Barchester Healthcare Homes Limited

Braeburn Lodge

Inspection report

Braeburn Road
Deeping St James
Peterborough
Cambridgeshire
PE6 8GP

Tel: 01778752500

Date of inspection visit:
08 March 2017

Date of publication:
07 April 2017

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?	Good

Summary of findings

Overall summary

The inspection took place on 8 March 2017 and was an unannounced inspection. The home is registered to provide accommodation with personal care and nursing to 60 people. At the time of our inspection there were 36 people living in the home.

There was a newly appointed manager in post. The manager had recently submitted their application to the Care Quality Commission to become the 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 home is run.
People and their relatives told us that they felt safe at the home. Staff were trained in adult safeguarding procedures and knew what to do if they considered someone was at risk of harm, or if they needed to report concerns.

There were systems in place to identify risks and protect people from harm. Risk assessments were in place and gave sufficient information as to what action staff should take. Staff were competent and provided support in accordance with people's care plans. Referrals were made to appropriate health care professionals to minimise risks and meet people's health needs.

There were sufficient staff to keep people safe and meet their needs. The manager had followed safe recruitment procedures. Medicines were given to people on time and as prescribed.

Policies and procedures were in place to guide staff in relation to the Mental Capacity Act 2005. Staff understood the processes in place for ensuring decisions were made in people's best interests. Staff and the manager ensured these steps were taken for people living at the home. Staff sought people's consent and recorded this.

Staff were caring, they knew people well, and they supported people in a dignified and respectful way. Staff acknowledged and promoted people's privacy. People felt that staff understood of their needs and they had positive working relationships with them.

People and their relatives were involved in the assessment and review of their needs. Staff had knowledge of people's changing needs and they supported people to make decisions or changes to the way their planned care was delivered. Staff offered choices to people regarding all aspects of their care and support, and upheld these choices. People told us that they had access to activities and hobbies.

People and staff knew how to raise concerns and these were dealt with appropriately. There were processes in place to obtain the views and feedback of people and their relatives. The views of people, relatives, health and social care professionals were sought as part of the service's quality assurance process. Effective quality assurance systems were in place to regularly review the quality of the service that was provided.

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.

Staff knew how to recognise and report abuse and had received safeguarding training.

There were enough staff to ensure needs were met and people were safe.

The service managed risk effectively and regularly reviewed people's level of risk. Medicines were managed appropriately.

Is the service effective?

Good

The service was effective.

The service provided staff with training and they received support from the management team with their roles.

People were supported to maintain good health, and received enough to eat and drink.

There were effective processes in place to work in accordance with the Mental Capacity Act 2005. Staff sought people's consent and recorded this.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and dignity .They took time when delivering support and listened to people. Staff acknowledged people's right to privacy.

People were consulted about their care and had opportunities to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People received personalised care which was responsive to their

needs.

People were supported to maintain hobbies and interests they enjoyed.

There were processes in place to identify if people had concerns about the home.

Is the service well-led?

Good

The service was well led.

The manager sought the views of people regarding the quality of the service. Improvements were made when needed.

There were quality assurance processes and action plans in place for checking and auditing safety and the service provision.

Braeburn Lodge

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 inspection took place on 8 March 2017 and was unannounced. The inspection was completed by two inspectors 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.

Before the inspection, the provider completed 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 looked at information we held about the provider. This included notifications, which are events that happened in the service, that the registered provider is required to tell us about. We also contacted social care professionals within the county for their views.

We spoke with seven people living in the home and two relatives. We also spoke with the manager; the registered nurse; a senior carer; a care staff member; the activities coordinator; trainer; the clinical nurse specialist; and the chef. At the time of our visit, we also spoke with the provider's representative, the regional director who was at the home. We spent time observing care provided to people during the day.

We reviewed the care records of three people, training records and staff files, as well as a range of records relating to the way the quality of the service was audited.

Good

Is the service safe?

Our findings

People living at the home told us that they felt safe. One person said, "I feel safe as the carers are very good and no strangers can get in." Another person told us, "Absolutely safe and very secure" and one more person confirmed, "They are all lovely and make me feel safe."

Staff that we spoke with had a good awareness of how to protect people from harm. There was training in safeguarding available and staff knew how to raise a concern. There was dedicated time for people to discuss safeguarding concerns at team meetings. The manager also covered safeguarding concerns within their audits to ensure all were followed up.

