Barchester Healthcare Homes Limited

Forest 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

We inspected this service on 16 April 2018. The inspection was unannounced.

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

Forest Care Home is a nursing home that accommodates up to 20 people living with early onset dementia with complex needs. On the day of our inspection, 17 people were living at the service.

The service had a registered manager at the time of our inspection. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the previous inspection in January 2016 we identified some improvements were required in three key areas we inspected; 'Safe', 'Effective' and 'Well-led'. This resulted in the service having an overall rating of 'Requires Improvement'.

During this inspection we checked to see whether improvements had been made, we found further improvements were required in 'Safe' but improvements had been made in the other key areas.

Some shortfalls were identified in the management of medicines. Risks had been assessed and planned for and these were monitored for changes. However, inconsistencies were identified in the guidance provided to staff about managing people's needs associated with their anxiety that affected their mood and behaviour.

Staffing levels were assessed and monitored and were short on the day of the inspection but this was an unusual occurrence. The deployment of staff needed reviewing to ensure people's safety at all times. Safe staff recruitment checks were carried out before new staff commenced.

The service was found to be clean and improvements were being made to the cleaning schedules to ensure these followed best practice guidance. Accidents and incidents were recorded, monitored and reviewed for any themes and patterns. Documentation did not always show post action and monitoring. Staff were aware of their responsibility to protect people from avoidable harm and had received safeguarding training.

Staff received an induction and ongoing training and support. Staff were knowledgeable about people's health conditions. People had their needs assessed, planned and monitored. People received a choice of meals and their nutritional needs were known, understood and met by staff.

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. Where people lacked mental capacity to consent to their care and support, assessments to ensure decisions were made in their best interest had not always been consistently completed. However, this was addressed by the provider in implementing improved documentation. Where people had a DoLS authorisation with a condition, this had been met. People were supported to access primary and specialist health services.

Staff were aware of people's needs, routines and what was important to them. Staff were kind, caring, and they supported people ensuring their privacy, dignity and respect was met. Independence was encouraged and supported. Information about independent advocacy services was available.

Staff had information to support them to understand people's needs, preferences and diverse needs. People received opportunities to participate in meaningful activities. The provider's complaint policy and procedure had been made available to people who used the service, relatives and visitors. The registered manager had plans to meet with people and or their relatives to discuss their end of life wishes and to review their care and treatment.

Systems and processes were in place to monitor and improve the quality and safety of the service. An action plan was in place to drive forward continued improvements. People who used the service and their relatives received opportunities to share their experience about the service.

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.

Some shortfalls were identified in the management of medicines.

Risks had been assessed and planned for, but information available to staff about managing people's mood and behaviour was limited in places.

Staffing levels were sufficient but the deployment of staff needed reviewing. Safe staff recruitment checks were completed.

Improvements were being made to cleaning schedules to ensure these followed best practice guidance.

Accidents and incidents were recorded, reviewed and analysed for patterns and trends. It was not always clear from documentation of action taken post incident.

Staff were aware of their responsibilities to protect people from avoidable harm.

Is the service effective?

Good

The service was effective.

The provider used best practice guidance and care was delivered in line with current legislation. People were supported by staff that received an appropriate induction and ongoing training and support.

People's rights were protected by the use of the Mental Capacity Act 2005 when needed.

People received choices of what to eat and drink and menu options met people's individual needs and preferences.

People received support with any associated healthcare need they had and staff worked with healthcare professionals to support people appropriately.

Is the service caring?

Good

The service was caring.

People were cared for by staff who showed kindness and compassion in the way they supported them. Staff were knowledgeable about people's individual needs.

People had information about independent advocacy services to represent their views if needed.

People's privacy and dignity were respected by staff and independence was promoted.

Is the service responsive?

Good

The service was responsive.

People's individual needs, preferences, routines and what was important to them had been assessed and recorded and were known by staff.

People received a personalised and responsive service and they or their relatives were included in discussions and decisions. People received opportunities to participate in meaningful activities.

A complaints procedure was available that informed people of their rights to make a complaint. Plans were in place to complete reviews and end of life plans with people and or their relative.

Is the service well-led?

Good

The service was well-led.

