Bupa Care Homes (GL) Limited

Lindley Grange Care Home

Inspection report

Acre Street
Lindley
Huddersfield
West Yorkshire
HD3 3EJ

Tel: 01484460557

Date of inspection visit:
05 September 2017
08 September 2017

Date of publication:
15 November 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 5 and 8 September 2017. Our last inspection took place on 24 February 2015 when we gave an overall rating of the service as 'Good'.

Lindley Grange Care Home is registered to provide accommodation for persons who require nursing or personal care and treatment of disease, disorder or injury for up to 45 older people.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Protocols for the use of as and when required medicines were not always in place. The registered provider had identified this in a recent audit and action was taken to remedy this during our inspection. Not all staff responsible for the administration of medicines had an up to date assessment of their competency. However, medicines were mostly found to be stored appropriately and administered as prescribed.

Audits and monthly reviews had been completed. The registered provider had an overall home improvement plan.

The registered provider gathered feedback from people and relatives using a number of methods. Complaints were appropriately managed and information from satisfaction surveys had been analysed and feedback was on display.

There were sufficient numbers of staff to meet people's needs. We saw staff provided timely assistance when this was needed. Rotas showed staffing cover was provided as identified by the registered provider who regularly reviewed people's dependency levels.

Staff were seen to be attentive to people's needs and quickly intervened to de-escalate situations where people demonstrated behaviour which may challenge others. Staff were familiar with people's care needs and preferences. People's privacy and dignity was respected.

Care plans were sufficiently detailed which meant staff had access to relevant information in order to provide effective care. However, the involvement of people and their representatives in the planning of their care was not always evident in the care plans we looked at. A programme of activities was taking place and we saw good recording of people's involvement.

Risks to people had been identified, assessed and reviewed and least restrictive practices were in place. The registered manager analysed accidents and incidents and records demonstrated appropriate action was taken in response to lower risks to individuals.

People were enabled by staff to receive timely support from healthcare professionals where this was needed. A visiting health professional was complimentary about the care provided at Lindley Grange.

Training records showed staff were up to date with their training needs. Although individual and group supervisions were taking place, we recommended the recording of individual supervision be strengthened. The registered manager told us they would address this immediately.

The mealtime experience was found to be positive, although due to the layout of the building, there was limited dining space.

Staff felt they worked well as a team and told us leadership in the home was strong as the registered manager was approachable and listened to them.

Fire safety checks were regularly carried out and the building was maintained as required. Some furnishings in the home looked dated.

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.

Medicines were not always safely managed as protocols for the use of 'as required' medicines were not always in place.

Relatives told us they felt their family members were safe. Staff knew how to recognise and respond to abuse. Recruitment practices were mostly safe.

There were sufficient numbers of staff to meet people's needs. Risks to people had been identified, assessed and reviewed.

Is the service effective?

Good

The service was effective.

Staff were up to date with their training programme. Individual and group supervisions had taken place, although recording required strengthening.

Decision specific mental capacity assessments had been completed. Deprivation of Liberty Safeguards were appropriately managed.

People's dietary needs were appropriately supported. Staff enabled people to access healthcare services when they needed this.

Is the service caring?

Good

The service was caring.

People and relatives were complimentary about the staff. Timely assistance was provided to people and staff demonstrated they were familiar with people's care needs and preferences.

People's privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

Care plans were sufficiently detailed, although evidence of the involvement of people and their relatives was not always clear.

A varied programme of activities was taking place and recording of people's involvement demonstrated how they engaged with activities.

People and relatives were able to provide feedback about the service they received. Complaints were found to be appropriately managed.

Is the service well-led?

Good

The service was well-led.

Audits and monthly reviews had been completed.

Staff worked together as a team and told us they were well supported by the registered manager who people and relatives also spoke positively about.

People and staff were invited to provide feedback about the services and their views were acted on.

