Eastern Healthcare Ltd

Blyford Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Blyford residential home provides accommodation and personal care for up to 37 people.

The service also provided short stay admissions for people who require assessment to determine their eligibility for NHS Continuing Healthcare (NHS continuing healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need").

Short stays were also provided to people who required a period of reablement (The purpose of reablement is to help people who have experienced deterioration in their health and have increased support needs to relearn the skills required to keep them safe and independent at home).

The service is divided into three units; Foxfield and Rosedene (residential care for people permanently living in the service) and Woodleigh, for people admitted for a short period of time.

When we inspected on 2 and 6 March 2017 there were 35 people using the service. This was an unannounced 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.

During this inspection, we found that the registered provider was in breach of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a lack of opportunity for people to engage in meaningful activity outside of the day centre provision, which people did not always wish to attend. People were not always protected from social isolation, particularly those people who were cared for in bed due to illness or frailty. The range of activities available were not always appropriate or stimulating for people living with dementia. This constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing level arrangements were being reviewed by the management team to ensure they met the needs of people using the service at all times. The provider increased staffing levels in some areas of the service, but on-going review is required due to the unpredictability of some admissions into the service on a short term basis. We have made a recommendation about this.

Quality assurance systems were in place to monitor the quality of provision, however, accidents and incidents were not always analysed to identify trends and patterns and to ensure people were kept safe. The auditing systems in place did not identify all of the issues we found during the inspection.

People's nutritional needs were assessed, but this was not always monitored effectively. Food and fluid charts were not always completed or totalled, but the management team took action to address this.

The service was meeting the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). Staff understood the need to obtain consent when providing care. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The culture in the service was welcoming, friendly, and person-centred. The management team presented as open and transparent throughout the inspection, seeking feedback to improve the care provision.

Procedures were in place which safeguarded the people who used the service from the potential risk of abuse. Staff understood the various types of abuse and knew who to report any concerns to.

Safe recruitment procedures were in place, and staff had undergone recruitment checks before they started work to ensure they were suitable for the role.

Appropriate arrangements were in place to ensure people's medicines were obtained, stored and administered safely. People were referred to other health care professionals to maintain their health and well-being.

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 consistently safe.

The management team were reviewing staffing levels to ensure they were sufficient to meet people's needs at all times.

Infection control procedures had failed to identify areas requiring improvement.

The likelihood of harm had been reduced because risks had been assessed and guidance provided to staff on how to manage risks and keep people safe.

Staff knew how to protect people from abuse, and who to report concerns to.

People received their medicines in a safe and timely manner.

Is the service effective?

Good

The service was effective.

The dining experience was relaxed and staff were available.

The service was working within the principles of the Mental Capacity Act 2005.

People's food and fluid intake was not always monitored effectively, but the management team took action to address this.

People were supported to maintain good health and had access to healthcare support in a timely manner.

Is the service caring?

Good

The service was caring.

The atmosphere in the service was relaxed and people were listened to.

People were supported to see their relatives and friends.

People's dignity and privacy was respected and maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities were provided in the day centre, and by care staff on the units when time allowed. However, this was not at a level which would meet the individual and specialist needs of all people using the service.

Care plans guided care workers in the care that people required and preferred to meet their needs. These were updated in line with people's changing needs, but did not always include information on their life history.

Care plans for some people admitted on a temporary basis, required more detailed information so it was clearer what the aims were for the person.

There was a complaints process in place. Improvements were being made to how this was displayed in the service so people knew who to contact to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Quality assurance systems were in place, but had failed to identify areas we found requiring improvement. Some audits required further analysis to monitor trends and recurring themes.

People and relatives were complimentary about the management team. They were responsive to our feedback and took prompt action to rectify areas we found as requiring improvement.

People, staff and relatives all felt they could raise concerns or issues to the management team, and felt listened to.

Blyford Residential 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 2 and 6 March 2017, was unannounced and undertaken by one inspector, an infection control nurse, 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.

Prior to the inspection we reviewed information we had received about the service such as notifications. This is information about important events which the provider is required to send us by law. We also spoke with community healthcare professionals and local safeguarding teams.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us, for example, people living with dementia.

