Premier Nursing Homes Limited

Beechwood Care Home

Inspection report

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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 inspection took place on 6 and 7 December 2016 and was unannounced.

Beechwood care home is registered to provide accommodation for up to 60 older people some of whom are living with dementia . There were 56 people living at the service when we inspected. The service cared for people with predominantly residential care needs on the ground floor and nursing needs on the upper floor. The service was purpose built and had several communal areas and gardens. It had specialist equipment to assist people with mobility problems and was close to local transport links.

The service had a registered manager. 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.

Staff were able to tell us what they would do to ensure people were safe and people told us they felt safe at the service. The registered provider had sufficient suitable staff to care for people safely however the registered manager had experienced difficulty recruiting sufficient suitable staff which meant that staffing levels were sometimes not at an optimum level.

Care plans were kept up to date when needs changed, however staff did not always have sufficient information about people preferences and what was important to them to ensure they gave people personalised care. Medicines were safely handled and risks were well assessed to protect people.People's individual risk management plans were in place. However, these sometimes focused on recording information and did not always give clear instructions to staff on how to translate the information into clear management plans to protect people around risk.

The environment was safe for people and monitoring checks were regularly carried out. People were protected by the infection control procedures in the service.

Staff had received training to ensure that people received care appropriate for their needs. Training was up to date across a range of relevant areas.

Staff had received up to date training in Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Staff understood that people should be consulted about their care and they understood the principles of the MCA and DoLS authorisations. People who lacked capacity were supported to make decisions and where necessary protected from making unwise choices.

People's nutrition and hydration needs were met. People enjoyed the meals. Specialist advice around people's health care was sought and followed.

People were treated with kindness and compassion. We saw staff had a good rapport with people whilst treating them with dignity and respect. Staff had knowledge and understanding of people's needs and worked together well as a team. Care plans provided detailed information about people's individual needs and preferences. Records and observations provided evidence that people were treated in a way which encouraged them to feel valued and cared about.

People told us their complaints were responded to and the results of complaint investigations were clearly recorded. Everyone we spoke with told us that if they had concerns they were addressed by the registered manager who responded quickly.

The registered provider had an effective quality assurance system in place and was well supported by the senior management of the organisation.

The service was well managed and staff were well supported in their role. The registered manager had a clear understanding of their role. They consulted appropriately with people who lived at the service, people who were important to them, staff and health care professionals, in order to identify required improvements and put these in place. The registered manager was improving the way in which the quality assurance system informed improvements and effective governance systems were in place to protect people.

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.

Staffing levels were not always sufficient to ensure that the safety and long term well- being of people could be protected.

Risk management plans did not always result in clear instructions for staff to manage risk safely and so that people's freedom was maximised

People were protected from the risks of acquiring infection because the service had infection control policies and procedures and staff acted on these.

People were protected by the way the service handled medicines.

Is the service effective?

Good

The service was effective.

People told us that they were well cared for and that staff understood their care needs.

Staff were supported in their role through training and supervision which gave them the skills to provide good care.

The service met people's health care needs, including their needs in relation to food and drink.

People's capacity to make decisions was assessed in line with the Mental Capacity Act (2005) (MCA).

Is the service caring?

Good

The service was caring.

Staff were skilled in clear communication and the development of respectful, caring relationships with people.

Staff involved people in decisions.

Staff had respect for people's privacy and dignity.

People were cared for with compassion when they reached the end of their lives.

Is the service responsive?

Good

The service responsive.

People did not always receive care that was sufficiently personalised but this had been identified by the registered manager and action taken to address it.

Care plans were regularly reviewed so that people's care remained appropriate for their needs.

People were supported to complain and their complaints were investigated.

Visitors were welcome at any time.

Is the service well-led?

Good

The service was well led.

There was a registered manager in place. Leadership was visible and there was a quality assurance system in place so that the registered manager could monitor the service and plan improvements.