Lindley Grange Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 5 and 8 September 2017 and was unannounced. On day one, the inspection team consisted of two adult social care inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On day two, two adult social care inspectors completed the inspection. On both days of our inspection there were 37 people living in the home.

We spoke with a total of three people who lived in the home as well as seven relatives who were visiting at the time of our inspection. We also spoke with the registered manager, the regional director and eight members of staff. We observed care interactions in the communal lounges. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at four people's care plans.

Before our inspection we usually ask the provider to send us a provider information return (PIR). This 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. We did not ask the provider to complete a
PIR prior to this inspection.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

During this inspection, we looked at five people's medication records. We looked at whether medicines were stored and administered safely and found this was not always the case.

We saw 'as and when required' (PRN) medicines were not always supported by written instructions which described situations where PRN medicines could be given. We also saw examples where these instructions were not sufficiently detailed. These protocols are used to guide staff supporting people who might have difficulty communicating their needs, for example, people who were living with dementia.

One person living with dementia was given paracetamol on a regular basis, although there was no PRN protocol in place. We asked a staff member how they knew this person required pain relief. They told us the person was able to verbally express pain. At the end of the first day of our inspection we saw a PRN protocol had been put in place. Another person had a PRN protocol in place for the administration of paracetamol which indicated staff should look for 'facial expressions' but did not detail which expressions.

We found a third person who had been prescribed PRN eye drops which were dispensed on 21 August 2017. This medicine did not have instructions on the label to indicate when it should be administered and there was no PRN protocol in place. The eye drops had not been opened and when we looked at the medicine administration record (MAR), we saw it had not been administered or offered. We asked a member of staff about this, they told us the medicine was to be administered when the person complained of dry eyes, although this was not recorded.

One person had been prescribed a barrier cream to protect their skin's integrity. We saw there was a topical medicine administration record in place which stated staff should apply this 'when areas are red or to protect vulnerable pressure areas', although this did not clearly indicate the cream was prescribed as PRN. We spoke with a member of staff who told us staff knew to apply the cream if the skin was red and any concerns would be reported to senior staff. One relative told us they were confident staff were applying topical creams as prescribed for their family member.

When we looked at the monthly medicine audit for August 2017, we saw the deputy manager had already identified some people did not have PRN protocols and an action plan had been put in place.

We saw the opening date for one person's eye drops had not been recorded, although these had been administered on 27 July 2017. The instructions showed these should have been discarded four weeks after opening. We spoke with a member of staff who confirmed these had been administered up to 4 September 2017 and this was also recorded on the MAR. The staff member told us they would order a new prescription that day.

One person received their medicines covertly (without their knowledge). We saw this person's mental capacity had been assessed and it had been agreed with relevant people including the GP, this was in their best interests. We saw the home had tried to contact the pharmacy to get advice in relation to crushing this

person's medication as required. However, there was no evidence this had been agreed for the medicine given. National guidance recommends that medication can only be crushed following advice from a pharmacist as some medicines might lose their efficacy, strength or there might be other unwanted effects. We shared our concerns with the senior nurse. Before the end of the first day of our inspection, we saw evidence which demonstrated staff had taken advice from the pharmacist.

We looked at people's MARs and saw each one contained a medication profile with information about their known allergies as well as a photograph of the person which helped to ensure medicines were given to the person they were prescribed for. We observed staff administering medicines and saw they were focused on the task in hand in addition to having a positive interaction with the person they were supporting. On the second day of our inspection, one person expressed they were in pain to a member of staff who was immediately responsive to this.

We saw temperatures where medicines were stored were checked and recorded regularly and found these remained within the required range.

We looked at the management of controlled drugs which are medicines liable to misuse. We checked the controlled medicines register and found these were recorded and administered in accordance with good practice.

People and relatives we spoke with all told us, with the exception of one relative, that people were safe living at Lindley Grange. Relatives said the quality of care provided by staff gave them confidence their relative was safe and cared for.

