they participated in a lot of training. One member of staff said they had completed training in a variety of topics including moving and handling, first aid and food hygiene. We checked the training records for three members of staff. This evidenced these staff had received regular training in a variety of subjects. This included infection prevention and control, safeguarding and mental capacity.

We also looked at the training matrix for the service. The manager was aware of one person whose safeguarding training had just expired and this was due to be renewed within the next couple of weeks. This meant although the training was out of date, they had effective systems for identifying this and taking remedial action.

Staff told us they felt there was 'good communication. One member of staff said, "Anything we are not sure about, we just ask the nurse or manager". The registered manager explained that there was a daily handover to all care staff given by the nurses, and where appropriate, nurse to nurse. We observed throughout the day, positive and clear communication between staff ensuring each person knew their roles and responsibilities. This demonstrated staff were keen to make sure they had the latest information when caring for someone and were aware of any significant events for that person for that day.

One staff member told us, "We don't look at the care plans as we don't have the time". This meant there was a risk that someone's particular needs could be missed. We observed frequent verbal information sharing but it is important that staff have the time to read the written information. We acknowledge this was one person's view on the day of our inspection and had no indication that staffing ratios were too low not to allow time for this to occur. Care plans were readily accessible in the nurses' office.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

One person who was living at the home was subject to a DoLS authorisation. The registered manager was aware this was due for a review in twelve months. The registered manager also told us about another person who they had felt may require a DoLS assessment. They explained they had discussed this situation with the mental health team who had felt this course of action was unnecessary. This showed the registered manager was aware of their responsibilities under this legislation.

We asked staff about their understanding of how capacity was assessed and the principles of best interest decision-making. One member of staff told us, "(you) tell them what you are doing, often they consent through nodding, or they will say yes". Another emphasised that, "Most (people) can make simple choices, about what to wear, what to drink; having that choice gives them a better quality of life". This showed that staff were aware of the need to check people's wishes and seeking consent before undertaking any tasks. Daily records noted that one person was 'shown a selection of clothes and (they) picked out what they wanted to wear'.

Good

Is the service effective?

We looked at five care records which evidenced capacity assessments including regular review dates. There were records of best interest decisions with regards to people having the influenza vaccination and also evidence of decision-specific assessments allowing people to express their choices as far as they were able. This showed the service had a good understanding of the both the requirements of the Mental Capacity Act 2005 with regard to its responsibilities but also to a day-to-day application for each person living within the home.

Staff told us about they had regular contact with people's GPs and we witnessed staff interaction with a district nurse who was overseeing someone's skin care under the direction of the tissue viability nurse while in the home. There was good communication and information sharing between the staff at the home and the nurse to ensure the current information was known.

The staff said that GPs were "very responsive" to any concerns they raised, responding to changes in people's medicines promptly and the local care home liaison team was particularly supportive. Care records showed that people received the necessary input of other health and social work professionals when required. This showed the service had effective procedures in place to manage changes in people's care needs in a timely manner.

Good

Is the service caring?

Our findings

People told us they were 'happy' and staff were 'good'. This was observed in people's moods in the communal areas where the atmosphere was relaxed and jovial. Another person sitting near to the door was always spoken to by staff as they passed. We observed a high level of interaction with all people and everyone was acknowledged. One person was celebrating their birthday and staff were keen to acknowledge this, both with the person and with other people in the home. They sang 'happy birthday' and presented them with a cake.

Staff told us, "It's a very rewarding job; we get to know them; that's the benefit of working mostly on one floor, we get to know people", "We try to tailor the care to them and their needs; we give them a life that is dignified and well managed".

One resident was walking with their coat and outdoor shoes on and frequently asked the way out. Each time this happened staff responded sensitively and supportively, offering them a cup of tea and a seat on different occasions. The person's request was always acknowledged and they followed staff guidance happily. They were discouraged from going outside as it was very cold and there were frequent heavy wintry showers. We later spoke with staff who advised us that the person had previously been the subject of a Deprivation of Liberty safeguard but that the best interest assessor no longer felt this was required after a recent review.

Another resident appeared anxious and unsettled, we observed staff being very patient, offering a blanket and responding to all the person's questions. Explanations were given by staff as to why it was not possible for them to return to their room as the carpet was being cleaned. Each time the person was unsettled, we saw staff always responded with patience and clarity about what was happening. This showed that staff were able to listen and respond effectively, always considering the person at the forefront of their actions.

During the medication round in the downstairs lounge a person tried to take the blister packs off the top of the trolley as they were intrigued by them. We observed staff handle the situation calmly and sensitively by diverting the person's attention and calling for assistance from another member of staff. The response from another member of staff was swift and the situation was discreetly handled.

