Springdene Nursing And Care Homes Limited

Spring Lane

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 24 April and 4 May 2017. The inspection was unannounced. Spring Lane is a care home registered for a maximum of 63 adults. At the time of our inspection there were 52 people living at the service.

The service is located in a large purpose built building. We previously inspected the service on 22 March 2016 and the service was found to be meeting the regulations inspected.

Spring Lane had a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found staff were caring and kind to people living at the service. People laughed and joked with staff and each other, and the home had a relaxed and friendly atmosphere. Visitors brought in their dogs and there was a buzz of energy in the main reception area where people routinely sat.

We found that in the last year there had been two occasions when the provider had not followed their own recruitment process. However, the provider could show with more recent recruitment, all appropriate checks had been undertaken before staff began work.

On the day of the inspection we saw there were enough staff to meet people's needs. The provider was using agency and bank staff to fill vacancies and interviews had taken place to recruit to vacant posts.

The service was clean throughout and in good décor. People's rooms were personalised and homely.

Medicines were stored securely, within temperature range and administered safely. The provider had recently implemented an electronic system of monitoring the medicines that were given to residents and this had provided a number of benefits to the service, including quickly identifying any errors.

Risk assessments, were on the majority of care records to provide guidance to staff in relation to identified risks. New processes had been introduced in the last 12 months to reduce the risk of falls.

Staff told us they received appropriate support through training and supervision and we saw regular staff meetings took place. Staff told us they could contribute their views to the running of the service.

There were a wide range of activities taking place at the service and there was a specific activities worker for people with significant cognitive impairments. There was also a Namaste programme designed to improve the quality of life for people with advanced dementia.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We could see the provider was compliant with DoLS.

There were elements in which the service was well led. In the last 12 months increased quality assurance processes had been introduced. We could see systems were being implemented to prompt key activities such as supervision, training and renewals of DoLS applications. Audits of care records took place on a regular basis. Senior managers reviewed key indicators on a weekly basis and an action plan for the service had been developed to continually improve the service and was being implemented. The provider had introduced a new electronic medicine monitoring system and planned to roll out an electronic care records system towards the end of 2017.

However we saw areas in which quality assurance processes had not been embedded sufficiently to show the service was consistently well led over a period of time. These included the falls process, the recruitment process and the detailed auditing of care plans.

Senior managers acknowledged there were areas in which the quality of the service could further improve and had developed an extensive action plan to implement in the coming 12 months.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Medicines were stored and managed safely.

Risk assessments were in place to provide guidance to staff.

People told us they felt safe and staff knew what to do if they had any concerns regarding a safeguarding issue.

Is the service effective?

Good

The service was effective. Staff were supported in their role through training and supervision.

The service understood and complied with DoLS legislation and staff understood the importance of consent.

People's health needs were met by the service and relatives confirmed they were updated if there were any concerns.

Is the service caring?

Good

The service was caring. People and their relatives told us staff were kind and caring and we saw this on the day of the inspection.

A specialist service focusing on massage as a key component was available for people with a significant cognitive impairment.

People's religious and cultural needs were met by the service.

Is the service responsive?

Good

The service was responsive. There were lots of activities at the centre and people were supported to be involved in them.

Care plans were comprehensive and up to date.

There was a complaints process in place and complaints were dealt with in a timely way.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Although there were

improved quality assurance processes in place these had not embedded sufficiently over a period of time to show the service was consistently well led.

An action plan was in place to guide the work of the service for further quality improvements in the coming 12 months.

Regular staff meetings took place and staff told us they felt supported in their role and could contribute to the running of the service.

Spring Lane

Detailed findings

Background to this inspection

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

The inspection took place on 24 April 2017 and was unannounced. It was undertaken by three inspectors for adult social care, a pharmacist inspector, a specialist advisor registered nurse, 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. One inspector returned on 4 May 2017, this date had been arranged with the provider.

Before the inspection we reviewed information we held about the service. This included information provided by the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law. We also spoke with two health and social care professionals who regularly worked with the service prior to the inspection visit.

During the inspection we spoke with 19 people who lived at the service and four relatives or visitors to the service. We spoke with 15 members of staff including the registered manager, the operations manager and a member of the kitchen staff. We also spoke with a health and social care professional as they were at the service on the day of the inspection. After the inspection we spoke with six relatives.