The service had an experienced registered manager and relatives and staff were positive of their leadership, and improvements they had made since being in post.

People received opportunities to share their experience about the service.
There were processes in place for checking and auditing safety and quality. The management team had a commitment to continually drive forward further improvements and an action plan was in place to achieve this.

The registration and regulatory requirements were understood and met by the registered manager.

Forest 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 was a comprehensive inspection that took place on 16 April 2018 and was unannounced. The inspection team consisted of one inspector, an assistant inspector, a specialist advisor who was a registered nurse in dementia nursing care 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.

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.

The inspection was also informed by other information we had received from and about the service. This included previous inspection reports and statutory notifications. A notification is information about important events, which the provider is required to send us by law. We also sought feedback from the local authority, who commission services from the provider and Healthwatch.

On the day of the inspection, we spoke with one person who used the service and two visiting relative's for their views. Due to the needs of people, it was not possible to obtain verbal feedback from many people about their views. We observed care and support in communal areas of the service and 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 talk with us.

During the inspection, we spoke with the registered manager, regional director, clinical development nurse, nurse, chef, housekeeper and three care staff. We looked at all or parts of the care records of seven people, along with other records relevant to the running of the service. This included how people were supported with their medicines, quality assurance audits, training information for staff and recruitment and deployment of staff, meeting minutes, policies, procedures, and arrangements for managing complaints. We

also spoke with a visiting pharmacist.

Requires Improvement

Is the service safe?

Our findings

We reviewed the ordering, storage and administration of people's medicines and found some shortfalls. We identified gaps in some of the monitoring records of the temperatures of stored medicines. For example, the temperature recording in one area had not been recorded since the 8 April 2018. The paperwork used to record the temperature, did not have accurate guidance for staff on acceptable temperature range, stating that over 25 degrees was acceptable, this is incorrect. The visiting pharmacist told us they had brought this to the attention of the service at their previous audit in August 2017.

Some people were prescribed a medicine that should be given in the morning 30-60 minutes before food, caffeine based drinks and other medicines to ensure their effectiveness. This guidance had not been followed in line Nursing and Midwifery Council (NMC). Whilst we noted this information had not been recorded on the Medicine Administration Records (MAR) by the pharmacist, a nurse would be expected to know this information.

Where people were prescribed medicine on a PRN basis, this means as and when required, the majority had protocols which advised about the circumstances these should be administered. The reason for giving the medicine and its effect, was not always recorded on the back of the MAR chart. For example, one person had received their PRN seven times over the previous fortnight; the reason was only recorded on two occasions. This information is important as frequent use may mean a review of the person's medicines is required.

A number of people were prescribed PRN pain relief. However, there was no information of how their pain was assessed, such as describing specific behaviours for staff to be aware of. This was particularly important were the person was living with dementia that affected their ability to verbally express their needs.

One person was receiving their pain relief medication via a pain relief patch placed on their skin. There was a rotation chart in place showing the administration site which followed best practice guidance. However, the removal of the previous patch to avoid the risk of overdose was not routinely recorded and there was no record of daily checks that the patch was still in situ. Daily checks are important, as patches are prone to falling off or accidentally being removed by the person. Where there are barriers to communication, people could experience unnecessary pain.

We observed part of the administration of medicines in the morning, the nurse stayed with the person to ensure they had taken their medicines safely.. We noted the nurse completed the administration of medicines at 11.35am. We were concerned if there was an appropriate gap between the next administration of medicines. The management team assured us this had been considered and no person was at risk. Due to people's complex needs meant their sleep pattern could be affected, impacting on the time they took their morning medicines. When people had their morning medicines late due to being asleep, their medicines were staggered throughout the day to ensure sufficient time was had between medicine administration times. Staff records confirmed nursing staff responsible for the management and administration of medicines had completed appropriate training and competency assessments.