Communication between management and staff was regular and informative.

The culture was supportive of people who lived at the home and of staff. People were consulted about their views and their wishes were acted upon.

Beechwood 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 registered 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 6 and 7 December 2016 and was carried out by two adult social care inspectors and two experts 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. The inspection was unannounced.

Prior to our inspection we reviewed all of the information we held about the service. We considered information which had been shared with us by the local authority. Before the inspection, we received 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 also gathered the information we needed during the inspection.

During the inspection visit we spoke with 14 people who lived at the service, seven visitors, eight members of care staff, including three nurses, the registered manager and two senior managers and we spoke with two health care professionals.

We looked at all areas of the service, including people's bedrooms, when they were able to give their permission. We looked at the kitchen, laundry, bathrooms, toilets and all communal areas. We spent time looking at eight care records and associated documentation. We looked at records relating to the management of the service; for example policies and procedures, audits and staff duty rotas. We looked at the recruitment records for four members of staff. We also observed the lunchtime experience and interactions between staff and people living at the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we had highlighted that the registered manager had arranged for safety gates to be fitted to some people's rooms. This was to protect their privacy when they liked to look out onto the corridor as some other people would enter their room uninvited. However we identified that this posed a risk to people who may fall over these. The registered manager had arranged for all but one of these to be removed and for sensors to be fitted to doors instead which would alert staff to people going in and out of rooms. One person had chosen to retain the gate in place and the registered manager was considering how best to reduce the risk to others as a result of this choice.

During the past year, the registered manager had experienced difficulty recruiting and retaining sufficient suitable care and nursing staff. This had led to difficulties in achieving optimum staffing levels. The registered manager advertised for staff regularly and was using agency nurses to fill gaps in the rota. They had offered incentives and had a banner in the car park of the service advertising that they were recruiting. However these methods had not always been successful in attracting staff to work at the service. The registered manager had therefore voluntarily decided to halt admissions until they felt they had sufficient staff to safely manage increased occupancy.

We asked the registered manager how they decided on safe staffing levels. They told us they calculated this using a dependency tool.
Before the inspection we asked the registered manager to send us a risk management plan for staffing levels, to ensure people were cared for safely. This plan set down three levels of staffing. This covered optimum numbers, safe numbers and levels below which there was a risk of unsafe care which would trigger contacting the local authority and CQC. The registered manager had not had cause to refer unsafe levels of staffing. However, when we checked the staffing rotas for November we found there were a number of times when the service was running with staffing levels at the safe but not optimum level. The registered manager told us that in these cases the optimum level was sometimes achieved at short notice by staff willing to arrive early for shifts, or to work late, or by the registered manager working as an extra member of staff. These additions had not been recorded and so the staffing levels at times appeared to be less than they actually were.

On the day of the inspection visit, staffing numbers were operating at what the registered manager considered safe rather than optimum levels on both night and day shifts. Staff told us and we observed that there were sufficient staff on duty to care for people safely. The rota had been drawn up with a consideration for skill mix and experience and we observed staff attend to call bells quickly. However we noted that staff did always have sufficient time to visit people regularly who may feel isolated in their rooms or engage sufficiently in activities. Also, rotas did not take account of the layout of the building which featured long corridors that took time for staff to negotiate. The feedback we received from staff, our observations and discussions we had during the day indicated that it was not sustainable to run the service with the safe rather than optimum level of staffing for anything other than a few days. The registered manager told us that the risk plan would be revised to ensure this level of staffing did not continue for more than this time.

Before our inspection we received concerns that staff were supporting people out of bed from as early as 05:00 for their own convenience. Also that staff were not attending to people's personal care in the early evenings so that night staff found a greater number of people than might be expected needing personal care support when the shift changed at 20:00. We attended the home at 07:00 to check on how many people were up. Of 56 people there were a total of seven people out of bed at that time. Those people who were up were dressed warmly, most were wide awake and clearly ready for the day. Staff told us that one person had been up in the early hours walking and chatting with staff and in the early morning we saw they were asleep in a chair. This person was living with dementia. They appeared comfortable and staff explained they would leave them until they woke naturally.