We looked at 10 care records related to people's individual care needs and daily recording notes including food and fluid charts for six people. We look at the records associated with the management of medicines and fourteen electronic medicines administration records (eMAR).

We reviewed seven staff recruitment files and eight supervision records. We looked at the training records for the whole team. We reviewed documentation related to essential services at the premises.

As part of the inspection we observed the interactions between people and staff and discussed people's care needs with staff. We also looked around the premises.

Good

Is the service safe?

Our findings

People told us they felt safe living at the service, and were not afraid of behaviours of other people living there. "Yes I do feel safe here; there are plenty of people around all the time." Relatives told us "Yes. She's surrounded by other people and staff." And "We've been very happy with her being here. There are lots of people around and we visit every day and we can bring in the dog, which is great." Also "I have been coming here for years and no untoward incident so no concerns about safety."

Staff were able to tell us what they would do if they had safeguarding concerns and were aware of whistleblowing procedures. We were aware that the service had complied with safeguarding investigations carried out by the local authority over the previous 12 months and had processes in place to notify the relevant organisations of any concerns. However we saw in the complaints folder two complaints raised that the service had dealt with but the provider had not sought advice from the local authority as to whether they needed to notify them formally under safeguarding procedures, and therefore also notify CQC. We discussed these complaints with the operations manager who explained their rationale, and we could see the action taken, but they agreed to seek advice from the local authority and CQC if they were in doubt about any incident or complaint.

The provider had not followed their own recruitment process in obtaining two references prior to a new staff member beginning working with people. We discussed this with the operations manager who undertook to review all recruitment documents for staff employed in the last year at Spring Lane by the end of May 2017. However, we could see from recruitment records that the provider had, since January 2017, adopted a more robust recruitment system prior to staff starting work. There was an in-date Disclosure and Barring Service certificate (DBS) on each record we looked at, and evidence of right to work in the UK as well as application forms.

Risk assessments were in place and covered areas such as falls, nutrition and skin management, to guide staff in managing and minimising risk behaviour. They were updated briefly on a monthly basis or more regularly if required by team leaders or senior carers. Staff on the third and fourth floor had received training from the local CCG in carrying out risk assessments. We noted that there was one person who was receiving pureed food and was considered to be at risk of choking by staff but did not have a speech and language therapist (SALT) assessment on file. Neither their malnutrition universal screening tool or care plan mentioned swallowing difficulties, nor was there a risk assessment for this on file. This placed this person at risk. However, following the inspection the provider could evidence these documents had been updated and a new referral had been made to SALT as the previous advice document could not be located.

We looked at the accident and incident book at the service for the last three months. We could see that records were completed accurately and reviewed by a team leader or senior manager to ensure appropriate action had been taken. The provider had put in place a number of processes in an attempt to reduce the number of falls at the service. A 'falls champion' role was being established at the time of the inspection and this person was due to attend specific training which could then be shared with colleagues. A dementia specialist who was also an occupational therapist was recently employed by the service and had

undertaken training in falls prevention which was being shared with care staff.

To aid understanding of how falls occurred and to ensure remedial action had been taken, a new 'falls pathway process' had been introduced. This included a post falls review which outlined all the actions taken to minimise the risk of falls and provided a tool for senior managers to monitor the number of falls and see if there were people regularly falling.

We noted action had been taken following people falling, although not all the actions were clearly set out in the 'post falls' review document which would have provided a clear audit trail for falls management. We found for one person the professional health advice for a head injury had been sought appropriately within 24 hours although this was documented elsewhere and not in the falls review folder. Sensors, which alerted staff to people moving from their bed or chair, were in place for people who would benefit from them as part of a falls reduction plan. We noted that sensors in place were working on the day of the inspection although there was no system to check they were working. We discussed this with the operations manager and we could see by the second day of the inspection they were being checked daily.

