

HC-One Limited

Brooklands Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	Good 
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

The inspection took place on 3 and 4 September 2018 and was unannounced on the first day. At the last inspection in August 2017, we rated the service Requires Improvement. We found breaches in regulations which related to information in care plans, consent and overall governance of the service. We asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective, Responsive and Well-led to at least good. Whilst we found some improvements in all areas at this inspection, there were some continued concerns in the way care plans were recorded. At this inspection, we have rated the service as Requires Improvement again.

Providers should be aiming to achieve and sustain a rating of 'Good' or 'Outstanding'. Good care is the minimum that people receiving services should expect and deserve to receive and we found systems in place to ensure improvements were made and sustained were not fully effective. As this is the third time in a row the service has been rated Requires Improvement, we will meet with the provider to discuss their action plan for improvements.

Brooklands Care Home accommodates up to 63 people. The building is purpose built with lift and stair access to the first floor. Accommodation consists of single occupancy rooms situated in three units over two floors. At the time of our inspection there were 57 people using the service.

Brooklands Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a registered manager in post. A registered manager is a person who has registered with the CQC 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.

There were inconsistencies with people's care plans. Some people had care plans, which contained good information and guidance for staff in how to meet their needs; these had improved since the last inspection. However, other people's care plans lacked important information which meant there was the possibility of care being overlooked. This was a continued regulatory breach in relation to person-centred care. You can see what action we told the provider to take regarding the above areas at the back of the full version of the report.

The provider's systems to assess, monitor and improve the quality of the service provided had been effective in driving improvements in relation to risk management and consent, but required strengthening to sustain the improvements with care plan records. A new deputy manager had been recruited to support the registered manager to sustain the required improvements.

Staff were recruited safely. Improvements had been made to the number and deployment of staff. The registered manager used a tool to calculate staffing numbers and monitored this to ensure the levels remained safe. They had recently requested from the senior management team additional staffing hours during the day to provide a 'staff float', who would work across the units to provide additional support and cover for staff breaks.

Medicines were managed safely and people who used the service received them as prescribed. There were safe systems in place to manage risks to people's health and safety. Staff had received training in how to safeguard people from the risk of abuse. Staff knew what to do if they had concerns.

The environment was clean and tidy and staff had access to personal protective equipment to help prevent the spread of infection.

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.

Staff received appropriate induction, training, supervision and support, which enabled them to feel skilled and confident when supporting people who used the service.

People's nutritional needs were met. Menus provided people with a choice of nutritious meals and people liked the meals. We saw people were provided with regular hot and cold drinks and nutritious snacks during the day.

People who used the service and their relatives had positive comments about the staff team and their approach when supporting people. People's privacy and dignity was respected.

Staff supported people to access health professionals when required and they could remain in the service for end of life care if this was their choice. Some health care professionals considered aspects of communication and clinical care had been affected by the high use of agency staff. The management team were confident that the positive recruitment of nursing staff and the appointment of a new clinical lead would ensure consistency of care and communication.

People were encouraged to participate in a range of activities within the service and local community, although trips out had been more limited recently due to hot weather.

Staff, people who used the service and their relatives, told us the registered manager was accessible and approachable. There was a complaints procedure on display in the service and it was included in information given to people. Staff knew how to manage complaints and people spoken with felt able to raise concerns. There were systems in place to enable people to share their opinion of the service provided and the general facilities at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

Improvements had been made to the number and deployment of staff. Staff were recruited safely.

Improvements had been made to the management of risk. Staff had received safeguarding training and knew how to protect people from the risk of harm and abuse.

There were effective systems in place for managing medicines and the prevention and control of infection.

Is the service effective?

Good ●

The service was effective.

People were supported to make their own decisions. Improvements had been made in how the provider implemented the Mental Capacity Act 2005. When people were assessed as lacking capacity, the provider acted within the law. Staff obtained consent before carrying out care tasks.

People's nutritional needs were met. They were supported to eat a healthy, balanced and nutritious diet. Staff ensured people had access to community health care professionals when required.

Staff received training, supervision and support which provided them with the skills and abilities to carry out their roles effectively.

Is the service caring?

Good ●

The service was caring.

People who used the service spoke warmly about the staff team and their approach when caring for them.

Staff promoted people's privacy, dignity and independence.

Staff maintained confidentiality and personal information was stored securely.

Is the service responsive?

The service was not consistently responsive.

Although people's needs had been identified, they did not always have plans of care in place that provided staff with information and guidance on how to meet them in a person-centred way. People could remain in the service for end of life care if this was their choice.