We saw from our own records, and from records in the service, that there had been an increase in safeguarding incidents in the past year. These had all occurred in the unit that supported people with dementia. We saw that work had been carried out to determine the reasons for these incidents and actions had been taken to address them. We saw all these concerns had been individually dealt with in conjunction with the safeguarding team at the local authority. Steps had been put in place to minimise the reoccurrence of incidents. This showed us that staff and the management team dealt with incidents that presented harm to people and responded effectively.

At our previous inspection on 25 November 2015 we identified some issues around how people's individuals risk were recorded and monitored. At this inspection visit we found that improvements had been made.

People told us that they felt the staff knew about risks to their safety and how to make them safe. People also felt that they had access to equipment they needed to minimise their risk. One person told us, "I have a bad sore so I have to keep lying on my side when I can, I have a special mattress." Another person told us, "I have my (wheeled) walker now so can get around more easily."

We saw in people's care records that these risks had been identified and assessed in order to keep people safe. We saw that one person was at a high risk of falling and that their mobility needs had recently changed. The person's care record reflected all changes to the person's mobility over a period of time. There was information regarding the equipment that this person needed. When we observed staff with this person, we saw that they had the equipment in place and staff supported the person in accordance with their risk assessment. Another person was at risk of falling from bed. Their care record reflected this and stated that a crash mat should be in place, with a profile bed. We observed that a profile bed was in place with a crash and sensor mat, meaning staff were alerted if the person got out of bed. Despite both of these individuals being at high risk, we saw from accident records, that neither had fallen in the past three months. Throughout the day we observed staff reminding people to use walking aids, and fetching things for the person.

Some people were at a high risk of developing a pressure area. We saw this was also detailed in care records with an appropriate risk assessment. We saw that one person needed to have their mattress adjusted according to their weight. This person needed to be weighed weekly. We spoke with the senior carer who

worked with this person. They showed us the person's weekly weight chart and what pressure the mattress should be at. When we checked the mattress it was at the appropriate level. The senior member of staff was able to explain why this person was on an airflow mattress. They went on to explain how many times this person should be supported to reposition in bed; we saw that this corresponded with what was in a person's care record.

Some people living at the home had behaviour that could sometimes be viewed as challenging by others. We saw that this was detailed in a peoples care records. For example, one person was at a higher risk of contracting infections which affected their behaviour. We saw in the record that this person needed to be prompted to drink plenty of fluids, but was often non-compliant with drinking. The care record stated that drinks should be offered regularly and if they were refused another member of staff should try; this was also relevant for meals. We spent some time at the inspection visit observing interactions between this person and staff. We saw that staff offered a drink and if refused another staff tried. At lunchtime the person refused food, and another staff member encouraged the person to come and eat. Staff spent time with this person and interacted with them all the time the person accepted it. Records for this person showed that staff kept a log of when the person had shown behaviour that could be seen as challenging. These records contained information of the incident and reviewed whether the person might have had an infection. We saw that there were relevant referrals to the GP and to the mental health team to minimise the risk in the future.

There was information available to staff for dealing with emergencies, and staff told us where this was. Staff could tell us what they did in the event of an emergency and this was consistent with the documents we viewed. Additionally the home had in place generic assessments for the health and safety and maintenance checks for around the home, which served to ensure people were kept safe.

We concluded that staff knew the risks that people faced and had put in place steps to monitor and record these. The manager was aware of the people at the highest risk. They had in place systems to involve the most relevant professionals if a person required support from outside the home.

People living at the home and staff had mixed views about whether there were enough staff to meet people's needs. Some people felt that there were not enough. One person told us, "They have been very short at the moment, often at night" with another person agreeing, "There are only two here [residential unit] and some people take their time up more." However other people felt that staffing was sufficient to meet the needs of people. One person said, "I try not to use it [call bell] but the few times I have, they have come with no delay." Another person told us, "I have no problem calling for assistance, they always come." With someone else agreeing, "There is always somebody about."

Staff we spoke with also had mixed views. One staff member told us that they felt there were not enough staff, and that agency staff were used too often. Another staff member told us that they felt the unit they regularly worked on had enough staff, and that they had time to spend with people living at the home. During the day we carried out a number of observations around the home. We saw that staff responded well to people who called for assistance and spent time with them. We observed staff in the dementia unit dancing with people and singing, however staff still responded in a timely manner when someone had called for help.