Records showed that bed rails assessments were in place for people using them. It was not always recorded when they were not in use but had been considered. One person's bed rails risk assessment was not on their care records. Following a discussion with the inspection team the provider showed they had drawn up a new risk assessment and this had been placed on the person's care records. Care records noted when people needed to be hoisted, and individuals had their own sling but without their name on it. Two out of ten care records did not note the size of sling to be used on care records. These issues could contribute to the wrong sling being used for hoisting a person which could impact on their safety. We could see by the end of the second day these issues had been rectified.

Senior managers discussed the number of falls that had occurred on a weekly basis and the service was working with staff from the local CCG to ensure effective falls prevention strategies were in place.

The service was clean throughout. There were hand gels and soap in all bathrooms visited and staff used gloves and aprons when carrying out personal care. The main kitchen area was clean and had received a maximum five star rating for hygiene in December 2016. Kitchens on each floor were clean and fridges had food labelled and sealed appropriately.

We checked medicines storage, eMAR charts, and medicines supplies. All prescribed medicines were available at the service and were stored within the appropriate temperature range. They were stored securely in locked medicines cupboards within a clinic room. This assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for the people living at the service.

People received their medicines as prescribed, including controlled drugs. There were no gaps in the recording of medicines administered, which provided a level of assurance that clients were receiving their medicines safely, consistently and as prescribed. The provider had recently implemented an electronic system of monitoring the medicines that were given to residents, including stock quantities and omitted doses that were flagged to senior managers within 24 hours of an error occurring.

Medicines to be disposed were placed in appropriate pharmaceutical waste bins and there were suitable arrangements in place for their collection by a contractor. These were monitored by the electronic system which tracked the amount of medicines disposed. Controlled drugs were appropriately stored in accordance with legal requirements, with daily audits of quantities done by two members of staff and the

electronic system.

We observed that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. People's behaviour was not controlled by excessive or inappropriate use of medicines. For example, we saw seven PRN forms for pain-relief/laxative medicines. There were appropriate protocols in place which covered the reasons for giving the medicine, what to expect and what to do in the event the medicine does not have its intended benefit.

Medicines were administered by team leaders or senior carers that had been trained in medicines administration. We observed a member of staff giving medicines to a person living at the service and found that staff had a caring attitude towards the administration of medicines for people. For example, we saw a member of staff clean a resident's eyes in accordance with the manufacturer's instructions before administering their eye drops to ensure maximum efficacy and cleanliness.

The provider followed current and relevant professional guidance about the management and review of medicines. For example, we saw evidence of several recent audits carried out by the provider including safe storage of medicines, fridge temperatures and stock quantities on a daily basis. A recent improvement made by the provider included ensuring that warfarin records were maintained in a dual format (electronically and paper based) and to be authorised by both methods before warfarin was administered. This had been highlighted previously from a previous medicines error and showed the provider had learned from medicines related incidents.

There were 16 staff on duty in the morning, 12 in the afternoon and six staff overnight. On the day of the inspection we saw there was enough staff to meet people's care needs throughout the day including at lunchtime.

We asked people living at the service and visitors their view of the staffing levels. One person told us "Yes I do feel safe here; there are plenty of people around all the time." Another person said "Sometimes short staffed but [they] never keep you waiting long." We were also told "I presume there are enough but I've never had to ask for anything." And "Some are good and some are too helpful! I'm a very private person and I like to be left alone!" One person told us "Sometimes not, especially at weekends."

Relatives told us generally they felt there was enough staff. One relative told us in relation to staffing "Yes. She's surrounded by other people and staff." Another said "That's always an issue. The permanent staff are great but they also have agency staff that are good on the whole but they don't know the 'subtleties'. In general, they need to check in more with people and be more proactive."

We asked the registered manager and operations manager how they ensured there were sufficient staffing levels. They told us they gathered information relating to each person's needs on a monthly basis, and collated this every six months. More recently senior managers had reviewed the collated levels of need for the third floor over a period of months and determined increased staffing was required.

At the time of the inspection there were twelve vacant care posts. The provider used bank staff and regular agency staff to minimise disruption to people using the service. They also ensured care staff moved across floors to ensure there was a good spread of permanent and agency staff on a particular floor, but retained team leaders on specific floors so they provided oversight and guidance to staff working each shift. The registered manager and operations manager told us the provider was keen to recruit permanent staff. To this end they had improved staff pay and conditions in recent months to make the posts more attractive to recruits. They were also providing career progression opportunities at the service to help retain experienced

care staff.