People had access to a range of activities.

The provider had a complaints policy and procedure and people felt able to raise complaints when required.

Requires Improvement 

Is the service well-led?

The service was not consistently well-led.

The provider had a quality monitoring programme and this had identified shortfalls and areas for improvements. However, the audit system for care records required strengthening to identify all shortfalls and sustain effective improvements.

Staff told us the registered manager was approachable and would listen to any concerns they had.

There were regular meetings for staff, people who used the service and their relatives to raise issues, provide feedback, and share information about the home.

Requires Improvement 

Brooklands 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 3 and 4 September 2018 and was unannounced. On the first day of the inspection, the team consisted of three inspectors and an expert by experience. The second day of the inspection was completed by one inspector.

Before the inspection we reviewed the information we held about the service. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let the Commission know about.

We contacted the local authority safeguarding and commissioning teams. We also contacted the local Healthwatch. Healthwatch is the local consumer champion for health and social care services. Information provided by these professionals was used to inform the inspection.

We used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including activities and meal times.

We spoke with eleven people who used the service, twelve of their relatives and five health care professionals. We also spoke with the area director, registered manager and a selection of staff; these included the deputy manager, agency nurse, two nursing assistants, four care workers, the activity co-ordinator, the administrator, the cook, a housekeeper and a laundry assistant.

We looked at eight people's care records, three staff recruitment files and reviewed records relating to the

management of medicines, maintenance of the premises and equipment, complaints and staff training and development. We checked how the registered manager and provider monitored the quality of the service; we also looked around the environment.

Is the service safe?

Our findings

At our last inspection we found there were times when people were not adequately supervised and staff were overstretched to meet people's needs in a timely way. We made a formal recommendation to review staffing levels and deployment of staff. At this inspection the staffing numbers had been increased in line with the rise in occupancy and dependency levels at the service.

The registered manager explained how they monitored the dependency levels closely and carefully considered the assessed needs of potential new admissions, to ensure people's needs could be met by appropriate numbers of staff. The registered manager confirmed they had recently requested approval and were awaiting confirmation for additional hours from their senior management team for a staff 'float', to work across the units to provide additional support and cover for staff breaks. During the inspection although we observed staff were busy, we found people's needs were being met.

At our last inspection we identified there was a high use of agency nursing staff at the home. At this inspection, there was a significant reduction in the amount of agency staff used. The service now employed four permanent nursing staff including a new clinical lead/ deputy manager to support the registered manager. Agency nursing staff continued to cover absences and we saw the same ones were used and this provided continuity of care. The staff recruitment had been positive and there was only one vacancy for a senior care assistant on night duty. There had been improvements with people having timely access into the building, all relatives and visiting professionals confirmed they did not experience delays with staff letting them in.

At this inspection we received some mixed feedback from people who used the service and their relatives about staffing arrangements. Comments included, "The staff all seem very busy, but [family member's] needs have always been attended to in a timely manner", "There are not enough staff down stairs, there are more upstairs as residents there need more attention", "I think they do provide the care he needs, occasionally they are short staffed, but usually it's okay", "I can't fault the care, we would like them to have more staff on duty so they could spend more time with people", "There is always a member of staff around and they answer the calls bells as quickly as they can" and "Yes, there's always staff about and I feel confident they're being cared for. They are visited every day, so we'd see if things weren't right." During both days of the inspection we observed people's call bells were answered in a timely way.

Staff were recruited safely and full employment checks were carried out before they started work at the service. These included an application form to assess gaps in employment, two references, an interview and a disclosure and barring service (DBS) check. DBS checks included police cautions and convictions and to see if potential candidates were excluded from working in care settings. There was a system in place to check qualified nurses were registered with the Nursing and Midwifery Council and that there were no restrictions on their practice.

People, told us they felt safe and trusted staff. All relatives said they did not have any concerns about the safety of their family members. Comments included, "I never feel frightened. I was ever so ill when I first

came in and they got me better" and "I feel [Name of family member] is safe and have no worries about leaving them at the home."

People were protected from avoidable risks from infection as staff had completed food safety and infection prevention and control training. We observed staff wearing gloves and aprons appropriately and hand sanitizers were available at points throughout the building. Staff understood actions to take if someone was suspected of having an infectious disease and required barrier nursing. The sluice areas had been refitted and the laundry was well-managed. All areas of the home were clean and odour free.