Whilst there were mixed views we saw that there was a dependency tool used to determine staffing levels, and this was consistent with the staff mix we saw on duty. The manager was aware that recent changes to both the management team and staffing team had impacted on the home, and had caused difficulties with addressing staffing levels. This was because there had been a number of vacancies. The manager told us that they had worked with an agency to ensure consistent agency staff were sent to the home, and a

number of people had recently been recruited to the home. The manager told us that a recent quality audit had also concluded that the dependency scores needed to be reviewed and they were in the process of reviewing all care records. The senior member of staff who led the dementia unit had created 'at a glance' information sheets for agency staff, to highlight important information about people on the unit. This showed that actions had been taken to reduce the impact to people and staff.

The manager followed safe recruitment practices, which included the appropriate criminal record checks and references. The manager told us about the recruitment they had completed and the process this followed. This meant only staff that were deemed suitable were employed to work with people living at the home.

People told us that they were supported with their medicines. One person told us, "I have eye drops at the moment, which they do." Another person said, "I have my inhalers from the doctor for my chest", another person agreed and told us, "I can ask for paracetamol and a sleeping tablet if I need it."

There were safe medicine administration systems in place and people received their medicines when required. We observed staff administering medicines and they followed a methodical procedure and updated records as they went. We observed staff asking people discreetly before administering medicines and staff waited until the medicines had been taken. We saw that medicines were kept securely and that each person had a Medicines Administration Record (MARs) that was individual to them. These records also showed people's personal preferences on how they liked to take their medicines. Where a person required a medicine as and when it was needed, a PRN medicine, these were administered effectively. Staff asked a person if they wanted a specific medicine and recorded the response. We saw that a PRN protocol was in place and staff were able to tell us about this.

Staff told us that they received medicines training and that they shadowed more experienced staff whilst they learned. Competencies were checked regularly and on the day of our visit we saw that an observational supervision was in progress. Staff were knowledgeable and confident with the process of medicines management.

Good

Is the service effective?

Our findings

People spoke positively about staff and how they supported them at the home. One person told us, "They [staff] are good; the new ones take time to get to know us." A relative confirmed and said, "Most seem very pleasant and helpful to them."

At our last inspection on 25 November 2015 we highlighted some concerns around staff training. At this inspection visit we saw that improvements had been made and that there was a plan in place for further improvements.

The manager shared a dedicated person with other homes owned by Barchester Healthcare. It was the responsibility of this person to support with the training and development of staff. On the day of our inspection visit this person was at the home and had carried out some observations of staff, relating to the care they delivered. Staff told us that they had access to different training and we saw records that confirmed this. We saw that training opportunities included, but were not limited to, medicines, safeguarding; infection control; caring for people with dementia and fire safety. We saw staff that were new to Braeburn Lodge, undertook an induction which included the Care Certificate standards (the Care Certificate is a set of standards that social care and health workers adhere to in their daily working life.) The manager confirmed that they and the trainer discussed with the staff member their training and development needs. They also confirmed that any observation sessions were discussed with the staff member to continue their personal development.

New staff undertook induction shifts with more experienced members of the team and told us that they found these useful. Staff could shadow for as long as they felt they needed to, in order to be confident. One staff member told us that they had not received supervision, this is a one to one meeting where staff can talk about their roles and any development support they may need. Our previous report and a recent quality audit had also highlighted that this was an issue. We spoke with the manager and they were aware that this needed to improve and they had arranged for the continuation of observational supervision. However, we were confident that staff could access support from management at the present time in a less formal manner. We saw that observations were carried out; staff had time to discuss these and told us that the management team were visible. We therefore concluded that the manager was aware of staff needs and a plan was in place to make this more formal in the future.

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 checked whether the service was working within the

principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

A number of people who lived at the home either had a DoLS authorisation already in place, or they had an application that had been applied for. We saw that people's care records reflected the stage of the authorisation. We reviewed the records of two people who were restricted from leaving the home during the day or night. The care record explained the reasons why and what staff should do if either person wanted to leave. When we observed care, we saw staff working with one of these people and they attempted to distract the person with activities when they became distressed. Another person sometimes showed signs of distress and the DoLS, best interest meeting and care record stated staff should sit and reassure this person. On our inspection visit we observed this practice taking place, and this settled the person.

Staff had an awareness of MCA and could explain some of the principles of the Act. We saw, where it had been identified that people lacked the capacity to make a decision a, best interest meeting was held to ensure the decision being made was in the person's best interests and the least restrictive. For example, one person was at a high risk of falls from bed. Records confirmed that there was a best interest decision and that bed rails were not the safest or best method for this person. Instead they required a profile bed with crash mat as the least restrictive and safe method. We saw this person's room and this was the practice being used.