On the day of our inspection, the staff team was short by one member of staff. Whist action was taken to get this staff shortage covered it was unsuccessful. Staff told us it was very unusual for staffing to be short and the staff rota confirmed what we were told. Whilst we saw overall staff provided support and assistance to people in a timely manner, we were concerned that people in communal areas did not have staff present at all times. Staff told us they tried hard to monitor the corridors, but communal areas were not continually monitored. We were concerned about a person we heard knocking on their bedroom door from the inside. We checked on this person and on entry to their room, found they were stood behind the door facing the wall. The door was heavy to open and we were concerned the person may have had difficulty opening the door and had no means of calling for assistance. We reported this to the registered manager who agreed to discuss this with the staff team.

During the morning of our inspection, we walked into a dining room where five people were sitting at dining tables without a staff member present. One person was found with their drinking glass smashed on the floor underneath their feet. The registered manager was with us and took action to respond to the situation. We were told this person sometimes had falls and displayed 'jerky' movements that a health professional had queried epilepsy however there was no diagnosis. We were concerned that staff were not present to monitor this person's needs and those of others. The registered manager told us they were confident normal staffing levels were appropriate but agreed to review the deployment of staff.

People were supported by staff who had been through the required recruitment checks as to their suitability to provide safe care and support. These included references and criminal record checks. Recruitment files showed the necessary recruitment checks had been carried out.
People's needs had been assessed in relation to how any risks associated with behaviour was managed. However, we found some inconsistencies in the level of detail provided to staff about how to manage these needs. For example, whilst one person's care plan stated the person 'may become physically and verbally aggressive' there was no detail to how this behaviour presented itself. Neither, was there guidance for staff of how to manage a change of mood and anxiety. Whilst in another person's care records, the care plan provided staff with a good level of detail as to the possible triggers to behaviour and the distraction and diversional strategies to use. However, staff were found to be knowledgeable about how to support people indicating this was a recording issue. The registered manager agreed there were some variables with care plans that required a review.

Risks associated with people's needs had been assessed, planned for and were monitored. People's care records showed how their relative had been included in discussions about how risks were managed, to ensure people did not experience any undue restrictions. These included risks associated with nutrition, falls, skin care, moving, handling, and choking. A clinical risk register was in place that identified what person was at risk and the action taken to reduce and manage the risk. This included additional observations and referrals to external healthcare professionals such as the GP, dietician, falls team and tissue viability team. Staff were knowledgeable about people's needs and risks and how these were managed.

Where people had particular needs associated with their heath such as skin care, staff had received training in pressure ulcer prevention. One person was currently nursed in bed owing to physical frailty and was at high risk of developing pressure ulcers. We saw the person had an appropriate pressure-relieving mattress, which was inflated correctly for their needs; they also had other pressure relieving equipment in place to support them. The person's care records described the frequency required of repositioning and records confirmed staff were completing this correctly. A staff member told us, "We check on [name of person] every hour and turn them two hourly and we also have to check the mattress, when we do personal we check their skin for any signs of pressure." This matched what was recorded on the person's care plan and records and

demonstrated a responsive and person centred approach in meeting the person's needs.

Staff were observed to use appropriate moving and handling techniques and equipment when supporting people with their mobility needs. Where people had been assessed as requiring equipment such as pressure relieving mattresses and cushions these were in place and being used.

People were living in a safe, well maintained environment and there were systems in place to minimise risks. This included risks associated with fire and legionella, and control measures were in place to reduce risks. Staff had been trained in health and safety and how to respond if there was a fire in the service. There were risk assessments in place in relation to the risks people faced if they needed to evacuate the building in an emergency. Staff had access to the provider's business continuity plan that advised of the action required should there be an event that affected the safe running of the service.

Staff told us there were sufficient staff to meet people's needs and safety. One staff member said, "I've never worked a shift where there hasn't been enough staff." The registered manager told us about the assessment tool they used to support them to assess what staffing levels were required.

Staff were aware of infection control measures and had received training in infection control and food hygiene. Cleaning schedules were in place and up to date but these were insufficiently detailed, to provide adequate assurance cleaning followed infection control best practice guidance. However, the registered manager showed us new cleaning schedules that were in the process of being implemented. These checks were much more detailed and informative and followed the expected best practice guidance. We found the service was clean and odour free.