We found no evidence to support the view that people were getting up very early against their wishes. We remained at the service until 21:00 to check on whether staff in the early evening needed to attend to more personal care than they might expect. We observed that staff on both day and night shift attended to people as and when this became necessary. We interviewed care staff who were on night duty and none of the staff we spoke with felt they regularly had extra caring duties to carry out at the beginning of their shift. We were satisfied that there were sufficient staff on duty so that people were able to exercise choice in their daily routines. Ancillary staff were also employed, such as cooks, maintenance, laundry and domestic staff so that care staff could devote time to their caring duties.

Most staff worked twelve hour shifts with a fifteen minute handover time to ensure that important information about people's safety was shared appropriately. One nurse told us, "We have good handover and staff are really on the ball about passing on important information." We observed two staff handovers on the nursing floor, at the beginning and end of the first day. The lead nurse on duty gave detailed information to the nurse who was assuming responsibility for the shift, and care staff also sat in on the handover so that they were aware of any changes and areas to monitor.

We looked at the recruitment records for four staff which showed recruitment checks, such as criminal record checks from the Disclosure and Barring Service (DBS) for each member of staff were available and that two references were obtained before staff began work. DBS checks assist employers in making safer recruitment decisions by checking that prospective care workers are not barred from working with certain groups of people. References were not always gained from staff's last employer. The registered manager explained that some previous employers did not respond to requests for references and in these cases the registered manager followed this up with a call. However, when they were unable to gain the references they required, they had made sure to obtain more than one reference from another source. We saw evidence that this happened. This meant that the service had taken steps to reduce the risk of employing unsuitable staff.

Care plans identified a person's level of risk and records showed that these were regularly updated to reflect people's changing needs. When they were able to do so, people told us that each area of risk had been discussed and agreed with them and we saw records which confirmed this. Risk assessments were proportionate and included information for staff on how to reduce identified risks while promoting independence. For example, the risk of falling was scored, and then a plan was put in place with a falls diary for each individual. We also saw a number of behavioural risk assessments, for when people became distressed or displayed aggression due to their condition. We also saw that a trip had been organised to Richmond where the risk to individuals had been assessed to allow them to enjoy this outing.

We spoke with a community mental health nurse who was visiting the service. They told us the registered manager worked alongside them to minimise the risks to people and staff.

Risk management plans focused on gathering information about clinical care, such as Waterlow scores for

pressure care or the Malnutrition Universal Screening Tool (MUST) for people at risk of malnutrition. However, it was not always clear how this information had been used to minimise identified risks. Also, we noted a member of agency staff was supporting a person in way which was not fully promoting their safety and we intervened so that the person was at less risk of falling. This member of staff had not received sufficient guidance on how to support this person.

We discussed with the registered provider the need to consult best practice guidance on developing risk management plans. They recognised that using recognised models for risk management would lead to clear actions to minimise risk being developed and communicated to all staff.

Accidents and incidents were recorded and the registered manager explained that they analysed these for trends so that the risk of further incidents was minimised. Accidents were associated with body maps so that staff could clearly note the area of the body they were to monitor. This meant the registered manager had information they needed to analyse trends and promote people's safety.

The registered manager had developed environmental risk assessments, which identified known risks in the building and set out the checks that should be in place to minimise these. The service was purpose built, supported safe movement around the building and there were no obstructions. The service had a fire risk assessment in place and all firefighting equipment was regularly serviced to ensure it remained safe for use. Each person had a personal emergency evacuation plan (PEEP) which was available on the floor where the person's room was located in a 'grab bag' for easy access.