Staff we spoke with had received safeguarding training and were able to identify abuse as well as understanding the importance of reporting safeguarding concerns. One staff member said, "I recognise there are different types of abuse. I would tell [registered manager] or the nurse in charge. I wouldn't have a problem contacting 'speak up'." The registered provider's 'speak up' policy was available for staff to report suspected wrongdoing at work. This is sometimes called 'whistleblowing'.

We reviewed four staff files and looked at the recruitment process followed. In three of the staff files we looked at we saw references had been taken, identity documentation had been verified and checks had been completed with the DBS. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people. However, in one staff file we saw a last employer reference had been taken from an individual using their private email address, rather than through their work contact details. We discussed this with the registered manager who recognised this was not best practice. We saw two other suitable references for this staff member had been taken. The registered manager told us the week before our inspection, they had attended a 'master class' training in pre-employment checks and assured us this process would be strengthened in future. Ongoing checks had been made to ensure that nursing staff were competent and fit to practice.

As part of our inspection we checked how the service was managing risks to people living at Lindley Grange. When we looked at people's care records, we saw the registered provider used risk assessments for pressure care and identifying people at risk of malnutrition. The registered provider also completed moving and handling risk assessments which were used to generate related care plans. We looked at one person's falls risk assessment and related notes and found measures in place were effective in managing the risk of this person getting injured without restricting their mobility.

We saw a risk assessment had been completed for works taking place in the home which meant risks to

people whilst this work was taking place had been reduced.

We looked at records of accidents and incidents and found these were detailed and clearly demonstrated that appropriate action, including the involvement of other professionals, was taken to lower risks to people. For example, where one person had experienced an unwitnessed fall, a sensor mat had been put in place which would alert staff to the person mobilising, so they could provide assistance.

Throughout our inspection we saw that where needed, assistive technology such as various movement sensor and other items, such as crash mats were in place to lower levels of risk.

We looked at staffing levels and how they were deployed throughout the service. One person told us, "Everybody is very kind. When you call them they come straight away." Some relatives we spoke with suggested there could be more staff, particularly during busy times of the day. We saw staff observed people who were mobile to ensure they were appropriately supported. Where people were vocal, we observed staff interacting with them to provide reassurance and help them to settle.

Staff we spoke with consistently told us they felt there were enough members of staff on shift to meet people's needs. One staff member said, "Yes, it's not a case of tough, manage. Where staff move floors, level of experience and skill is taken into account." A visiting healthcare professional told us there was always a staff member in charge when they arrived. We looked at staff rotas for a four week period and saw nursing cover was always in place. The number of care staff routinely covering shifts matched the number needed according to the registered provider's dependency tool which was used to assess people's support needs.

We saw where people's support needs had increased the registered manager had taken action to secure funding for one to one assistance. At the time of our inspection, three people living at Lindley Grange needed this support. In one case, the registered manager arranged for extra staffing hours to be in place to support a person whilst one to one funding was agreed. This meant people's dependency levels were continuously monitored to ensure staffing levels were sufficient to meet people's needs.

On the second day of our inspection we arrived early enough to speak with the night staff. We found a night staff member had not arrived for their shift, and although efforts to cover the shift had been unsuccessful, arrangements for a day staff member to begin their shift earlier than planned had been made to ensure there was adequate cover. Throughout our inspection we monitored how quickly staff were able to respond to call buzzers and saw timely responses. In one instance, we found staff arrived quickly in response to a member of the inspection team accidentally triggering a sensor.

We looked at fire safety records and found relevant checks had been made as per the registered provider's schedule. For example, fire drills had taken place on both day and night shifts to ensure staff understood their responsibilities in the event of a fire. Personal emergency evacuation plans were in place and a fire risk assessment had been completed in January 2017. Fire panels and escape routes were checked daily. We saw weekly fire alarm tests from different points in the building as well as monthly checks of the emergency lighting. We checked fire extinguishers and saw these had been serviced in July 2017.