During the inspection we spoke with seven people living at the service, three relatives, two social care professionals and one health professional. We spoke with the registered manager, deputy manager, regional manager, and a representative of the provider. We spoke to six members of care and catering staff. We also observed the interactions between staff and people.

To help us assess how people's care needs were being met we reviewed eight people's care records and other information, including risk assessments and medicines records. We reviewed four staff recruitment files, maintenance files and a selection of records which monitored the safety and quality of the service.

Requires Improvement

Is the service safe?

Our findings

We received mixed feedback about the staffing arrangements in the service. One person told us, "Nine times out of ten there are enough staff, if I need help they come in a few minutes". Another said, "There is not quite enough staff sometimes, after dinner or after tea there is nobody about, that's what worries me, I don't think staff should go together, they should leave one with us so you have got somebody to rely on".

Woodleigh unit received admissions for a time limited period where people were being assessed for NHS continuing healthcare, or receiving reablement. People's level of need on this unit varied greatly. Some people were living with dementia, some needed a lot of staff assistance, whilst others were reasonably independent. One person told us of an occasion when there were no staff available and they felt frightened being left without a staff member present. They told us, "I don't want to be left alone with people with [condition], we have been left alone [in the lounge] whilst the staff are at meetings".

We asked staff if they felt that staffing levels were sufficient. A staff member said, "With Woodleigh unit you never know who is coming in, sometimes they need extra support, as they aren't familiar with the home, so that means we need to spend more time with them. [Registered manager] has arranged for 'one to one' carers to come in when it's been needed though". Another staff member said, "Staffing levels are usually ok. If someone goes sick it can be harder, but management help out then". And, "I can usually find another staff member to help me if I need to. It's harder on Foxfield unit, it's busier in the mornings on there". We also spoke to night staff who concurred, and said that if a new person is admitted who presents in an unsettled state, or if a person becomes unwell, this can put pressure on them to cover all of the three units. Our observations during the inspection were that staff responded to people in a timely manner, and there was a calm atmosphere on the units, however, at times we observed that lounge areas were left unattended.

We discussed our concerns with a representative of the provider and the management team, and on the second day of the inspection we were informed that staffing levels had been increased on Foxfield unit to support staff in the morning, and with delivering activity after lunch. We also saw that the management team had sent a memo out to all staff informing them of the changes, and that lounges were not to be left unattended whilst staff were writing daily notes or when handover was taking place. The registered manager told us that staffing levels would be reviewed to ensure they were sufficient during the day and at night.

The management team were not using any formal method to determine their staffing numbers, and we discussed this with them. Following this discussion, the regional manager implemented a dependency tool which provided them with a calculation of suggested staffing levels. This will provide the management team with information which will inform staffing levels going forward. Given the mixed feedback, we were not assured that staffing levels were meeting the needs of people at all times.

We recommend that the service routinely asks people using the service for their views and experiences of staffing levels and the availability of staff during the day time and at night. This could also include the views of staff members and visitors to the service.

Infection control audits were being completed, however, they had been ineffective in identifying the issues we found requiring attention. For example, commode cleaning schedules had not been completed routinely, commodes and toilets were not being sanitised thoroughly, some mattress checks were not signed for, and items in the first aid box were out of date. We spoke with the deputy manager about this, who also visited people's rooms with us, and agreed that improvements were required.

They took action to rectify some areas which could be dealt with immediately, such as replacing the first aid items. Other actions included discussions with domestic staff about expectations and the importance of ensuring cleaning schedules were completed. We saw a memo which was sent out to staff requesting that mattress audits were completed within two weeks, and a reminder that commode cleaning schedules were to be signed each time the commodes were cleaned. They also informed us that in the future, service directors would be checking the cleaning audits.

People's care records included risk assessments and guidance for staff on the actions that they should take to minimise risk. These had been reviewed to ensure any needs which had changed were updated in the records. These included moving and handling, falls, nutrition, and skin integrity. Outcomes of risk monitoring informed the care planning arrangements, for example weight loss prompted onward referrals to dietetic services. Staff were knowledgeable about the people they supported and were familiar with the risk assessments in place.