We found improvements had been made with the management of risk. Assessments were completed to guide staff in how to keep people safe and minimise the risks associated with specific activities of daily living. These included areas such as falls, pressure damage, nutrition, swallowing difficulties and the use of equipment such as bedrails. Staff told us they had been provided with all the information they needed to support people safely and effectively. They were knowledgeable about the risks to the people they supported and how to manage those risks.

Staff confirmed they did not use any physical interventions when delivering care support. They described how one person who used the service could be resistive to personal care support and how they used distraction techniques successfully to deliver safe care. Staff explained how they would leave the person and return later if they were too anxious and this worked well.

Where accidents and incidents took place, they were recorded and acted on appropriately. The registered manager reviewed accident and incident reports to check all action had been taken for people's safety and wellbeing. Medical advice was sought where necessary and preventative care plans and equipment such as pressure sensors to alert staff when people at risk of falling were moving, were put in place.

There were robust systems in place to ensure the premises were maintained safely. This included audits to make sure all maintenance and servicing was up to date. The registered manager completed walk rounds of the service each day and monitored the safety, cleanliness and maintenance of the environment. There was a business continuity plan and equipment used in the service was maintained.

Staff had received training in how to recognise signs of abuse. All staff spoken with were aware of their responsibilities to report any concerns they may have and the actions they would need to follow if abuse was suspected. We noted where safeguarding concerns had arisen, they were reported and responded to appropriately.

Safe systems were in place to make sure people received their medicines as prescribed. Medicines were stored securely and the storage facilities were clean and well organised. We watched the deputy manager giving people their medicines and saw this was done safely and attentively. Medication administration records (MARs) we reviewed showed a small number of gaps in signatures, where no code had been used. We checked and the medicine counts were correct indicating the medicine had been given as prescribed. The deputy manager confirmed this was an area of improvement they would be focusing on. All 'as required' medicines were supported by written instructions which described the situations and presentations when these medicines could be given. Controlled drugs (medicines subject to tighter controls because they are liable to misuse) were stored and recorded in the right way. Records evidenced the management of stock control in the service was consistent and safe.

Is the service effective?

Our findings

At the last inspection in August 2017, we had concerns that staff did not have a clear understanding of the implications of the Mental Capacity Act 2005 (MCA) and the need to record assessments of capacity and best interest decision-making. We found improvements had been made in this area.

The 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 MCA 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 application procedures for this in care homes 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. We found the registered manager had made 36 applications to the local authority for DoLS, five of which were authorised and the remainder were awaiting assessment. This showed us the registered manager was more aware of the criteria for DoLS and had acted appropriately. People who were assessed as lacking capacity and who had restrictions for their safety such as bedrails, sensor mats or wheelchair lap straps had best interest meetings recorded in their care files. This ensured relevant people involved in their care were consulted about restrictive practices and discussions had taken place about why these were necessary.

Staff understood the principles of the MCA, they obtained people's consent prior to supporting them and the person's decision was respected. One member of staff told us, "We always make sure we ask people before we do anything and we give people time to respond." Staff explained how they ensured they obtained the consent of people who were unable to provide this verbally, through a variety of gestures and expressions.

Staff we observed throughout the day interacted well with people and provided safe and effective support. People told us and relatives confirmed their needs were consistently met by competent staff. They told us they felt well cared for and received the care and treatment they needed to meet their needs and respect their wishes. Comments included, "Mum came in two years ago on end of life care and just got better", "The staff they've got now are good, there's not one bad one amongst them" and "The new staff come in and get trained up."

Records showed people had access to a range of health care professionals and were supported to attend hospital appointments when required. Staff were knowledgeable about specific issues such as the prevention of pressure ulcers and how to spot the signs of a urinary tract or chest infection and the action to take. Overall, feedback from professionals was positive in relation to how people's health care needs were met and the positive working relationships they had with the service. However, a small minority of professionals told us that because there had been a high usage of agency nursing staff this had had some impact on how effective the service was in relation to fully understanding people's clinical needs and

ensuring clear communication between shifts. They felt this was an area for improvement.

The registered manager told us they had recently appointed a new clinical lead and were currently reviewing how the nursing staff worked at the service to effectively meet people's clinical health care needs. This included providing nursing staff with clinical supervision and reviewing people's clinical needs in their care plans.

Staff had training following their induction to develop the skills and knowledge they needed. All staff had refresher training covering core topics such as safeguarding, fire safety and moving and positioning people. Completion rates for training the provider considered essential were currently at 92%. Those staff who administered medicines had annual training and competency assessments in medicines administration. Staff also received training specific to their roles. Nursing staff completed a range of clinical courses to maintain their competence and support their professional practice. Staff were expected to work towards qualifications relevant to their role, such as diplomas in health and social care for care staff.