We saw systems were in place to ensure equipment was maintained and serviced as required. We saw evidence that independent safety checks had been carried out annually for gas and electrical safety, water hygiene and lifting equipment.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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

Training records we looked at showed staff had received up to date MCA and DoLS training. Staff we spoke with had a good understanding of MCA and DoLS as they were able to describe the principles of both and how this was relevant to the people they supported.

Throughout our inspection we saw people given choice by staff as part of their daily routines. For example, we observed one staff member asking a person if they wanted some breakfast and how they wanted their toast; giving the person options of butter and jam. When the staff member returned with the breakfast, they asked if the person wanted their paper and the TV on, as well as checking the person's preference around whether they wanted their door to be left open or closed.

Relatives we spoke with said staff asked people for their permission before providing care. One relative said, "They approach him very well by telling him what they are doing, before they do it and that helps him." One staff member said, "You can't just go in and do whatever. That's not good practice."

We saw care records contained decision specific mental capacity assessments and best interest decisions. For example, one person required floor and door sensors. We saw the appropriate assessments had been completed with the involvement of relevant people. However, the same person did not have a MCA assessment in relation to medicines. We found the care records for one person did not contain information about a Lasting Power of Attorney (LPA) order which was in place. We shared this with the management team who told us they would review these arrangements following our inspection.

The registered manager had an up to date tracker showing the number of DoLS applications and authorisations in place. All authorised DoLS were found to be in date and applications had been recently chased with the local authority.

The registered provider also employed an admiral nurse who provided support and training for staff regarding mental capacity assessments, DoLS and Best Interests Decisions. They visited the home at least once a month or more often if needed.

Relatives we spoke with told us they felt staff had the appropriate training as they knew how to provide effective care and support. One relative told us, "The way they approach him tells me they know what they are doing." Another relative said, "I think they are trained. For example, it's how they approach him, how they speak to him. They show me how to take his cardigan off because before I was not managing and he was getting frustrated. It's the little things that you notice."

Before staff commenced working on shifts, we saw evidence of a robust induction which helped prepare them for their role.
We saw evidence of a group supervision in July 2017. This was held to support staff through the potential impact of a number of deaths in the home, which happened to have occurred around the same time. This demonstrated staff emotional wellbeing was valued and it was recognised staff had worked hard to provide people with dignity and respect during end of life care. We saw evidence of other group supervision relating to moving and handling which gave staff the opportunity to ask for more training in addition to what they had already received. A further group supervision looked at situations where staff may need increased support due to work pressures. One staff member told us they had an opportunity for career progression and told us, "It is nice being recognised."

Recording of individual supervision needed to be strengthened to evidence more of the staff voice. We shared this with the registered manager who told us they would enhance the level of information recorded.

We looked at training records and saw high levels of completion in subjects such as dementia awareness, food safety, infection control, pressure care and fire safety. We saw that before our inspection, refresher training had been arranged in managing behaviour which challenges others. This meant the registered provider identified when training was needed and made arrangements for this to happen.

We looked at how the registered provider met people's dietary needs. We asked people and relatives about the quality of the food. One person said, "The care home is alright. Nice food, I like lasagne." One relative told us, "We are all relieved he's here. He eats well." Another relative told us, "I've noticed that if he doesn't want what's on the menu they will offer something else." We asked one staff member about the meals provided. They commented, "I would say it's good. There's always a cooked breakfast."

We saw people's care plans contained a section on eating and drinking. For example, one person's eating and drinking care plan stated '[Person] has a very poor diet. [Person] likes sweet foods and will often refuse main meals. [Person] prefers tea with 2-3 sugars'. We looked at this person's weight which was monitored monthly and found it was stable.

Some people required their food intake to be monitored due to a risk of weight loss and health deterioration. Staff recorded food offered and consumed by the person or if any food had been declined. A visiting health professional told us, "They will report if a weight is falling. I haven't got any concerns."