We found that some people had thickened fluids prescribed, which would indicate they were at risk of choking. One person who was at very high risk of choking had clear guidance in place to reduce the risk. However, not all people who were at risk had risk assessments in place. For example, those people who were eating and drinking in bed. This information is needed to provide guidance to staff on how to minimise the risks associated with choking, such as positioning safely when they were eating or drinking. We brought this to the deputy managers' attention, and following the inspection they informed us that risk assessments were put in place for all people at risk of choking.

Staff had received safeguarding training and were able to identify different types of abuse and what action they needed to take if they suspected someone was being abused. One staff member told us, "I would report any concerns to the team leader or manager, and I would write an incident report". Another said, "We [staff] always report to senior staff if we have concerns. Some signs of abuse aren't as obvious. We sometimes hear conversations between relatives or visitors that might cause us to have concerns". Safeguarding flow charts were visible on the units, which guided staff on action to take in the event that a person was being abused. During the inspection, the deputy manager made us aware of a potential safeguarding concern they were dealing with. We saw that they had made contact with the appropriate professionals to ensure this was escalated.

People told us they felt safe living in the service. One person said, "I feel safe here because I have people around me, if I felt unsafe I would speak to someone, one of the carers". Another told us, "I feel safe, you couldn't wish for nicer people to look after you, I have my pendant alarm I have with me all the time." A relative told us, "I feel my [relative] is safe living here, absolutely. If I had any concerns I would speak to the manager".

The service followed safe recruitment practices. Disclosure and Barring Service (DBS) checks (which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups) had been undertaken before new staff started work. This ensured that new staff coming to work in the service were suitable for their role.

People told us they received their medicines when required. One person said, "I have my tablets in the morning the staff give them to me". Another said, "My tablets come to me through the day, no problems there".

There were safe medicine administration systems in place and people received their medicines when required. Weekly medicines audits were being carried out which identified any shortfalls, and these were shared with the staff team, for example, staff were reminded to always sign the topical applications charts held in people's rooms.

The deputy manager had implemented improved processes around medicines for people coming into the service, particularly those coming in at short notice and for a temporary period of time. Staff were clear on their responsibilities, and when we observed a medicines round, staff were able to explain clearly the systems and processes which were in place and how they had improved. One staff member said, "We [staff] ensure no mistakes are made. It's a much better process now".

Personal Emergency Evacuation Plans (PEEP's) were available in people's rooms. These showed the support people required to evacuate the building in an emergency situation. However, for people on Woodleigh unit, their PEEP's gave a generic phrase of, "I do not know Blyford and will therefore need assistance". The registered manager told us that people on this unit were temporary and therefore their abilities weren't always known when they first came in. The lack of this information meant that staff would not know how to support people to evacuate the building in the event of an emergency. The registered manager told us they would review these.

Risks to people injuring themselves or others were reduced because equipment, such as hoists had been serviced and checked so they were fit for purpose and safe to use. There were systems in place to monitor and reduce the risks to people in relation to the water system and legionella bacteria. The nominated individual for the provider told us that they had previously received an improvement notice in relation to water safety, and they had made the required improvements which Environmental Health came back to check, and were satisfied with. This was confirmed following the inspection via an email from Environmental Health.

Good

Is the service effective?

Our findings

Systems were in place to ensure that staff were provided with training and support, and the opportunity to achieve qualifications relevant to their role. Training included medicines, moving and handling, safeguarding, dementia, and behaviours which challenge. A high proportion of people in the service were living with varying levels of dementia. Staff told us they felt confident supporting people who were living with dementia. This included people who presented with complex behaviours. One staff member told us, "I feel confident supporting people with dementia, we [staff] are trained to deal with this. We know how to calm people down, what techniques to use". Another said, "Last week we had a [person] who became agitated, we walked around the home with them until they settled".

Where some of the newer staff had not yet undertaken dementia training, we saw that dates were being arranged for this, and for staff who needed an update. This included training on behaviours which challenge, dementia awareness, dignity and mental capacity, and safeguarding. One staff member said, "I'm up to date with all my training, and I've just completed my NVQ [national vocational qualification] level 3".