Checks for essential services had been carried out in the last twelve months. Personal emergency evacuation plans were in place for people living at the service. Six fire drills had taken place since February 2016. The fire brigade had visited the premises in February 2017 and had no further recommendations related to fire prevention matters.

Good

Is the service effective?

Our findings

We asked people who lived at the service and their relatives if they thought the staff had the necessary skills and knowledge to carry out the role of caring. People told us "Staff very nice. Talkative – they keep you going – ask how they can help." and "Yes, they always give me the impression they know what they're doing."

Relatives were all in agreement that staff had the necessary skills and experience to care for their relatives. They told us staff "absolutely" and "definitely" had the skills to care for their relatives. One family member told us "Yes I do [feel they have the skills] and [relative] has enough cognitive ability to let me know if anything is wrong."

We checked how staff were supported in their roles. We saw new staff had a two week induction which was comprehensive and incorporated shadowing a range of shifts, key training and an initial supervision session. Staff told us how supportive they found the staff team and that it was a supportive place to work. Staff told us they could raise any concerns at monthly staff meetings and felt listened to by managers. Staff told us they received regular supervision and that bank staff also received supervision.

Of the eight supervision records we checked six people had received regular supervision in the last twelve months, and the majority of these had received an appraisal in 2016. Two people had not received regular supervision as one person had a gap of 14 months between supervision and the other 15 months. The supervision policy did not specify the regularity of supervision for staff.

We discussed this with the operations manager who told us the service was improving the regularity of supervision and would update the policy to reflect this. This was outlined in the service action plan. They had also developed systems to prompt and monitor that supervision had taken place. Two staff were noted on a spreadsheet as having had an appraisal in 2017 but these had not in fact taken place as the service was rolling out a new appraisal system. The new appraisal system linked training, career progression and pay to incentivise and retain staff. Staff had been made aware of these changes.

Training had taken place in key areas such as safeguarding, moving and handling, fire prevention, health and safety and infection control. Nineteen staff had completed a course in reducing falls in care homes. At the time of the inspection 13 people were overdue to undertake refresher training in moving and handling. However by the time of writing this report, another course had been held at the service and another was due to run late May 2017 so staff would have received refresher training in this area. The service committed to the remaining 48 staff completing the course by the end of May 2017. We looked at the training material for staff related to falls reduction which emphasised actions that can be taken to reduce falls, but also the importance of continuing to support people to keep walking and mobilising to keep their bodies strong.

Twenty staff had completed a course in prevention of pressure ulcers. As part of the quality action plan the service committed to train the remaining 46 staff by the end of June 2017. Other courses some staff had attended included understanding the Mental Capacity Act (MCA), record keeping and malnutrition and

nutritional care. The service had committed to train all the staff in these areas by the end of September 2017.

The service had recently employed a specialist dementia worker who was also a trained occupational therapist. This staff member was able to provide training in a number of areas and run a number of dementia related courses. The operations manager told us additional training courses in improving outcomes for people with dementia and challenging behaviour in people with dementia were planned for the coming twelve months.

Staff could get advice and support from this specialist worker in managing and supporting people with significant cognitive impairments. This was helpful as their skill in understanding non-verbal communication assisted staff understanding of people's needs. For example, the specialist dementia worker at the service told us many of the pain medicines were supplied PRN. They had undertaken a pain audit in the last 12 months. This involved reviewing people's pain scoring, when pain medicines were provided and whether a full or half dose were given. This staff member offered guidance for care staff to understand when behaviours for people who had communication difficulties might reflect pain being felt. The outcome of this audit was that some people were now provided with pain relief before being offered care and staff were given greater guidance on pain relief for individuals through training. This was very positive for people living at the service and gave staff confidence in understanding people's needs.