Accidents and incidents were recorded and monitored by the registered manager for action required to reduce reoccurrence. They were then further reviewed and discussed at clinical governance meetings. The clinical development nurse also analysed incidents for any pattern, triggers or trends. Incidents that occurred had a root cause analysis completed for staff to understand what had occurred and to consider the control measures in place to reduce further reoccurrence. Records identified one person had experienced a high number of falls and this had resulted in the registered manager securing one to one staffing to support the person's safety. During the inspection, we saw this person received this support. Another person had experienced an incident of choking and the speech and language therapist had completed an assessment and recommendations to reduce further risks. This person's care records showed a further choke incident whereby they had access to fruit that they ate which caused them to choke. The register manager told us staff had been informed to ensure foods belonging to others and other foods were not left unattended.

One person's care records showed they had a fall where they sustained an injury that required attending hospital for treatment. The registered manager said whilst a seizure had been queried it was thought by the GP the fall was due to low blood pressure. The person's care records were unclear of what further monitoring post incident had been completed. The registered manager gave assurance that the person had been monitored and the GP and psychiatrist were involved in the person's ongoing care. Following our inspection the registered manager forwarded us information to confirm what we were told. .

Staff were aware of their role and responsibility to protect people from avoidable harm including discrimination. One staff member said, "Our role it to protect people's safety and report any concerns." Staff told us they had received training to support them in keeping people safe and training records confirmed this. The registered provider had safeguarding policies and procedures in place to guide practice. From our records we were aware safeguarding issues had been appropriately reported and responded to.

Good

Is the service effective?

Our findings

The provider used best practice guidance and care was delivered in line with current legislation. For example, the provider used recognised assessment tools used in the assessment and monitoring of nutritional needs. Assessment of people's needs, included the protected characteristics under the Equality Act and these were considered in people's care plans. For example, people's needs in relation to any disability were identified. This helped to ensure people did not experience any discrimination. The provider employed a specialist dementia care director, who supported staff in developing and promoting the needs of people living with dementia.

Staff received an induction, training and ongoing support to develop their skills and awareness. People told us they felt staff were competent and knowledgeable and understood their needs. A relative said, "Yes I definitely think they've (staff) had the training to cope with [family member]. They can be difficult to deal with sometimes but they are able to handle it well. I've learnt things from them."

Staff were positive about the support they received. One staff member said, "I felt the induction and training was beneficial. I did three shadow shifts too. I have had face to face meetings to discuss my training and any concerns." Another staff member said, "The training is good quality, makes you look at things differently." Staff were positive the training provided was in areas that were useful and supportive. One staff member said, "I recently attended a course on dementia which was really good as it gave me lots of tips on de-escalation." Staff told us they had completed or were working towards the Care Certificate and that they received opportunities to discuss their work. Staff also told us they were supported to complete a diploma in social care (formally known as NVQ). Training records showed on the whole staff were up to date with refresher training the provider required them to complete. Plans were in place for any training shortfalls. The registered manager had a staff supervision and appraisal plan in place.

People received support with their nutrition and hydration needs. We observed people received a choice of drinks and snacks in-between meals. We saw staff supported some people with their meals and drinks and overall found staff to be gentle, patient, unhurried and compassionate.

People's nutritional and support needs associated with eating and drinking had been assessed. This information was shared with kitchen staff to ensure people were presented with meals that met their nutritional needs. This included any allergies, specific health needs such as diabetes and religious and cultural needs. In addition, people's preferences including size of meals was recorded and understood by staff. Where concerns had been identified about people's weight and food and fluid intake, this had been discussed with the GP or dietician. Some people had been prescribed supplements to increase their calorific intake and we saw people received this. Some people were at risk of choking and required their food and drinks provided in a specific way and support from staff and this was provided.

Staff were found to be knowledgeable about people's nutritional needs and the importance of offering regular snacks and drinks. One staff member said, "We can order additional snack in between the main meals. The kitchen provides a selection of snacks, fresh fruit, they keep the fridge (in the dining area)

stocked with sandwiches during the day and they top this up before the kitchen closes for supper and snacks during the night."

The provider had a hospital transfer document they used to share information about people's needs to ensure other staff had relevant information in a person's ongoing care and treatment needs.