A staff member was observed talking generally to a person while assisting them to eat their breakfast. Another staff member helped wipe someone's face after their breakfast, gently explaining what they were doing and why. This demonstrated that staff were keen to promote someone's dignity by ensuring they were clean as they may not have been aware themselves.

Staff were observed using the hoist and were heard to explain what they were doing and reassure the person throughout the manoeuvre. This helped the person remain calm and relaxed.

During lunchtime people were offered choice of food and drink. One person was shown both jugs of juice to decide which they wanted. On other the unit we saw choices being given through verbal options rather than visual prompts.

We asked staff how they promoted a person's dignity and one staff member told us, "We don't do personal care in public. We always close doors and curtains". We were told person-centred care: 'it's about them'. We observed people being guided to the toilet from the communal lounge and saw that staff supported people to use the bathroom independently by closing the door but remaining close by and talking quietly through the door to check whether the person needed support.

We noticed specific instructions on people's doors such as their rooms to be kept locked/not locked at their request. These instructions were adhered to. Staff always knocked on people's doors before entering their room. They also announced who they were.

During our inspection we observed the hairdresser was cutting, washing and drying people's hair in one of the communal lounges. We discussed with the registered manager our concerns that this may not be very dignified for people. The registered manager told us they were already aware of this issue and the potential to compromise people's dignity. They told us they were seeking to convert a bathroom for this purpose.

Good

Is the service responsive?

Our findings

We asked relatives if they had ever had to raise any concerns, and if so, how were these responded to. One person told us, "I have no complaints. (Person) always looks nicely dressed". Another said, "I'm very happy and have no complaints". When we spoke with the registered manager we were told there had been only one complaint which the Care Quality Commission had been notified of. We saw a detailed response to this within the complaints file where all the concerns were addressed.

The registered manager also advised us that all staff were due to undergo a new training course regarding complaint handling. This was to ensure all staff had up to date information regarding the importance of logging and responding to complaints in a timely manner. We also saw the complaints file where the last one had been received in early November 2014 and a detailed written response produced to address the concerns raised. There was also evidence in the relatives' meeting minutes for November 2014 that people were asked for their suggestions as to how the service could be improved.

Outside of each person's bedroom room was a wall-mounted box. This contained important items for each person which helped to orientate themselves to their rooms and reflected the importance of their life story.

During our observations in one of the lounges we witnessed staff interacting with residents. One staff member was doing a jigsaw with two people, another was encouraging a resident to wrap some wool round a piece of card. Staff asked people who had been winders in the local mills. We observed two people respond positively and happily undertake this activity with support. This showed that staff had considered appropriate tasks for people to engage in and were aware of the significance of working with someone's long term memory to promote well-being.

We observed a member of staff identify a person who was becoming anxious at the banter between two other people. A member of staff asked this person if they wished to go outside for a cigarette and they were encouraged to get their coat and go to the patio area outside. They returned to the lounge more settled. The other people exchanging the loud banter were each diverted effectively. This demonstrated staff treated people as individuals and met their respective needs promptly.

In the upstairs lounge we observed a member of staff reading a book with a person for a short period of time. During the afternoon a film was put on the TV but the volume was too low for people to hear it and people were not encouraged to engage with it. This was a lost opportunity for staff to have some meaningful engagement with the people within the home.

We looked at the activity files and saw evidence of a wide range of activities. These included pamper sessions, (where nails and make up were applied), pom-pom making, dominoes, ball games, jigsaw-making, painting and watching a DVD. There were also more routine activities such as folding napkins and matching socks. After breakfast music was put on in the downstairs lounge. People were encouraged and had the option to join in where they wished.

The activity records detailed the impact on the people involved. One recording noted a significant improvement on a person's mood who had become more settled after having their hands massaged. It was noted another person had made a tower from dominoes and enjoyed knocking it down and rebuilding it. It was recorded that the person was laughing frequently and engaging in positive interaction with others. It was clear that people were benefiting from these more personal interactions and it helped promote a positive atmosphere.

The records also detailed a reminiscence activity. One entry recorded staff had brought in some old photographs of people and events in the 1950s and had people encouraged to look at them. It was noted that people enjoyed talking about their memories and the discussion had encouraged others in the room to join in. Staff were showing an awareness of the significance of someone's past and how talking about this could support people who struggled with short term memory issues.

We saw evidence of over twenty different activities offered for the month of February prior to our inspection. Some of these were individual activities and others included more people. It was noted that on the previous day fourteen people had watched 'Frozen' and it was recorded how engaged they had been, and much calmer for the rest of the day. Staff recorded that the singing engaged people's interest.