We noted that records in the registered manager's office and the kitchen area regarding the use of thickener in people's drinks did not match. However, in practice we saw staff preparing people's drinks according to their prescribed dosage of thickener and recording this, as well as the amount of fluid taken by the person. The registered manager took immediate steps to ensure both sets of records were up-to-date.

On day one of our inspection, we observed the lunchtime experience on both floors. We observed limited seating in the ground floor dining area which meant some people and their relatives had their meals sitting in the lounge area. A hostess took a leadership role in ensuring people received the correct meal and checking people were assisted as necessary. Staff assisted people with wet wipes before and after their meal

which helped to ensure good standards of hygiene. Staff were calm and provided reassurance to people who became anxious. Drinks and snacks were available throughout the day.

In April 2017, the home had been awarded a 'Healthy Choice Award,' by Kirklees Council for being committed to good standards of food hygiene and healthy food options.

We asked one relative if they were confident staff helped their family member have access to healthcare services when this was needed, they told us, "They're pretty good like that."

The care records we looked at demonstrated staff at Lindley Grange worked with a range of healthcare professionals such as GPs, opticians, chiropodists, social workers and the care home liaison team. We spoke with a visiting health professional who told us staff made timely referrals. They told us, "They always give us a ring if they're concerned." The registered provider also had a positive working relationship with nursing staff at a local hospice.

Good

Is the service caring?

Our findings

People were comfortable and relaxed when interacting with staff who provided warm and compassionate care. For example, we saw one staff member providing hand and neck massages to a person living with dementia. The interaction was seen to be positive and the person was relaxed. We saw one person attempting to put a hair clip in a staff member's hair. The staff member was welcoming and asked the person, "Am I as pretty as you now?"

We observed staff were attentive to people and intervened when they became agitated and anxious by distracting them until they settled. Staff were familiar with people's presentation and showed they knew about their interests and preferences as they took action to divert people and engage with them positively which helped to calm them. One relative told us, "The carers are genuinely interested in the 'residents'. They go the extra mile." One staff member said, "I like interacting with the residents." A visiting healthcare professional told us, "They know the patient. They're keen on documentation."

One relative told us, "He wouldn't let me help with his personal hygiene when he was at home. When he came here they tried different ways to help him and try to get him less stressed until they found the right way. I couldn't have managed that. "They are very caring with the 'residents'" Another relative said, "The carers are lovely they give him a cuddle if he looks down, they are so good."

Staff we spoke with demonstrated they knew how to protect people's privacy and dignity. For example, one staff member said, "If you're going into a person's room, knock, then enter." Another staff member explained they ensured doors and curtains were closed during personal care. One relative told us, "They are respectful, the way they approach him and talk to him. I come often and I see them with the other residents they always treat with respect, they are wonderful." One staff member told us, "If someone [meaning a staff member] isn't taking on the importance of what we do, I tell them."

We saw staff members who had been allocated to work on a one to one basis with three people living in the home provided appropriate support to de-escalate behaviours which may have challenged others.

We asked the registered manager how they supported people's equality, diversity and human rights. They said if additional support was needed they would contact the lead admiral nurse or the care home liaison team. The registered manager said, "Everyone's individual." One staff member we spoke with told us, "There would be no prejudice against anyone coming in." We found a monthly religious meeting was held in the home which meant people were supported to maintain their personal beliefs.

At the time of our inspection, advocacy services were being accessed, which meant where people who were assessed as not having capacity did not have anyone to act on their behalf, the registered provider recognised the importance of having an impartial advocate to assist the person with their decision making and help to represent their wishes.

Bedrooms were personalised depending on whether people wanted to have lots of personal effects or little

on display. We spoke with relatives who confirmed this was based on the person's individual choice and needs.

We saw one compliment which stated 'Thank you so much for caring so passionately about everything you do. Thank you for making Lindley Grange the best it's ever been'.

Good

Is the service responsive?