Staff new to the service completed a two week induction, which consisted of mandatory training and shadowing of more experienced staff. We were shown an induction checklist, which contained areas of practice staff needed to be observed undertaking, and were then signed off when deemed as competent. All new staff were expected to complete the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their work. One staff member told us, "I had a good induction. I shadowed other staff for a long time until I was ready to work on my own".

Staff told us they received regular supervision. These sessions discussed their progress, reflected on their work, and identified training needs. One staff member said, "I get regular supervision from [deputy manager] they are very good". Another said, "I get supervision every six to eight weeks from the unit team leader".

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 decision made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to restrict people's liberty.

DoLS applications had been made to the local authority as required to ensure that any restrictions on people were lawful. During our inspection the registered manager was in the process of arranging an urgent DoLS authorisation, as one person was attempting to leave the building. This demonstrated an appropriate response to protect the person's human rights, and ensure that any restriction was lawful.

People's care records made reference to their ability to consent to care for less complex decisions that needed to be made. These included tasks that staff assisted people with, such as personal care, the application of creams, and managing their medicines. This meant that staff had considered that it was in the person's best interests to assist them with these tasks, but could also demonstrate that they had done so in line with the principles of the MCA. It also acted as a guidance tool for staff by describing what constitutes a less complex decision, and the principles of a best interests decision.

Where one person was receiving their medicines covertly (crushed and given to them in food or drink without their consent), a best interests decision was in place. This included consultation with the person's GP, family members and their named representative. However, we observed that this had not been reviewed recently. We advised the deputy manager to ensure this was reviewed on a more regular basis to ensure it was still required, and they took immediate action by making contact with the GP.

We observed staff asking people for consent prior to assisting them with tasks such as administering medicines, assisting people to eat, and deciding where to spend their time. One staff member told us, "We always ask for consent; ask if we can assist them with their personal care". Another said, "Sometimes people give implied consent if they can't communicate well, like in their body language, they may hold out their arm so we can help them wash. We get to know the residents well".

People were supported to eat sufficient amounts and maintain a balanced diet. Where people required assistance, they were supported to eat and drink. This included keeping records of their food and fluid intake when there were risks. However, some food and fluid charts had not always been completed or totalled to establish the total fluid intake for each day and to monitor that the intake was adequate for their needs. This meant it was not consistently clear how concerns in relation to food and fluid intake were addressed. We brought this to the attention of the management team who told us they would review this, and also informed staff via a memo, about the importance of ensuring that food and fluid charts were completed, and asked for these all to be reviewed.

Where people had needed the specialist advice of dietician's or speech and language therapy, referrals had been made to the appropriate professionals. A relative told us, "When [person] first came in they were on a pureed diet, but now their swallow has improved they have a semi solid diet. The staff feed [relative] and give them their drinks. They are very good".

People told us they enjoyed the food. One person said, "The food is very good you can't fault it, if anybody says anything about it they are finicky. I get more than enough, drinks all the time if you want it". Another said, "The food is very good, some people are diabetic and they cater for those".

We observed the lunchtime meal on two units. Staff were available throughout the meal, supporting people where needed. People who needed support to eat their meal were assisted by staff in a dignified way, and verbal guidance was given to swallow the food where this was required. The atmosphere was relaxed and staff interacted with people in a positive manner. Tables were set with a table cloth, but there were no napkins, cutlery or condiments laid out in advance. Setting up the tables fully would support people living with dementia to recognise that lunch was about to be served.

A choice of two meals were offered, and a picture menu was used so people could see the food options. Food was served from a trolley allowing people to request the preferred portion size if they chose to. The second meal option was cauliflower cheese, which could be considered to be an accompaniment to a main meal. We spoke to the chef who told us there was a summer and winter menu, and that people were asked to feedback on food they would like to see added to the menu. They said when preparing people's food

where a specialist preparation is required (Such as pureed food) they referred to professional advice which had been given.