The service handled and disposed of medicines safely. Solid medicines were dispensed using a monitored dosing system (MDS). MAR charts had a photograph of each person on every individual record. This reduced the risk of medicine administration error. Those medicines which were not stored in the MDS and were provided in boxes or bottles were stored in medicine storage trolleys. Medicines had the correct medication information on the label and this matched the MARs, which reduced the risk of administration errors. All medicines stored in this way were dated on opening and a running stock balance of tablets and fluids was kept so that stocks could be accurately monitored.

Some medicines required fridge storage and the fridge temperature was recorded each day to ensure this was safe. We noted that on the nursing floor, the temperature was often close to the highest maximum safe level. We mentioned this to the registered manager as it may mean that the fridge was not working efficiently. PRN (as needed) medicines were not always recorded consistently, and guidance for application of topical creams, though included in the MAR, sometimes stated 'as directed' rather than giving staff clear direction.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, (CDs) which are medicines that require extra checks and special storage arrangements because of their potential for misuse. This meant that people were protected around the management of CDs. The registered manager had appropriate policies and procedures to support staff to handle medicines safely.

We spoke with a GP who told us they regularly visited the service to review the medicines prescribed to ensure these remained appropriate for people's medical needs.

The registered manager ensured that staff followed policies and procedures in the control of infection to protect people.

Good

Is the service effective?

Our findings

People told us that they could see a doctor whenever they felt they needed one. Most people told us they enjoyed the food. One person said there was plenty of choice, another person told us they liked the fact there was always a "knife and fork dinner" and there were lots of opportunities for snacks and drinks throughout the day. Another person said the food was always well cooked. One visitor told us they were reassured their relative received a set amount of fluid every thirty minutes, in line with their care plan.

Staff received induction training before they began their mandatory training. During this time they developed a good understanding of each individual's care needs and the philosophy of the service. Most staff were knowledgeable about the needs of the people they supported and knew how people's needs should be met. For example, one member of staff accurately told us about the care a person required including how they should be supported with their pressure care, eating and drinking. However, we found that some agency staff had not received induction which meant these members of staff may not have the information they needed to offer effective care.

Staff told us that new employees spent time shadowing a more experienced member of staff before they were permitted to work alone and only did so when they were confident. This was to make sure they understood people's individual needs and how risks were managed. A staff member told us about the induction they received which they prepared them for their role. They said "I had three full days on the job training and I did my training online. I worked alongside colleagues to start with."

Staff received a range of training relevant to their role including specially sourced training which related directly to the client group they supported. . Staff told us about other additional clinical training they had completed such as diabetes care, dementia care, pressure ulcer prevention, tissue viability and palliative care. Staff told us that the training was delivered in a variety of ways according to what was most appropriate. This included e- learning and externally provided face to face training. However, staff told us they sometimes did not feel equipped to deal with behaviour which challenged them as their dementia care training did not contain sufficient emphasis on this.

Staff told us about an incident which had taken place where staff did not know how best to respond to a person. We spoke with a community mental health team (CMHT) professional who told us they worked alongside staff to support them offer the most appropriate care for this person. Staff told us that de-escalation techniques were not always sufficient and they required further support to work with this person effectively. We witnessed a productive conversation where the CMHT professional, the registered manager and staff discussed possible triggers for distress and learning points for avoiding these in future. This included sourcing training which focused upon behaviour which may challenge.
The registered manager was aware of training which needed to be completed, such as medicines update training for nursing and senior staff. Records confirmed this training took place and that a large percentage of staff had completed these. For example, in the PIR the registered manager told us that 90% of the staff team had received dementia care training.

Staff, including nurses told us that they received regular supervision and appraisal. Nurses told us that they received clinical supervision and support through the quality support manager for the home. We saw evidence of this in the staff records we reviewed. Staff told us this supported them to develop professionally and to offer the care people needed.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application process 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.