Staff told us they felt well supported by the registered manager and provider. The supervision records reflected this and showed staff were supported to think about reflective practice, their responsibilities and people's changing needs. Staff who had worked at the service for over a year had received an annual appraisal. They had the opportunity to review their learning over the previous year and set new objectives and learning opportunities.

People told us they enjoyed the food and were offered a nutritious and well-balanced diet. Comments included, "I like my food, I always get enough" and "Lovely meals. The cooks are very good and we get plenty of choice." A relative said, "The food is good, I've had meals here. When [name of cook] makes the cakes they're really lovely."

The cook was very knowledgeable about people's specialist dietary needs and said they were informed each day by the senior staff on duty if there were any nutritional changes for people they needed to be aware of. People were consulted about their preferences and the menus provided choice and alternatives for people including vegetarian options and textured meals. Staff considered portion size and ensured plates were not overloaded with too much food. People helped themselves to snacks and drinks or staff offered them to people throughout the inspection. People who were living with dementia were offered visual and verbal choices of food and drinks. We noted the lunch time meal experience on the dementia unit for people on the first day of inspection was chaotic at times, but observation on the second day showed the meal service was better organised and people were well supported in a calmer atmosphere.

The environment was suitable for people's needs. The lounge area on the first floor had been opened up to allow people living on the dementia unit free access. We observed this area was well used and people living with dementia had more space to walk about and interact with others. There was appropriate signage to help people living with dementia locate specific rooms; we also noted toilet seats and grab rails in communal toilets were of a contrasting colour to white to help make them more visible. There were grab rails in bathrooms/toilets and handrails in corridors, which were wide enough for people who used wheelchairs. There was a range of moving and handling equipment.

Is the service caring?

Our findings

There were positive comments from people who used the service about staff approach and the way they were cared for. Comments included, "Yes, staff discuss things with me and they are caring", "The staff are great, they treat us well, we are not just a number" and "All the staff here are kind, always coming round checking if we need anything. I have nice chats with the housekeepers."

Relatives also praised the staff. Comments included, "Oh yes, from what I've seen they do care. Even the younger ones are very caring towards the residents", "Most are very caring indeed" and "As mum says, they do seem to care. If they weren't caring we'd move her."

Staff were confident they provided good person-centred care and gave examples of how they ensured people's privacy and dignity were respected. We observed staff knocking on doors and waiting for permission to enter where they knew people could answer them. We also saw prompts and support with toileting were managed sensitively and people were supported to return to their rooms for personal care. Visitors thought their relations were listened to and that staff respected them as individuals. Everyone was very clear that their dignity was preserved, and that privacy was upmost in the staff's actions. Comments from relatives included, "They make sure he's dressed properly and they always close the door when they see to him. I'd feel okay living here" and "Yes, staff are respectful of people's privacy and dignity, for example, [Name of relative] doesn't like being in nightwear for visits even though they are confined to bed. They are always wearing nice day wear. Staff understand how much this matters."

Throughout the inspection we observed positive interactions between people who lived at the service and staff. Staff were attentive to people's needs and respectful. Staff showed patience and understanding if people had communication difficulties. We saw staff comfort people when they were anxious or distressed.

Staff knew people well, their background and histories and what was important to them. This meant they could support them effectively. People had 'remembering together booklets' and other information in their care records that detailed their background, history, personal preferences and cultural and spiritual needs. This helped staff to get to know people.

People chose where and how they spent their time. They told us they could choose activities and the times they got up and retired to their rooms and to bed. One person said, "I can be myself, its home from home." We noted the routines on the dementia unit were more task based at times and discussed this with the registered manager and area director. They acknowledged the issue and explained how the new dementia model of care 'Harmony' was being rolled out to all the provider's care services for people living with dementia. The area director told us they had already contacted the provider lead for 'Harmony' and requested Brooklands Care Home be considered and prioritised for implementation of the new care model.

Families could visit at any time and described staff as welcoming. They told us, "The atmosphere is homely and caring" and "I'm definitely made welcome. I call it my second home, I'm here so often."

Relatives felt comfortable to ask staff questions about care and discuss ideas and suggestions with them. They confirmed they had been consulted and involved in formulation of care plans. Some said they discussed their relatives care daily and felt well informed. People who needed an independent representative to speak on their behalf had access to an advocacy service.