Our findings

The registered provider carried out a pre-assessment of people's needs prior to them moving into Lindley Grange. This assessment included a description of the person's health conditions, medication, preferences, communication, eating and drinking and mobility needs. This helped to ensure people's needs could be met.

We found specific care plans and risk assessments were in place to identify people's care and support needs. Examples of care plans included; senses and communication, personal safety, moving around, skin care, washing and dressing. We observed staff were responsive to people's individual needs and care plans reflected people's preferences and choices.

We saw care plans for people who lived at the home contained a life history section called 'My day, my life, my story' which detailed their interests and relationships with relatives and friends. One person's record stated, '[Person] likes visits from her [relative]. [Person] enjoys chatting and likes music from musicals'.

We found the equipment in use was listed in moving and handling care plans. However, details such as which loop to use on a sling or the type of hoist to be used was not always documented. We recommended the registered manager review these arrangements to ensure this information is recorded.

We found the quality of the care plans was sufficient as staff had enough information to provide people with person-centred care. For example, one person's communication care plan stated, '[Person] finds it difficult to hear at times and might became frustrated if trying to speak. [Person] likes staff to maintain eye contact, speak loudly and slowly, allowing time for [person] to process information and respond'. Another person's safety care plan stated, '[Person] likes to have his bedroom door unlocked at all times'.

Although we could see care plans and risk assessments were reviewed on a monthly basis, we found the involvement of people and their relatives was not always evident. We spoke with a staff member who said they did not always document the conversation they had with people and relatives. One relative told us, "They are very good they always communicate with me, they will ring me if there a problem." The management team told us they would review the recording of people and relatives involvement in care planning.

We saw records which showed one person had one to one support funded up to a specific time of the day. When incidents had started to take place outside the timeframes support was funded for, the registered manager had taken action to obtain agreement for additional support hours which were subsequently approved. This meant the service was responsive to changes in people's needs.

We spoke with the activities coordinator who worked full time which included two Saturdays per month. The activities coordinator had received a national award from the registered provider in recognition of their achievements.

One person we spoke with about activities told us, "The best thing about here is the people. It would be better if you could go out though." Relatives we spoke with told us staff tried to encourage their family members to join in with activities, although they added it was difficult to sustain their interest. The activities coordinator was able to describe how they knew when people with limited verbal communication wished to engage with activities. They told us it was important to recognise the need for a flexible approach to activities depending on what people wanted to do.

We observed as one member of staff went to collect pens and paper for a person who enjoyed writing on paper. The person appeared content and engaged in the activity. People who were unable to join in with activities in communal areas received visits from the activities coordinator if they wished. We looked at the recording of activities which clearly demonstrated people's involvement, including their level of engagement.

One relative told us they felt there were more activities taking place last year with singers visiting the home. We saw a list of external visitors which demonstrated singing sessions were still taking place. We also spoke with a musical therapist who visited the home weekly to provide stimulation for people.

Activities such as; arts and crafts, baking, armchair exercises, short walks into the village, reminiscence with the use of memory cards, and coffee afternoons were scheduled for September 2017. In addition, themed events were held in the home, such as 'delicious dining', 'Wimbledon' and a 'cruise week' with five stops in five days. This involved changing some of the decorations, wearing 'fancy dress' and offering different options on the menu to fit with the location of the cruise.

In November 2016 a trip to Blackpool had taken place. The activities coordinator told us they were looking to arrange a tour to the set of a television programme for the end of October 2017 as well as taking people to the theatre in early 2018.

Relatives we spoke with said that they felt able to raise a complaint with the management team and told us felt they would be listened to. One relative told us, "They do listen." Another relative said. "If I had any concerns, I know I could go to them and they'd sort it." We saw evidence of a suggestions box in the reception area which meant people could provide feedback anonymously if they wished. We reviewed the complaints file and saw where people and relatives had expressed dissatisfaction, timely and appropriate responses were provided. We saw evidence of accountability and lessons learned.