People's plans of care showed that the principles of the Mental Capacity Act 2005 (MCA) Code of Practice had been used when assessing people's ability to make decisions. The service had a policy and procedure on the MCA and DoLS to protect people. 14 people had been referred and assessed as being deprived of their liberty by professionals from the local authority. CQC had been notified of the DoLS in place.

Staff understood the principles of the MCA and DoLS and were able to tell us about the five main principles, for example that they should approach people with an assumption of capacity and they should support people to make their own decisions.

Decisions which needed to be made in a person's best interests were recorded and evidence was provided that this was carried out with a multidisciplinary team approach as the MCA advises. For example we saw Best Interests decisions in relation to receiving a 'flu vaccination, and the use of covert medicines. We also saw evidence of a mental capacity assessment with a Best Interests decision for a person who was expected to regain mental capacity following pneumonia. Written evidence was on file to show this person's mental capacity had been re assessed by a multidisciplinary team every two weeks to ensure that the person was not being unlawfully deprived of their liberty.

People told us they were regularly asked for their consent to care. We observed staff routinely asked for people's consent before giving assistance and waited for a response. Care plans contained instructions on how to look for consent when people were not able to give this verbally, for example, through observing body language or facial expressions. However, care records did not always show people who used the service had signed to show they consented to the treatment plan; or records of conversations which had been held with relevant people acting on their behalf; or whether relatives had the legal authority to make decisions on people's behalf. This meant that people may not always been asked for their consent to care and treatment.

The living environment had been organised so that people were supported with their needs for stimulation and activity. For example, following a King's Fund assessment, dementia friendly environmental changes and improvements had been developed. The dining room contained a large, clearly numbered clock with a board displaying the date and the weather. Pictorial signs to support people to navigate around the service were available, the service had a shop front with nostalgic displays of jars and tins and there was a display of comics such as the Dandy and Beano. There was also a post box painted bright red. We observed people taking interest in these areas. Objects of interest were available for people to engage with such as soft toys,

games and textured materials. The service had a sensory room, with coloured lights and music where we observed people enjoying some relaxation time.

Care plans contained details of how to meet people's clinical care needs. Examples included pressure care, nutrition and fluids, and how to support people to move safely. Risk assessments were in place around clinical care. The service used MUST which is a recognised risk assessment tool to determine whether people are at risk of malnutrition. Staff recorded health appointments and people told us they were supported to attend these.

We observed a discussion between a GP and the nurse on duty where the GP offered advice which the nurse responded to in a positive manner. The nurse showed they were was knowledgeable about people's clinical care needs and was to discuss problems and find solutions.

We saw that the service had links with specialists, for example the diabetic care nurse, tissue viability nurse and the speech and language therapy team (SALT). Advice from these specialists was written into care plans and daily notes confirmed that the advice was being followed. This advice helped staff to offer appropriate and individualised care. The registered manager told us that nurses had recently delivered specific training to care staff in the preparation of thickened fluids for those people who required this so that their needs could be met.

Where necessary, target fluids (meaning the optimum quantity of fluids a person should consume each day) were recorded and were specific to each individual. Food, fluid and turning/ monitoring charts were in place to protect people where necessary, though in one instance charts were missing. We raised this with the registered manager who told us they would remedy this. Those nutritional and fluid charts we checked were accurately completed with no gaps and reflected the guidance set down in the care plan and risk assessments. This ensured that the registered manager could monitor whether people were receiving appropriate food and drink for their needs.

Care plans contained information about people's food likes and dislikes. Those people we spoke with told us their preferences around food were respected. Allergies in relation to food or drink were also recorded. Specific diets to take account of medical conditions such as diabetes were recorded, and any fortified or prescribed supplements in use. This meant that people's needs in relation to food and drink were assessed and provided for.