A daily handover sheet was used to share information between staff during shift changeover. This included information such as how people had slept, times that certain medicines were given, pain observed, and the general welfare of people. Staff told us this was helpful in ensuring good communication between them. One staff member said, "The handover sheet is very good, I can see what needs looking at as soon as I come on shift". This ensured people were provided with a consistent service and any issues could be followed up in a timely manner.

People had access to health care services and received on-going health care support where required. We saw that referrals to relevant professionals were done so in a timely manner, and where needed, further advice had been sought. One person told us, "I've seen the doctor several times here, and the chiropodist comes in". A relative said, "The GP visits no hesitation. If needed, they [staff] get the GP in".

Good

Is the service caring?

Our findings

People told us they liked living in the service and the staff were respectful towards them. One person told us, "The staff are kind and caring, I don't have any complaints". Another said, "The carers are very good, we have lots of fun and laughter, but respectfully".

Staff knew people well, and people appeared relaxed in their company. Staff told us they had built up positive relationships with people and spoke about them in a respectful and caring manner. One staff member said, "We know the residents well, we have a good laugh with them". Another said, "We aren't institutionalised here, people get up when they want and do what they want. We [staff] support that". Staff told us how the people coming into Woodleigh unit on a temporary basis needed more time to settle, and familiarise themselves with the environment. One staff member said, "New people coming in need more time from us to make sure they are comfortable and not worried about anything. I'd like more time to make sure they are settled. Not always possible if more than one person is admitted at the same time". The registered manager told us that there had been concerns about more than one person arriving on the unit at the same time, and that they had worked towards improving this by raising their concerns with relevant health professionals involved in the admission process.

We observed the way people interacted with the staff. This included how people responded to their environment and the staff who were supporting and communicating with them. Several people were seen smiling, laughing and enjoying friendly banter with the staff as they were getting ready to eat their lunch time meal. We saw one person (who had received reablement) hugging a staff member as they left the service to return home.

Relatives were complimentary about the staff approach. One relative told us, "The staff are definitely caring, they are wonderful I wouldn't want [person] to be anywhere else. They are respectful and so supportive". Another said, "The staff are very caring, so loving and caring, they have a very strong repertoire, very responsive to [relative]. I feel [relative] is happy here".

People's care records made reference to tasks they could independently manage, such as aspects of their personal care, and their personal preferences, such as choosing which clothes to wear and how they liked to be presented. People's privacy and dignity was respected, and we saw that staff attending to people's personal care ensured that doors were closed, and when speaking about people, this was done so in a discreet manner so others close by were not able to hear.

On the wall in people's rooms there were 'One page profiles', which included key information about the person, such as what was important to them, what people liked about the them, and how to support them. This information ensured that staff were made aware of the things that reflected people's individuality, and what mattered to them most.

On one of the units we saw displayed on the wall a selection of old photographs called "Memory Lane". This included old pictures of the local area, and photographs of people living in the service when they were

young. Some of the photographs were of people in their professional careers, for example, the Navy. Staff told us that the display generated positive conversations between and with people about earlier times in their life.

The registered manager told us that quarterly 'Residents' meetings were held to ensure people had the opportunity to raise their views about what was happening in the service, and what they would like to see improved. Minutes of the meetings showed that people had raised several good ideas regarding activities they would like to take part in and which were meaningful to them. For example, planting and growing their own vegetables, gardening, and an evening spent singing along to old songs. However, the minutes of the meetings were not sufficiently detailed to indicate who would be taking forward any action points identified. There was no information on what had been discussed in previous residents meetings to ensure items had been actioned.

Requires Improvement

Is the service responsive?

Our findings

The approach to supporting people with their interests and to have meaningful and fulfilled days was inconsistent. The service did not employ a dedicated activity co-ordinator; the expectation was that care staff would provide activities for people in addition to their caring duties. We observed that care staff did engage with people in some activity during the afternoon, such as jigsaws and 'pamper sessions', however, this was sometimes interrupted, due to them needing to assist other people. One person said, "They [staff] keep running off, they keep saying they will paint my nails and off they go". Another told us, "I like to be independent and do things for myself. I can walk outside in the grounds, but I don't get outside in the community. I used to do rug making at home, I don't really do much here, I like reading and I try to keep my room tidy". Another said, "I don't do much really, sometimes we go out, there is usually more to do in the summer months". In the family survey given out in 2016, a relative said, "I would like to see more residents joining in with day care activities".