Staff told us how they monitored people's health needs and worked with external health care professionals in meeting people's health outcomes. A relative said, "I asked staff to ask the psychiatrist to check [family member]'s anti-depressant medication and they did do that. They're on it." People's care records showed the staff were responsive to fluctuations in people's health needs with input of external healthcare professionals such as the GP, dieticians, specialist nurses and opticians.

The service had started to create an environment based on best practice guidance in dementia care. This included consideration of how corridors were painted and finished and how the signage supported people to orientate around the home independently. People had access to secure and safe outside areas, the pathway was level and non-slip. People had a choice of communal rooms and areas to relax in and spacious corridors to walk in.

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 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.

Staff were aware of the principles of the MCA and DoLS but this was variable amongst some staff. They told us how they encouraged and supported people as far as possible to make choices. Staff were aware of the decision making process for important decisions that were made on behalf of people. We saw examples on MCA and best interest decisions in areas such as medicines, personal care when people were noncompliant and the use of assistive technology. However, the completion of these documents were variable in places. The provider's action plan had identified this was an area for improvement. Following our inspection the registered manager told us new MCA and best interest documentation had been implemented and they were reviewing people's mental capacity where required.

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 hospital are called the Deprivation of Liberty Safeguards (DoLS). Where people had an authorisation in place this was in the person's care records to inform staff. Some people had conditions as part of their authorisation and we saw these were being met as required. For example, one person was required to have a medicine review and this had been completed.

We saw some care records for people who had a decision not to attempt resuscitation order (DNACPR) in place and found these to have been completed appropriately. Some people had lasting power of attorney (LPA) that gave another person legal authority to make decisions on
their behalf. However, it was not always clear what the LPA was for finances or health and welfare. The registered manager told us they were in the process of seeking confirmation of this information.

Good

Is the service caring?

Our findings

People told us they found staff to be kind, caring and compassionate. One relative said, "Yes they are kind and respectful, they knock on [relative's] door, and they're sweet. They know their likes and dislikes."

Relatives gave examples that showed how staff were kind and thoughtful. For example, a relative said, "Staff know [relative's] got a sweet tooth so they'll say, 'hello [name of person] we've got some Bourbon biscuits and tea for you' and they'll put it down by their side."

An example was given by a relative that demonstrated how a member of staff had been thoughtful. This relative said, "The activities person heard [relative] mention Stirling Moss when they walked past the TV. They have always loved cars and used to sell them. The activities person found some biographies of Stirling Moss on the computer and [relative] sat and watched them – I was really pleased and surprised."

While we were talking with a person, two staff passed by and jovial exchanges were had which the person responded positively to clearly enjoying the exchanges. This person liked to sit in the hall where it was busy and watch everyone pass by and see what was going on. We saw how staff responded to the person's call for assistance. Whilst sitting in the corridor another person attempted to move their walking frame, on calling out staff immediately responded and resolved the problem. This demonstrated how staff reassured people who were anxious and distressed and responded promptly, calmly and sensitively.

One person told us it was recently their birthday and that staff made them a cake and they had guests visit. They told us they enjoyed the celebration. This person also told us before their birthday staff took them shopping into the local town and that they wanted to go shopping again. A staff member confirmed what we were told and said us they would arrange for the person to go shopping again. The person was pleased to hear this.

People's communication needs had been assessed and we saw staff communicated well with people. Interactions between staff and people were warm and respectful. Staff had an unhurried and patient approach and manner. Where people's anxiety heightened, staff responded well, using diversional strategies such as engaging the person with an activity or offering a drink.

Some people liked to sit in the corridors and staff were seen to stop and talk to people as they walked by or they purposefully checked on people and asked after their wellbeing. Some people chose to eat and drink in the corridors and staff were attentive and ensured they were comfortable and provided support where required.

We saw the registered manager, regional director and clinical development nurse all engaged positively with people, clearly demonstrating they knew people well. People responded well to their interactions and were relaxed in their company.

Relatives told us they felt involved in their family member's care, this included being informed of any

incidents, any health changes and consulted in decisions that their family member was unable to make for themselves.