We observed lunchtime and saw the tables were laid attractively. The staff team worked together to provide a calm and personalised service for people. There were meal choices available and we observed staff offering people sample plates to support them with their choices. Alternatives were offered and supplied as necessary. For example one person opted for toast and jam and was brought this. Snacks and drinks were available throughout the day and people who were asleep or otherwise engaged at meal times were approached later so that they did not miss out. Jugs of juice were available for people to help themselves to during the day. There was a wide choice at breakfast with a range from a full English cooked meal to cereal. Some people's families had expressed dissatisfaction with the quality of some of the meals at the latest relative's meeting held the evening before the inspection. The registered manager had listened to what was said and people expressed confidence that something would be done to improve the quality of some of the choices on offer.

Staff offered one to one support for people where they needed this in a respectful way and we observed people enjoying their food. One person who required additional support to understand it was lunchtime was dealt with patiently by the team and after a trying a number of options the person was provided with

finger food so that they could eat on the move. This meant staff worked with people to be sure their needs were met.

Good

Is the service caring?

Our findings

People told us that staff were caring. One visitor told us they were, "So pleased (the person) is here". They told us they were, "met with a friendly welcome" by staff and offered refreshments. They felt that staff gave "kindness and care" to every person. One visitor told us that the service was "calm and peaceful" and another said, "I have peace of mind", and that their relative was treated with kindness and compassion.

We spent time with people in the communal areas and observed there was a relaxed and caring atmosphere. People were comfortable and happy around staff. We saw that staff encouraged people to express their views and listened to their responses. We observed that staff knew people well and spoke with them about their lives, people who were important to them and what they were interested in. People responded well to this and staff encouraged them to chat about things they were interested in.

We saw staff reacted immediately to support people when they needed this. Staff responded in a low key way so as not draw attention to people who may be distressed or in need of support and they spent time reassuring people in a kind and patient way. Staff told us that they respected people's right to privacy and dignity and spoke using a kind tone of voice, listened to people and supported people discreetly and in a way which made them appear comfortable. Care plans contained instructions for staff on each person's needs in relation to emotional support.

It was one person's birthday on the nursing floor and we observed staff making a fuss of this person and wishing them a happy birthday. The person had chosen a special meal and had a birthday cake with balloons decorating their room. We observed other staff respond to individual people in different ways according to what people preferred. For example, staff hugged one person who appeared to enjoy this, but approached another person in a gentle and quieter way.

One staff member told us, "I love working here because although we are busy, we get to know people well either through speaking directly with them or through their relatives. We get to understand people well and what may make them happy or what may upset them."

Visitors were welcomed into the service and we saw that a number of people visited throughout the day. Visitors were welcome at lunch times, and our observations on the nursing floor were of a sociable time. Families chatted with the people they had come to visit and staff. Some visitors were supporting people with eating their meal and staff regularly checked whether visitors needed anything or if there was anything they could do to help.

The registered manager had organised for people who needed them to have communication aids so that they could make an informed decision about options open to them. This included support to attend sight and hearing tests and to have dental check-ups.

Staff told us they would like to have more time to visit people in their own rooms to provide social stimulation. They said that they were often too busy to spend much time chatting with people other than

when they were offering support with care tasks. Some people chose to have their doors open so that they could watch staff go by and we observed staff taking time to have a few words with people, though they rarely stopped for more than a moment or two. This meant there was a risk that some people would feel isolated in their rooms.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place, and where we saw these they were correctly completed and regularly reviewed.

Staff told us about the way people were cared for in their final days. Staff emphasised the need for close liaison with palliative care professionals, attentive monitoring to ensure people did not suffer pain and how important it was to ensure people had company at their beside. They also spoke about the importance of supporting relatives, the people who lived at the service and each other at that difficult time.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. One person told us, "We do some nice things." One visitor told us they had attended an organised activity led by an external provider which the person referred to as 'Motivation'. People were throwing bean bags on an alphabet wheel and had to think of a word to match the letter. The visitor's relative threw an 'H' and said 'Horses' which really pleased the visitor as they explained they used to own horses. It had given them a connection with the life they had lived before. She told us, 'that was a good day'.