Staff completed equality and diversity training and some information about people's diverse needs and protected characteristics, as defined by the Equality Act 2010, were recorded in people's care files. The registered manager confirmed the provider's quality team were developing a new assessment tool which would cover all areas. People told us they were treated equally and respectfully. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. One person told us how important it was to be supported to observe their religious beliefs and another person told us they preferred support from female care staff and this was always respected.

People were provided with a good range of information about the service. Staff were aware of the need to maintain confidentiality. People's personal care records and staff personnel files were held securely. Review meetings to discuss people's care were held in their own bedrooms or an office. Computers were password protected to ensure only appropriate staff had access to them.

Is the service responsive?

Our findings

At the last inspection in August 2017, we had concerns about how care was assessed and planned to make sure staff had full information on how to support people in the way they preferred. Whilst we found some improvements had been made, there remained some inconsistencies with care plan documentation.

We found the assessments completed by staff highlighted health care issues but these were not always followed through to care plans in a consistent way. Some care plans were detailed and described the tasks care staff had to complete to support someone in the way they preferred. Others lacked important information. For example, one person had recently fallen and sustained a fracture. Their mobility plan had been updated to reflect the changes in need, however there was no pain assessment tool or care plan put in place to support the person's pain management. Checks on the person's medication records showed they had received pain relief medication. Another person had been admitted for end of life care four weeks before yet there was no end of life care plan in place. Two people, who had behaviours which could be challenging due to their anxiety or distress had care plans in place, but these did not provide sufficient information to guide staff on the action to take at these times.

Records were made of when health and social care professionals visited and what treatment or advice they provided. However, we found care plans were not always updated to reflect this guidance. For example, one person's mobility needs had been assessed by the occupational therapist and they had advised the use of a pillow system to avoid contractures whilst the person was cared for in bed. The care plan had not been updated six days later and staff were neither aware or had put this in place. Another person with complex needs around their communication had undergone an assessment by the speech and language therapist (SaLT) in May 2018. Their communication plan had not been updated to reflect the recommendations made. The SaLT had continued to visit the person regularly to support with intensive interaction therapy (a communication approach for people with severe learning disability) yet this was not detailed in the care plan. The person was also continuing to experience weight loss and the person's nutritional plan was not updated to reflect guidance with offering regular small high calorie/ fortified meal and snack options.

Supplementary records were used to document some people's food and fluid intake, but we found staff had not always ensured the records were completed consistently or reflected that they had been responsive when a person's fluid intake had been poor. Although people had their individual optimum fluid targets recorded, when these had not been clearly achieved, we could not always see what action had been taken by staff to encourage people to increase their intake and monitor their progress. We discussed this concern with the registered manager, who took action during the inspection to put new food and fluid intake records in place and ensure senior staff were monitoring these records more consistently throughout their shift. Following the inspection, the registered manager confirmed they had implemented an additional layer of checks specifically to ensure consistent totalling of supplementary records was carried out at all times.

Not ensuring people's needs were accurately and consistently assessed, care planned and met in a person-centred way was a continued breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we directed the provider to take at the

back of this report.

The provider had a policy and procedure for end of life care. This stated people could remain at Brooklands Care Home until the end of their life if this was their choice. Some people's care plans reflected decisions about their end of life wishes. There was information about decisions regarding emergency treatment such as 'do not attempt cardiopulmonary resuscitation' in people's care files. Staff had received training in how to support people as they neared the end of their lives. A Macmillan nurse told us there were good systems at the home for end of life care support. They said staff regularly made referrals and had a collaborative approach. They also said they had a good relationship with the care and nursing staff. A relative we spoke with praised the staff for the excellent end of life care they were providing for their relation. They described how compassionate and kind the staff were ensuring their family member was dressed comfortably, pain free and their dignity was fully respected.

The provider was aware of the Accessible Information Standard. This was a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss could access and understand information they were given. Information could be provided in alternative formats.

There was an activity coordinator employed to organise events, activities and entertainers. The activity coordinator produced a monthly activity programme and we saw this included entertainers, Bingo, one-to-one sessions, quizzes, baking, art and crafts, films, reminiscence, exercises and choir practice. There were links with the local community and people could access religious services which were held regularly at the service.

All the people spoken with said there were sufficient activities organised for them. Comments included, "We've got a choir coming up for rehearsals for Harvest Festival. There's two teams of five taking part", "We used to get out, but we've been told they stopped the trips because of the hot weather. I used to love going out. They're planning to start it again, just the hot summer that stopped it" and "There is always something going on; I really enjoy the quizzes."