Staff supported people with choice making and encouraged independence as fully as possible. People were given choices of meals and drinks and how they spent their time. Staff were observed and heard to be discreet when people needed assistance. We saw how staff sought consent to interventions were people required support with personal care. We heard staff say, "Can I help you with that." "Are you comfortable." People's information was treated confidentially and was managed in line with the Data Protection Act. For example, information was stored securely and staff were aware of respecting people's personal information.

Staff were seen to knock on the doors to people's bedrooms and identifying themselves on entering the room and doors were closed when personal care was being given. Staff were also seen to interact with people during interventions providing reassurance and explanations.

Good

Is the service responsive?

Our findings

Before people transferred to live at Forest Care Home a pre-assessment of their needs were completed. The registered manager told us they completed the assessment by visiting the person and involving them as fully as possible, including their relative, representative and known healthcare professionals that supported the person. The registered manager told us that the pre-assessment was important to ensure the person's needs could be met, they also considered the person's compatibility with others already living at the service.

Following a person's pre-assessment, care plans were developed that informed care staff of a person's needs, routines and preferences including their diverse needs. This enabled staff to understand people's needs and what was important to them resulting in a person centred approach to care and treatment. The registered manager said the service had a commitment in treating all people equally and without prejudice and discrimination. People's care plans included how people liked to spend their time during the day. Some people had sensory and communication needs. Care plans provided staff with guidance of how to support people with their individual needs. We observed some people had unclear speech, staff were seen to be tuned in to their communication needs, able to interpret what they were saying or wanting. This demonstrated good active involvement in decision making. The management team told us that information could be provided in an additional format such as large print and braille if people required this support. This meant the provider had considered the requirements of the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss.

The registered manager told us they were aware that the involvement of people and their relative or representative in opportunities to be involved in review meetings needed to improve. The registered manager told us people were invited to attend six monthly review meetings. Whilst this was overdue, the registered manager showed us letters that had been prepared and were due to be sent to people's relatives and representatives inviting them to attend a review meeting. The registered manager added that in addition to formal review meetings, they had regular informal contact with people's relatives to discuss any changes or concerns. Relatives confirmed this to be correct. We also noted in a relatives meeting record the registered manager informed people that they had an open door policy and relatives were greatly encouraged to call in and have a "chat and give any feedback good or bad and any recommendations they may have." This meant the registered manager encouraged and welcomed relatives to be involved in their relative's care and development of the service.

Staff spoke about people in a very person centred way demonstrating that they knew people's individual routines, likes and dislikes. One staff member said, "Some residents can't tell you what is wrong but you can tell by little changes in their behaviours that something is not right."

Consideration of people's religious and spiritual needs had been planned for. People were supported to participate in a visiting religious service provided six weekly by an external local religious group. In addition, people were offered fortnightly opportunities to visit a place of worship on a Sunday morning. One person practised a particular faith and this was supported and understood by staff, they respected the person's

wishes. People's previous work history was also recorded and known by staff who showed respect and understanding of the importance of this. An example of this was a person who use to be a housekeeper. They liked to complete simple cleaning tasks. Staff had kitted out a trolley for the person that they could push around as if they were the housekeeper; it contained items of cleaning equipment such as a dustpan and brush and dusters. Staff told us how the person enjoyed this activity which was important to them. We saw the person caring out domestic tasks as discussed with us. Staff told us the person was very active and liked to keep busy. These activities were meaningful and kept the person busy.

Staff demonstrated how they had a person centred approach and involved a person's relative in overcoming a particular difficulty. At the end of the relatives visit, their family member became distressed that also impacted on them. This person's care records showed how a nurse had worked with the relative to develop an exist care plan after visiting their family member. The relative liked to assist their family member with their midday meal, the care plan showed that the staff facilitated this. However, it was agreed in the care plan that the best exit strategy was for the person's relative to leave in between courses. The person was distracted by their pudding (which they enjoyed) and no upset was caused. The care records confirmed that the relative felt this approach was working well.

Staff had identified that one person due to them choosing to spend time in their bedroom was at risk of social isolation. To reduce this the person's daily records showed that staff gave the person one to one time on a daily basis. This included spending time reading too them, doing manicures and hand massage and sitting with them to watch a star wars video which they enjoyed.