One visitor said there had been recently been a church service held in the afternoon, a craft afternoon and an entertainer. Another visitor said the staff had listened to them and made sure to support their relative to prepare for bed before tea time as they were usually tired and ready for bed soon afterwards. This was so the visitor could support their relative with tea and go home knowing they was settled for the evening which gave them peace of mind.

Care staff were provided with summary care plans which they could easily refer to and update. We observed that staff frequently referred to care plans during the day.

Some care plans contained detailed information about people's care needs which provided staff with the information they needed to provide personalised care. For example, one person's night time plan stated, 'I like the wall light on during the night'. Another plan stated, "[The person] is…proud [and] likes to dress elegantly and smart," and "[The person] wears dresses, skirt and top with matching jumpers." We saw that the person was dressed in this way. Details were recorded about when people preferred to get up and go to bed, the preferred gender of staff attending them, meal preferences and dislikes. Also, some plans contained details of people's social circle and interests which were important to people. For example one plan recorded that a person had an interest in aeroplanes, motorbikes and country and western music. Staff told us this helped them to find conversation topics which may be of interest to the person and to support the person with their leisure activities.

However, some people's plans were not so personalised. For example one person required a face mask inhaler because they did not understand how to use an inhaler. There was no explanation for staff in the care plan about how to reduce anxiety for the person. Some people's plans did not contain much detail about their interests or areas of their lives that were important to them. This meant that staff did not consistently have clear guidance to support them to offer personalised care.

Reviews were carried out each month and staff recorded in detail how people had been each month, what changes there had been to their care needs and what had been put in place to meet changing needs. There was often no evidence that people had been involved in their reviews and the focus of reviews was on health care needs, rather than people's experience for their care. Where staff had recorded that there were no changes to care needs, there was no rationale for this, or any mention on how this conclusion had been reached. This meant that reviews did not always reflect a personalised approach.

Staff engaged people in group activities each day. These included sing- alongs, dancing, quizzes, hand eye coordination games such as throwing and catching, jigsaws and puzzles, baking and gardening. People were supported to take part in individual activities they enjoyed such as going out into the town, however, these activities did not often take place often unless visitors supported this due to staffing levels in the service. Activities were recorded when people joined a group activity and were mentioned at the daily flash meeting to ensure they were happening and organised. Staff also spent time on a one to one basis with people in their rooms. However, the time they had to do this was limited due to staffing levels and most activities took place in the communal areas, with the risk that people may at times feel isolated in their rooms.

Despite this, the registered manager had recognised that reviews were not sufficiently personalised and had recently introduced a 'resident of the day' initiative. This meant that each person had one day a month when they had their care needs reviewed with their involvement. They had a 'special' day where they had their room deep cleaned, chose their favourite meal and were supported to take part in an activity they chose such as going on an outing or having one to one pamper time. The person was surveyed for their views, and all areas of staffing were involved, such as laundry staff, catering, maintenance and care staff. This initiative was still in its early stages, but staff who had taken part in this told us people enjoyed this and it was proving a good way to guarantee that each person's care was reviewed with their involvement each month..

People were supported to use the whole of the building and grounds and to be where they were comfortable. For example, on the day of our inspection visit, one person chose to spend part of the day outside in the garden area of the service. Staff supported the person to return inside and to go outside again when they decided to do this. Another person told us they also were supported to use the garden and enjoyed spending time there. Staff accompanied people who liked to walk around the corridors and chatted with them. One person chose to eat in a day room rather than the dining room and staff supported them to do this. Staff had a good rapport with people, calling them by name and involving them in what was going on.

Daily newspapers were available for people in the lounges. We observed one member of staff collected mail for a person waited for them to open it and then read the letter to the person at their request. Christmas carols were playing in the dining room to accompany the activity of dressing the Christmas tree. People who lived at the service were enthusiastically engaged in choosing decorations and in decorating the tree. A member of staff carried a box of decorations around to each person and invited them to choose one which meant that those people who were more withdrawn or not so mobile were also included.