Relatives said, "They have a good singing group", "Wednesday afternoon they have singers with bubbles and balloons. They've made butterflies and hang them on the trees" and "[Name of activity coordinator] does lots of activities. We've been on a few outings. I go with them to push their chair." One visitor told us their relation was a Christian and the home accommodated the local vicar visiting and a friend at the service also joined in the services.

The provider had a policy and procedure for managing complaints. The complaints procedure was available to people and relatives and a copy was provided upon admission to the home. An electronic device was also available in the entrance area of the home for people and visitors to record their opinions of the service. This device was linked to the provider's quality team.

Complaints were recorded and this showed they were investigated and addressed. People said that if they had any concerns they would be able to raise them. People we spoke with and their relatives told us they knew how to make a complaint or raise concerns and would have no hesitation in making a formal complaint if the need arose. One person's relative raised a concern, which was discussed with the area director and registered manager to address.

Is the service well-led?

Our findings

At the last inspection in August 2017 we found effective governance systems had not been maintained and there were shortfalls in recording systems. Whilst we found good improvements had been made towards consent records, there remained some inconsistencies with care plan documentation.

The provider had a quality monitoring system that consisted of audits, surveys and meetings to ensure people could express their views about the service. Quality and compliance audits were carried out monthly on a variety of areas. These included a selection of care plans, health related issues, health and safety, infection prevention and control, catering, medicines, complaints, accidents, recruitment, staffing and agency use, training and supervision. Maintenance personnel recorded safety checks and repairs that required attention. Visits were completed by the regional management and quality teams.

The provider maintained oversight of the service through a clinical governance system. The registered manager completed a monthly report which included falls, pressure sores, weight management, accidents, hospital admissions and infections, and any other incidents which occurred during the month. Incidents were monitored for trends so that methods for reducing incidents reoccurring could be identified.

We found quality records such as 'resident of the day' and the registered manager's daily walk around checks were completed more consistently. Good improvements had been made with staffs understanding of the Mental Capacity Act 2005 and records to support its application. Whilst there had been some improvements with the care plans, the quality of the records remained inconsistent and had not been fully addressed through the audit programme. The area director acknowledged this shortfall and confirmed the new deputy manager would be involved in care planning and review to ensure the quality of recording was improved and more consistent. They also confirmed the care plan audit programme would be strengthened. We considered overall that the regulation has been met and the rating in this key question reflects the need for improvements with care plan and supplementary monitoring records to be sustained over time.

We found the registered manager was more confident in her management approach and more organised. All records requested were readily accessible. The registered manager explained the difficulties they had experienced since the last inspection with recruiting a new deputy manager and the difference this would now make with the support for staff and monitoring the delivery of care.

People spoke positively about the management of the service. Comments included, "I have spoken to the manager on several occasions (and cried on her shoulder) she is very approachable", "The manageress here is good, she's really on the ball" and "I do think it's well managed. This manager they have now has her finger on the button. They have resident's meetings, we got invited to one just last week. I think they listen, otherwise we point things out to them."

Staff also provided positive feedback about the registered manager and told us they felt well-supported. Their comments included, "[Name of registered manager] is approachable and very supportive. She's

around and about in the home, she doesn't hide away. She knows everyone" and "The manager's door is always open and we can go to her if we have any issues."

Meetings were held each month for residents and relatives in order to gain their input and views of the quality of the service. People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. Action plans were put in place to support areas of improvement identified.

There were meetings and shift handovers to ensure staff had up to date information about issues affecting the service and people who lived there. A 'flash' meeting was held every day at 11am by the registered manager with senior staff to discuss any current issues, changes and urgent matters. This meant that staff were kept informed of any immediate needs. Staff meetings were held monthly. Staff told us there was a positive team culture at the service and many staff had worked there a long time.

Information about the provider's values and ethos around 'kindness in care' were clearly displayed in the entrance area and in discussions staff had a good knowledge of these. One member of staff told us, "We make time for people and always try our best to be kind, caring and compassionate."

The registered manager was aware that notifications of incidents which affected the welfare of people who used service had to be sent to the Care Quality Commission. This enabled us to check how the service managed incidents and kept people safe. At the last inspection we found that an incident had not been reported to us. Since then, we had received all notifications in a timely way.

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
Treatment of disease, disorder or injury	The registered persons had not consistently ensured care plans included important information and guidance for staff in how to support people in a person-centred way.