Good

Is the service responsive?

Of the four records we looked at, there was evidence of completed daily records and monthly reviews of each person's situation. Records also focused on the person and their preferences and characteristics to assist staff when helping to support them.

It was evident from care records that where concerns had been raised they were dealt with promptly. On one person's file there was a note where they had complained their arm was sore. This had been checked and a skin tear discovered. This was then dressed and a wound care plan created.

We spoke with staff who were also aware of each person's needs and could describe the best way to communicate with someone and how to interpret their communication in return. There was evidence in the care records and observed by us that distraction techniques had been considered and were being used where necessary. One care record highlighted that "when they are happy they smile, when they are unhappy they make high pitched noises". The record offered different distraction techniques.

We discussed with the registered manager our concern that one person's record stated they were to have a 'bath or shower weekly' but this was not confirmed by the daily record which said 'body wash'. There was no other recording to explain why the weekly bath or shower was not being offered or if the person had refused. We spoke with a member of staff who explained due to current support needs, a bath or shower was not considered safe due to risk of injury. We were reassured that staff knew this person well but records did not always reflect their current support need.

Good

Is the service well-led?

Our findings

We spoke with relatives and friends of people in the home about their view of the service. One person told us, "Staff are around. You can ask them anything, they tell you things and deal with stuff". Another said, "I've not had a problem. If there is anything wrong, I tell them and they sort it out". A further person said, "Any issues, I tell them and they sort it". This showed the service was keen to resolve any concerns as soon as possible, and that they were effective at doing so.

We asked staff their views of working in the service. One said, "Staff and residents make it a good place to work". Staff were also very complimentary of the registered manager: "I can go in any time, tell her things. They are very supportive, so are the care leaders". Another member of staff told us that weekly management meetings were held to 'inform of all the changes'. They added, "(Person) is a good manager – they are fair and listens to you, always got your back. They are not afraid to come on the floor and help". Another said they found the registered manager 'approachable'. This showed the home was displaying effective leadership which encouraged a high level of interaction between relatives and staff.

During the inspection the registered manager was visible throughout the day, spending time talking to residents and staff. She assisted at lunchtimes in laying the table with people, and encouraging people to sit down to have something to eat. We observed the registered manager talking to staff throughout the day. This was always in an open and positive manner, and staff were equally open in their manner.

There were robust auditing procedures in place, supported by the systems set up by the registered provider. We saw reports completed following the monthly visits by the regional manager and the quality manager. Each conducted an inspection of the home and produced action plans from their visits which the registered manager implemented. These findings had recently included updating the training matrix and it also identified that liaison was needed with the pharmacy regarding the use of food supplements. Both actions had been carried out within a month of identification. The registered manager told us any 'home-wide' issues were also followed through in staff supervisions. We saw evidence of this when we looked at staff supervision records.

In addition to this audit system, there were also specific audits around areas such, dignity, respect and involvement of people within the home. The home was judged to be 'good' in this aspect by the external auditor. Again, this evidenced that the home was working to promote people's dignity as much as possible by including them in decision-making where possible.

Monthly audits were also produced based on information submitted by the home. These analysed people who had significant weight loss, the use of medication including anti-psychotic drugs, a log of GP and care plan reviews, and an accident and incident log. We saw that this evidence was then used in people's care plans to tackle any areas of concern such as weight loss by highlighting this with the relevant health professionals or commencing a food diary.

The registered manager demonstrated her keenness to promote personal development amongst staff. She highlighted a success story where a care leader had recently left the home to become the manager of their own care home. The registered manager was proud of her staff team whose skills were used effectively: for example, senior carers had responsibility for supervision sessions with staff.

The registered manager told us they attended good practice events arranged in the locality and also those offered by the registered provider to promote good practice. She said she had recently learnt about an 'at a glance' clinical risk audit tool and was keen to implement this within the home. This meant the registered manager was open to new ideas and keen to learn from others to ensure the best possible outcomes for people living within the home.

The registered manager advised us they usually held weekly staff meetings which incorporated generic supervision and training issues. These were not always minuted as specific meetings. We saw minutes from meetings held in September and October 2014 for nursing staff, and care staff meeting minutes from September 2014. We saw a range of topics were covered which included; key worker responsibilities, staffing, mental capacity assessment and eating and drinking guidelines. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and treatment for people living at the home.

Good

Is the service well-led?

One relative we spoke with confirmed that meetings for relatives were held. We were shown evidence through residents' meeting minutes of initiatives such as the 'everyday hero' where residents and relatives could nominate someone on the staff team for outstanding care or service which was a mechanism for recognising both good care and encouraging other staff to learn from this and seek to improve their approaches to care.