The specialist dementia worker was also undertaking an audit of the Namaste service, and was reviewing how staff worked with people receiving the service. We were shown work undertaken to date and were told by the specialist dementia worker that the outcomes of the audit would inform training in this area. These examples are evidence of the provider proactively trying to improve the service offered to people living at Spring Lane.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We reviewed records and could see that the service was compliant with DoLS. There was a system in place to prompt DoLS referrals to the local authority when required for renewal. The service was clear who had been assessed as lacking capacity, with conditions set out in their spreadsheet. Staff understood about consent and people told us "Staff ask before they do things." And "I am asked if I want to get up or when to go to bed." We saw staff talking with people before offering care and being patient. Those who had a 'lasting power of attorney' (LPA) had this recorded in their care records with a statement that people did not have capacity to agree to care. There was evidence of consultation with those with LPA for decisions relating to care.

People were in the main positive about the food available. We were told "I eat it all, it's nice. I do not eat pasta so they give me something else." "Staff come with the menu the night before. Food is good." Another person told us "Good on the whole. Plenty of choice. I always eat in my room through choice." One person told us "food not very good. But they give you something else." Another said: "I find it all right [the food]."

Regarding choice "No, not all the time but it's reasonable." We asked if people were able to get drinks and snacks when they wanted and were told "On the whole, yes."

We saw there was a four weekly menu at the service that was changed in consultation with people living at the service. There were options for each day people could choose from. The kitchen staff were sent people's menu choices the night before and we saw the information provided reminded kitchen staff if they had a specific dietary need, for example, a pureed diet. At the time of the inspection the provider was updating the menu sheets to provide pictures of meals for the benefit of people with cognitive impairments.

Relatives were positive about the food. We were told "staff are persistent when it comes to feeding- not unpleasant but like a teacher – they keep a dialogue going and won't give up. Make sure [my relative] eats which I think is very important." Two other separate family members told us their relatives were 'difficult with food' but the service had managed to ensure they ate and drank enough. For one person this had meant they no longer had as many urinary infections as in the past which was positive. One relative told us told us their family member was vegetarian and this was catered for at the service.

We saw malnutrition universal screening tools were on care records for people at risk of malnutrition. Records of fluid intake, food charts, weekly or monthly weights, blood pressure readings, and pressure mattress settings were documented daily, and kept in a separate folder for all residents on each floor. People at risk of malnutrition were weighed regularly. Where required pressure relieving mattresses were in place. Daily checks of pressure-relieving equipment were documented, although we noted one person's weight was wrongly recorded which could have resulted in an inaccurate setting being used on the pressure-relieving mattress. We drew this to the attention of staff, who rectified it.

Records showed that people had access to health professionals as required including GP, dentist and chiropodist. Referrals were made to other relevant health professionals including district nurses, tissue viability nurses and speech and language therapists as required. A visiting health professional to the service told us "Staff here are always efficient and helpful". Also that "Staff here follow the instructions of the district nurse team well; I have no issues or concerns." People confirmed they were supported with health care appointments and family were unanimous in their praise of being updated if there were any health concerns related to their relative.

The premises were fully accessible with a lift to all floors. Rooms on the ground, first, second and third floors had ensuite facilities including a walk in shower. On the fourth floor there was a toilet en suite, but no shower. Communal bathrooms were available on all floors, but the baths were not easy to use if people had significant mobility issues.

Good

Is the service caring?

Our findings

We asked people if staff were kind, caring and patient. They told us "The staff are fantastic. They're kind and helpful." "Yes, most of them are (kind and patient)." And "Yes, yes they are." Family members also confirmed this. One relative said "She's treated with kindness, consideration and patience." Another said "She can get very anxious and they talk to her to calm her down."

We saw good person centred interactions between staff and people living at the service. Staff listened to people and tried to meet their needs. For example, one person complained about all their drinks and staff took them away and added milk, then tried a different drink. We saw staff talked with people even if they did not respond.

Care was provided in ways that people wanted. One person told us "I choose when to go to bed". Another said "I am asked if I want to get up or when to go to bed. I use the bell if I want something." People were encouraged to be independent and do as much as they could for themselves. One person said "I've been improving slowly here and I managed to shower myself and dress myself. I wanted to try to see if I could and I did it." Another told us "Showers make me dizzy and I cannot get in or out of the bath so get washed instead. Staff are kind when they dress and wash me".

People told us they were supported to maintain their religious or cultural identify. One person said "I cannot get to synagogue because of my [health condition] but the Rabbi sometimes comes."