There was a day centre provision within the building that people were invited to attend if they wished. In the morning we saw a few people joining in with baking, but the majority of people did not attend the day centre, as they felt more comfortable on the units that they were familiar with. The registered manager confirmed this was the case, and that although people were encouraged to attend, often they did not want to. Whilst people had the opportunity to attend the day centre there was little opportunity to engage in meaningful activity on the individual units of the service, where most people spent the majority of their time.

We saw that when people did engage with staff they responded in a positive way, smiling and talking. However, in between these times people were sat for periods of time with no stimulation, and were disengaged with their surroundings. We were also concerned that people who did not wish to leave their rooms, or who were cared for in bed, were not receiving 'one to one' activity time with staff. We spoke to the management team about this, and they agreed that the activity provision needed to improve. We saw a memo had been sent out asking staff to encourage attendance at the day centre (for those who wanted to), and that time was spent with people who were cared for in bed. However, the staffing level arrangements may not enable staff to dedicate regular time with people in addition to their caring duties. We could therefore not be assured that there was sufficient activity provision across the service to meet people's individual and specialist needs.

This constitutes a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some care plans contained information on people's life history. However, in some cases these were not completed. Having this information supports staff to have meaningful conversations with people about their lives and what was important to them. There was limited information about what brought wellbeing to people's lives, particularly for people living with dementia, or for people who may spend most of their time in bed due to frailty or illness. The deputy manager had already identified this as an area for improvement following an audit of care plans and was a 'work in progress'. They had sent a memo out to staff asking them

to speak with family members and ask them if they want to be involved in completing the life history information. They also planned to review records where life history information had been recorded, and separate these out into individual sheets, so it would be presented in a format which would encourage staff looking at the care plan to read it more thoroughly.

Care plans guided care workers in the care that people required and preferred to meet their needs, including night care routines, eating and drinking and how people mobilised. There were also 'quick reference guides' which staff or other professionals not familiar with a person could refer to. They listed people's likes and dislikes, their mobility, and key information about a person's care. Where relevant, care plans also included information which described specific medical conditions, such as diabetes, and included reference to diabetic diets and healthy eating advice sheets.

Where people were living with dementia, care plans contained guidance on how staff should support people who display behaviours which may challenge staff. This included triggers which might cause a person to become unsettled, for example, a noisy environment or an increase in pain, and techniques which staff could use to reassure the person. Having this in place provided staff with guidance on how to effectively support people according to their individual needs.

For people using the service on a temporary basis, their care plans were either completed by health professionals (for reablement), or by the staff in the service (for NHS continuing healthcare).

Reablement care plans identified goals whilst at the service, and where occupational therapists had completed assessments, or if there had been nursing input, information was visible. Multi-disciplinary meetings also took place twice a week in the service to discuss people's progress and planning for their discharge arrangements.

The care plans for people receiving NHS continuing healthcare assessment, required more detail in terms of the person's abilities leading up to admission, and their aims whilst they were in the service. Ensuring this information was available would guide staff on how best to support people, taking into account any behavioural or physical limitations. Staff did however complete behaviour charts and detailed daily notes as to the person's ability, which would provide information for health and social care professionals to determine the most appropriate future placement.

We asked people if they knew how to complain. One person told us, "I would speak to the team leader if I was unhappy about something". Another said, "I would speak to any of the staff". A relative said, I would speak to the manager, or the deputy, anybody in authority, they are all really friendly and approachable". The service had not received any complaints, but had a policy in place on how these should be dealt with and timescales for responding. Details on how to complain were displayed in the main reception, however, this was in very small print, and did not give details of who to contact. Details of how to complain were also not visible on the individual units. We brought this to the attention of the management team, who took action to rectify this.

Requires Improvement

Is the service well-led?