An activity coordinator arranged a variety of activities and opportunities for people to participate in. This included visits in the local community, a greenhouse had been purchased for people who liked gardening, the plan was to plant seeds and create hanging baskets and planters. Arts and crafts and games were available. The activity coordinator told us how they had seen a program on television about nursery children visiting care homes and was inspired by it. As a result they arranged for a local children's nursery to visit. They told us the event was a great success and that, "Residents were beaming." They added, everyone enjoyed the day and they had plans for it to become a regular event. External entertainers also visited and provided activities such as dancing, music and exercise activities. We saw people were supported by staff to be involved in various meaningful activities such as clothes folding, sock matching and knitting. People were seen to enjoy these activities, they were relaxed, calm and some people were seen to chat amongst themselves.

The provider's complaint procedure had been made available for people, relatives and visitors. The complaints log showed one complaint had been received in the last 12 months and this had been responded to as per the provider's complaint policy and procedure.

At the time of our inspection, no person was at the end of their life. The registered manager told us people's end of life wishes was an area that needed addressing and this was in the action plan of tasks to complete. Records viewed confirmed what we were told.

Good

Is the service well-led?

Our findings

Two relatives spoke highly about the registered manager. One relative said about their leadership, "Yes most definitely well-led now. The previous ones didn't have the management skills. She's made a huge difference the manager and the staff nurse. They lead." Another relative told us how they felt the service had improved under the leadership of the current registered manager. They thought it was a well-led service and that they did not wish for their family member to live anywhere else.

The provider had a clear vision and set of values for the service that was based on people receiving care and treatment that was person centred, responsive and transparent. Staff were seen to work to the provider's set of values; they had a calm and caring approach towards people in their care. Staff worked well together, they were organised and understood their role and responsibility. The service operated a whole home approach to care that ensured all staff across departments, received appropriate training to meet people's needs, thus developing an inclusive and effective staff team. Staff spoke positively about the registered manager's leadership. One staff member described them as, "Approachable, visible and she is supportive and professional." Another staff member said, "The manager is very understanding and supportive." A third staff member said, "I really like the manager, they are fair, honest and supportive."

Staff told us there were regular staff meetings and stated morale was good amongst the team and they attributed this to the new registered manager. One staff member said they felt their role as a care staff member was valued, because the registered manager encouraged ideas from the care staff.

As part of the provider's internal quality assurance checks annual satisfaction surveys were sent to people who used the service, relatives and friends. The last survey was completed in October and November 2017. We reviewed the provider's survey rating report that gave a consistently high score in all areas that included areas such as, staff and care, home comforts, choice and having your say and quality of life.

The registered manager told us they used staff meetings, one to one supervision meetings and observations to assure themselves staff were appropriately supported to provide effective care and treatment. The registered manager was an experienced and competent manager who led by example and worked alongside staff to provide support and assistance in the delivery of care. They told us how they kept up to date with developments such as new legislation and best practice, by receiving alerts of changes internally and externally and by reviewing relevant National Institute for Health and Care Excellence guidelines. The registered manager said they felt well supported and there were clear lines of communication and management structure within the organisation.

There were a range of different meetings with heads of department. This meant that staff were kept up to date about people's needs and staff received sufficient support from the management team and time to discuss their roles and responsibilities.

There was a system of audits and processes in place that continually checked on quality and safety. These were completed, daily, weekly and monthly. We found these had been completed in areas such as health

and safety, medicines, accidents and care plans to ensure the service complied with legislative requirements and promoted best practice. The registered manager was required to submit regular audits to senior managers within the organisation to enable them to have continued overview of the service. The provider's representative also completed additional audits. The service had an improvement plan, this included actions identified through internal audits and checks. This told us that the provider had procedures and systems in place that demonstrated the service was continually driving forward improvements to the service people received.

The service had submitted notifications to the Care Quality Commission that they were required to do and had policies and procedures in place that were in line with legislation and best practice guidance. The ratings for the last inspection were on display in the service and available on the provider's website.

The service worked well with external health and social care professionals in meeting positive outcomes for people. The service was part of the local community, people were supported to access their community and positive links had been developed such as with a local children's nursery.