Visitors told us and we observed they were welcome at any time. A number of people visited throughout the day and also at lunch and tea time to support people to eat their meal and to make mealtimes a more sociable occasion.

People told us they felt confident to raise concerns if necessary. They said the registered manager was approachable and available if they needed to speak with them about any concerns. Records of concerns and complaints showed that these had been investigated and the outcome had been communicated to people.

Good

Is the service well-led?

Our findings

One person told us, "The staff all know what they are doing, and they seem well organised." One visitor said the senior staff communication with their family members was excellent. One visitor said, "You say things and they are taken on board". The 'Relatives meetings' were well attended and acted as a support network for families. Visitors told us that issues of concern such as the meals and activities had been discussed and improvements were being made. People and their families told us they felt listened to.

The service had a registered manager in place. They were supported in their role by a clinical lead nursing staff, and by the senior management structure of the organisation. The registered manager told us that the management team offered good support to each other and they were encouraged to discuss issues in a positive way. Senior managers visited the service on both days of the service to support the registered manager and to explain their role to the inspectors and the way in which they managed the quality assurance system. The senior managers and registered manager carried out a range of clinical and operational audits to ensure that the service provided people with safe and good quality care.

Senior managers drew up action plans based on the information which they gathered and which the registered manager sent them, to ensure the service improved people's quality of care. Lessons learned and reflections for future learning were recorded for staff discussion in meetings. For example, where it was recognised activity resources were not adequate the area manager and registered manager had applied to the registered provider for additional funds for the next financial year.

The registered manager and senior managers reflected the culture and ethos of the service which placed each individual at the centre of their care.

The registered manager carried out a daily walk around the building where they identified any issues, and spoke with people and staff. The registered manager told us that this supported them to be more visible around the service and to pick up on things which needed attention.

People and those who were important to them had been surveyed for their views about their care and the registered manager told us that the surveys were analysed and any points for improvement were placed into an action plan.

A member of staff told us, "The manager is easy to talk to." A visiting professional told us, "We work together really well with the manager here." Other staff told us that the manager was open and positive with them, and that they felt supported in their role. They had regular staff meetings which gave them information and guidance to care for the people who lived at the service. Staff told us they felt able to raise ideas and concerns in the staff meetings. Minutes were kept and identified actions were recorded.

The registered manager was a visible presence in the home and they had a warm and friendly relationship with people. Staff told us that the registered manager and office team located themselves at the entrance reception so they could speak with visitors and show them they were accessible and willing to help. People

told us the registered manager often stopped for a chat, that they were easy to get along with and were helpful.

The registered manager held regular resident and visitors meetings. We saw some sample minutes of these meetings which showed that they were used as opportunities to listen to people's views and to pass on information. Visitors told us they had requested a change to the menu in the resident's meeting which had taken place the day before the inspection visit. The registered manager had agreed to make changes to the menus as people had suggested and fed back the findings of the meeting to the staff team the next day in what they called a 'flash meeting'. We attended a 'flash' meeting which included all senior staff on shift. This was informative and showed the team was working together to support the service. Flash meetings took place periodically when specific information needed to be shared in a timely way.

The registered provider had an up to date service user guide and statement of purpose which gave useful information to people who were planning a move into care. Policies and procedures were regularly updated to reflect any changes in legislation and the care given.

Staff understood the scope and limits of their roles and responsibilities which they told us helped the service to run smoothly. They knew who to go to for support and when to refer to the registered manager. They told us that mistakes were acknowledged and acted on in an atmosphere of support.

Notifications had been sent to the Care Quality Commission by the service as required. The registered manager also sent notifications to other bodies such as the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous occurrences Regulations (2013) (RIDDOR). This meant that the service provided for external scrutiny of incidents and accidents so that people's wellbeing was protected.