People told us they were supported to keep contact with friends and family. People told us their friends and family were made very welcome at any time. One person said "Visitors come and before they can sit down they are offered tea or coffee. They treat visitors well. "Yes. My niece is coming to see me today." A relative said "Staff always offer tea, coffee and a biscuit" and added "staff are observant and intervene appropriately."

We asked people if they were treated with dignity and respect, and whether they thought this was their home. People were generally positive about living at the service. One person said "Staff treat me with dignity. One carer even locked the door so no one could come in. I was asked if I objected to a chap washing me and getting me up. Does not bother me." Another person told us "Yes, it's being home amongst a whole lot of other people!" another person told us: "I can say things for myself and they know I like to sit here by myself." One person pointed out there are "Lot of staff new and [I] spend time finding out and building a relationship but they go, sometimes not left but on another floor."

Care records contained a short background supplied by the person or their family which gave family history, professional history, languages and interests. It was brief but helped staff to know the person's history and respect their previous achievements and cultural background. Staff had a good knowledge of people's backgrounds. This was particularly important on the upper floors of the service where people had cognitive impairments. People told us they were involved in developing their care plan and relatives confirmed they were invited to attend care planning reviews on a yearly basis. One relative told us the "Home is proactive in

arranging them. They call us when there is an issue to discuss so I feel there is care management as well as care development. They discuss care planning and end of life care."

We saw people's rooms were homely with personal effects; pictures, books and stuffed toys. They were spacious and the majority had ensuite bathrooms. One person told us "[I am] Happy here. Room lovely. I like sitting by the window. Good view and I don't feel hemmed in."

Good

Is the service responsive?

Our findings

Care plans contained history regarding people's backgrounds. Care plans covered a range of various activities of daily living and assessed for current abilities and support needs. These included hygiene, eating and drinking, skin integrity, pain, mobility and night routine. Staff understood people's needs well and were able to highlight preventative measures in care plans, including the use of equipment for mobilising; ensuring people's environment was free of obstruction and clutter, and the use of an alarm sensor to notify staff of the risk of a fall.

Care plans were person centred. For example, one person's care plan noted a person's preference to stay in their room reading the newspaper or playing scrabble with another person. Staff spoke easily with residents, healthcare professionals and visitors. A dementia specialist worker supported staff in drawing up an appropriate care plan for people with significant cognitive impairments. This was positive as this staff member had the skills to help care staff understand non-verbal behaviours as an expression of feeling or discontent. Team leaders provided continuity across units and updated people's care plans on a monthly basis.

There was a wide range of activities taking place at the service. There were two full time activity co-ordinators. One staff member focused on supporting those people with significant cognitive impairments who were on the upper floors of the building. Activities included poetry and storytelling, art, food tasting, flower arranging, as well as bingo, quizzes and exercises/movement classes. Music and drama therapists attended and ran activities at the service and at the weekend a volunteer brought in their dog for people to pet. There were opportunities for small groups of people to go out locally on a regular basis and in the summer activities took place in the garden which had tables and chairs for people to use.

We saw good person centred interactions from staff. They listened to people and tried to meet their needs. The activity coordinator tried to include everyone and spent time trying to get their attention before asking them if they would like to do the activity.

Some people preferred not to take part in group activities at the service. There was a Namaste programme operating at the service. This service was personalised and targeted at people with a significant cognitive impairment. For example, a person who really liked pets may watch a video of animals and then have a hand massage. Another person may prefer listening to music of their choice and then have a light massage. For some people this time was used for reminiscence. This service could be taken to people's rooms which was positive as some people chose to stay in their rooms. The staff member who operated the Namaste programme also supported people to walk in a calm and relaxed way as a gentle exercise. This was positive as keeping people mobilising and moving is of benefit in a number of ways to their health and well-being.

We looked at complaints and compliments for the service over the last 12 months. We noted these had been responded to in a timely manner and actions taken were noted by the registered manager. We asked relatives if they were aware of the complaints procedure at the service. Family members told us they weren't aware but were confident that any issues raised would be addressed by the senior management team. They

also told us when they had raised issues these had been dealt with in a timely and appropriate manner.

Requires Improvement

Is the service well-led?