Good

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We checked medication competency assessments and found these were not always completed in line with the National Institute for Clinical Excellence (NICE) who recommend an annual check of competency. We found two senior care workers competencies were out of date and whilst two nurses had completed the practical aspect of their assessment, the theoretical check had not been completed. During our inspection the management team took steps to ensure staff medication competency checks were brought up to date.

Night visit audits had been carried out in July and August 2017. Checks such as making sure staff followed people's preferred night times were carried out. The monthly home review for August 2017 identified the need for further night time spot checks to be carried out between specific times. The registered manager told us they and nursing staff had recognised the night time medicines round was taking a long time. They had responded by contacting the pharmacy to check whether specific medicines which were not time critical could be administered at a different time of the day.

We looked at a number of audits which covered, for example, the dining experience, nutrition and catering, care plans, medicines and wheelchairs. Actions were added to the home improvement action plan. The monthly home review for July 2017 recognised actions on the home improvement plan needed reviewing to ensure they were completed. The regional director carried out monthly home reviews which looked at, for example, staffing, recording of food and fluids, falls, checking weekly audits and fire safety.

During our inspection we looked at the use of slings which were used to support people as part of people's moving and handling needs. We saw these were shared between people and found there were no records of when they were laundered. We recommended the registered provider review these arrangements to help ensure infection control is well managed.

Staff meetings were set to take place on a quarterly basis, although we saw limited evidence these had taken place. In March 2017 a full staff meeting took place which covered, for example, infection control, training, safeguarding, staff code of conduct, supervisions and questions from staff. However, a daily meeting called '10 at 10' took place which was routinely chaired by the registered manager with department heads for areas such as nursing, care, kitchen, maintenance and activities. These meetings were in addition to shift handovers and were used to identify key messages and discuss areas of concern and other noteworthy information. This meant important updates were shared at these meetings, which also took place on a weekend. This helped to provide continuity of service and ensure good communication.

We saw evidence of a staff survey carried out in July 2017. The registered manager had analysed the findings and provided feedback to staff. We saw action had been taken in response to concerns raised by staff about

not always having an adequate supply of continence pads. The registered manager had arranged for a surplus to be purchased and had maintained this additional stock which we saw during our inspection. In addition, the registered had contacted continence services to discuss the supply of these products.

A satisfaction survey had been completed by 10 people in 2016. We saw people were largely satisfied with the service provided for them, although some had indicated they felt communal spaces, bedrooms and activities could be further improved. We saw evidence of action taken in response to this feedback. For example, we saw a weekly visit from a music therapist had been put in place and new dining chairs had been purchased. We looked at maintenance records and saw repairs were carried out as required.

People and relatives were able to identify the registered manager as they had a visible presence in the home. Staff we spoke with about the registered manager told us they were approachable. Staff comments included; "She talks to everybody, the staff and the residents and she joins in", "She interacts really well with the residents", "I think she's a good manager. She's a fair manager. She cares and she's always about" and "The door's always open for me to go in." The registered manager had clear insight into people's care and support needs and during our inspection they were responsive to information requested and any concerns we raised.

One relative told us communication between staff could sometimes be better as information they provided had not always been passed on. We observed the staff team communicating throughout our inspection. Staff commented positively about the way staff worked together. One staff member said, "There's a lovely team here." Another staff member said, "The management team we've got here are fantastic."

Staff were recognised on a monthly basis for outstanding contributions. Nominations were made by people, relatives, visitors and other staff members. One staff member said, "It's a nice thing for staff to get."

Resident and relatives meetings had been held in November 2016, February, May and August 2017. The meeting minutes for August 2017 showed discussions covered works in the home, staff recognised for their achievements, an explanation of paperwork staff completed and activities including an introduction to the music therapist. One relative told us they had attended a meeting where a representative of the Alzheimer's Society had given a talk which they found informative.
The registered manager told us meeting minutes were circulated to everyone and were not restricted to only those individuals who attended.