Our findings

Throughout the inspection the management team demonstrated an open and transparent manner, actively seeking feedback to improve the service. Following the inspection they contacted us to confirm that changes were already being implemented in response to our feedback. The registered manager told us that they were supported in their role by their deputy manager, regional manager and a representative of the provider, who was always available to discuss any issues should they arise. We observed that the management team worked well together, each clear on their roles and responsibilities.

There were quality assurance systems in place for assessing, monitoring and reviewing the service. Audits were being carried out by the management team and also by company directors. These included checks on medicines, care plans, nutrition, dining experience, home environment, infection control, and night spot checks. As a result of these audits, action had been taken to improve certain areas, for example, new nutrition sheets were devised, memos were put in place reminding staff to sign for topical applications, and identifying that life history information was not completed in all care plans. However, the audits had not identified all of the issues we found during the inspection; such as improvements needed in infection control procedures, completion of food and fluid charts, review of staffing levels, and activity provision.

Where incident and accident forms were completed, we saw that where certain incidents had occurred (such as between people using the service) advice had been sought from safeguarding teams. There was also a log of falls which had occurred and we saw that people were referred to the falls prevention team. However, these were not being analysed to identify themes and trends that may reduce the likelihood of recurrence. We discussed this with the registered manager who told us they would take prompt action to rectify this.

People were complimentary about the management team, but three people we spoke with didn't know who the registered manager was. One person said, "I haven't got a clue who the manager is". Another told us, "I am quite happy living here, I would recommend it. I don't know who the manager is". And a third person, "I don't know the managers name". Some staff told us that the registered manager was not always visible on the units, but was supportive and approachable. The registered manager and deputy manager were also available on a 24 hour 'on-call' rota, so staff could always contact them if issues occurred when the management team were not on site. This provided staff with access to guidance and support if they were uncertain of how to deal with any incidents.

The culture in the service was welcoming, friendly, and person-centred. Staff showed a good understanding of their individual roles and spoke with each other throughout the day as to what was happening and what needed to be done. They showed accountability for the work they carried out. For example, when we observed a medicine round, the staff member told us how important it was that they followed the processes that were in place to avoid making mistakes, and were meticulous in checking Medicine Administration Records (MAR) were correctly completed and that the correct medicine was given. Another staff member set an alarm on their watch for a person who had to have medicines at specific times of the day to ensure they were effective. Staff were kind and compassionate towards people who used the service, and supported

people in a patient manner. Staff told us they felt able to speak up, were listened to, and felt valued. One staff member said, "Very good management, door is always open, they always listen, and are very approachable". Another said, "I can speak to the managers about anything. [Deputy manager] is amazing, always ready to help". A relative said, "I do think it is well led, like I have said, there is a very good repertoire".

Staff meetings were held, and we saw from the minutes of these meetings that relevant topics were discussed, such as quality of recording in documentation, expectations of staff, and how the management team saw all of the staff team as 'equals'. The deputy manager told us, "We work well as a team, we do think of staff as equals, we appreciate their [staff] hard work".

We saw that satisfaction surveys and questionnaires had been issued to people, relatives and professionals for their feedback, and action from this had been taken. For example, people had asked to trial having their main meal in the evening rather than at lunchtime. This was implemented, but people asked for it to be reverted back to lunchtimes as this was their preference. Recent feedback from three health professionals reflected positive comments about the service. The registered manager told us that relative meetings had been arranged, but attendance was poor and they were therefore going to extend these to include evenings and weekends, which they hoped would increase attendance. This demonstrated that the management team valued feedback, by offering a more flexible time that relatives could attend.

The management team kept their knowledge updated by attending dementia care groups, and local link meetings, such as infection control. They also reviewed relevant publications from the local authority and training providers. Both the registered and deputy manager were undertaking leadership qualifications, to help them to develop their knowledge and skills going forward.

Despite the management team not independently identifying all of the areas requiring improvement we found during the inspection, they demonstrated a responsive approach and a commitment to address any shortfalls to ensure improvements were made in a timely manner.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Activity provision was not sufficient to meet everyone's needs. The range of activities available were not always appropriate or stimulating for people living with dementia.