Our findings

The registered manager and operations manager had set up systems to ensure management actions were taken in a timely way. For example, effective systems were in place for DoLS applications, there were spreadsheets to prompt supervision and monthly and yearly care plan reviews. Care plan audits were taking place on a regular basis and an action plan showed improvements required to care plans. Other quality audits included: health and safety audits on a monthly basis; checks of care at night; call bell audits; and checks for building and fire safety. We could see from the pain and Namaste audits the provider was considering how to improve their service and this was evidenced by a more comprehensive audit tool that was being introduced at the time of the inspection.

We saw the provider was attempting to reduce the number of falls people had and minimise the risk of them having repeat falls. The introduction of a new falls process required staff to record all the actions they had taken following a fall and these were then reviewed by the senior management team on a weekly basis. However, we found that not all information taken by staff was contained within these documents, even if the action had been taken. For example, It had not been noted by senior managers when they reviewed the falls folder that a person who had fallen and sustained a head injury had been seen by a medical practitioner within 24 hours. We found this information in other care documents. We also noted training in moving and handling was out of date for some staff at the time of the inspection, despite a safeguarding incident in the last twelve months in which moving and handling issues had been of concern.

Regular team meetings took place, with meetings taking place in the evenings to ensure night staff were included. Minutes showed that quality issues were addressed, and the provider was fostering a collective responsibility for good care, which was positive. Staff told us they enjoyed working at the service and felt supported. The operations manager and registered manager told us a 'no blame' approach had been adopted in relation to incidents so staff could discuss and learn from issues that arose. We saw staff had been asked how best to minimise the reoccurrence of a recent incident that had occurred and this was a helpful way to solve the problem.

The senior management team were keen to recruit to vacant posts and had tried different approaches to make their service attractive to new staff. These included increasing pay rates and improving opportunities for promotion within the service. This was positive as continuity of staff is beneficial when trying to make continuous improvements in quality.

We spoke with the newly employed Quality and Compliance Manager (QCM) whose remit included undertaking quality audits across the provider's services. Part of this role will include obtaining the views of people using the service, family carers and other professionals in a formal way. We saw that survey forms had been completed recently for people who had attended for respite or who had had a yearly care review meetings. We saw the summary information for January and February 2017 but despite asking we were not provided with all the survey forms, just a sample. We noted not all comments were being captured on the summary and there was no action plan. But the QCM told us the senior managers looked at the forms as they were completed and going forward the system would be further developed.

People's views were obtained through a mixture of regular meetings for people who live at the service, engagement for specific workshops, for example, new menu setting, and via complaints. People living at the service told us the manager was visible and accessible. Family members praised the service and although the relatives we spoke with had not received a survey questionnaire, the majority were extremely happy with the service. Family members said they would recommend the service to other people. A family carer group ran every month to offer opportunities for relatives and friends to gain support in their caring role and offer their views on the service offered at Spring Lane.

The provider and senior management team had made improvements to the management of the service in the last 12 months. Weekly director meetings looked at a range of issues including falls, training, vacancies and complaints. A new electronic medicines system had been introduced which was showing benefits, as any errors or omissions were quickly identified and ordering of stock was in line with exact requirements which meant less wastage. There were plans to introduce a new electronic care record system by the autumn of 2017 as part of the service quality improvement strategy.

The operations manager and registered manager acknowledged there were still areas for improvement in the management of the service, and this was also our view. We found the provider's recruitment process had not been followed robustly for some staff employed in the last year. Care records were being audited on a regular basis but not all the issues we found had been identified in the provider's audit. However, we saw the new audit tool the provider was introducing was more comprehensive and included all these issues.

Finally, we noted two complaints raised that the service had dealt with but the provider should have sought advice from the local authority as to whether they needed to notify them formally under safeguarding procedures, and therefore also CQC. These examples were evidence of systems not yet fully embedded to show the service was consistently well led over a period of time.

However, an action plan had been developed by the time of the inspection which incorporated service developments identified by the service provider and other stakeholders. This showed the provider was addressing quality issues. The action plan was comprehensive and set out clear expectations for senior managers and staff for the coming 12 months. This would provide a baseline for the service to continue to improve the service for people living there.