People told us that their consent was sought regarding the support they received. One person told us, "They [staff] always knock and ask me first before doing anything" another person agreed, "They [staff] are used to me now and ask me." We saw that people's individual care records showed that consent had been discussed between them and staff, people had then signed their care records with their agreement. Where appropriate, a family member or advocate had signed on the person's behalf. We checked records to ensure that these nominated individuals had the correct permission or power of attorney and that this was in place.

People told us that they enjoyed the food and received enough to eat. On the day of our inspection visit there were a number of family members joining people for lunch. One person told us, "It is lovely food, we get a choice of two dishes or we can ask for a different thing if we want it." Another person said, "I do not always have tea, as it is a lot of food in one day, I might ask for a tiny portion and they will do that for me." One person had specific dietary needs and told us, "It is very good food, I am gluten free and the chef makes sure I get the special porridge and the rest of my meals are right." A relative who had joined someone with their lunch told us, "How refreshing it is to have proper vegetables and a lovely meal."

The chef was able to tell us about the different diets people had, and that some people received a pureed meal or one that was fortified, depending on their needs. The chef, and staff, confirmed that a choice was available at all meals and we saw that people were asked their preference. Drinks were readily available throughout the day, including hot and cold drinks. People confirmed that they had a choice of squashes, water, tea, coffee or hot chocolate. People could either help themselves or were offered drinks by staff.

At the time of our visit some people were at risk of not eating or drinking enough. We saw in these instances that people had a food or fluid diary to track what they ate and drank. However, some of these records were difficult to follow as they were inconsistent in the way they had been completed by staff. Additionally fluid levels had been calculated using a person's weight, but had not always been updated as the person's weight had changed. There was no evidence on some fluid diaries as to what staff should do if a person did not drink enough. In the records we reviewed people had received either the amount stated in the record or slightly more.

Staff we spoke with confirmed which people were on a food and fluid chart. They were able to explain the amount stated in the record and why it was important to ensure people had enough to eat and drink. However, staff did not always know how to complete the food and fluid diaries in a consistent manner. We spoke with the manager regarding this and they had already been made aware that not all staff understood why a person had a food and fluid diary. They had arranged with the trainer, on the day of the inspection visit, that this was training that staff should receive and would be put in place. Additionally the manager informed us that they were in the process of reviewing all care records and the recording of food and fluid diaries would be addressed.

Some people living at the home had received support from a Speech and Language Therapist (SALT). We saw that people were regularly assessed for changes by staff. Staff had raised concerns about people and referred them to the GP or SALT when necessary. For example one person had received a SALT visit in February 2017. This person's needs had changed and they now required their drinks to be thickened and a beaker with a spout should be used. We observed staff making a drink for this person and saw that these instructions were followed and the correct beaker was used. They were able to explain to us the changes and when the SALT team had assessed this person.

We concluded that staff were aware of people's individual needs when it came to support with eating and drinking. We found that these needs were being met; however staff required more support to ensure this was recorded appropriately.

People told us that staff supported them to access healthcare services outside of the home. One person told us, "I had physio here after a shoulder injury in hospital, and can walk with the wheels [walking aid] now that I can use my arm better." Another person said, "When I had a bug, they got my doctor in quickly. I have my own chiropodist who still comes to do my feet as I lived locally. The surgery does a weekly round too." Another person confirmed saying, "I have a hearing specialist who comes in to check my hearing aids and get the chiropodist too."

We saw in care records that there were visits from other health professionals and that staff responded to instruction that was left. For example, where people required support from a chiropodist we saw that visits were regular and had been recorded.

Good

Is the service caring?

Our findings

People told us that staff were caring and kind. One person said, "It is a very happy place", another person agreed, "They [staff] are lovely." Someone else also confirmed and said, "They [staff] are very kind to us." A relative told us, "They [staff] are very patient and very tolerant as dementia can be disturbing." They went on to say "They [staff] are very kind and very caring, their total attitude is good."

We spoke with the manager when we arrived for our inspection visit; the manager had only been in post for a short number of weeks. The manager could tell us about each person living at the home and knew some of the people's backgrounds. We observed staff throughout the day and saw they talked with people about their interests and histories. All interactions we observed throughout the visit were encouraging, kind and caring. Staff felt it was important to get to know a person. The activities coordinator told us that only by getting to know someone, especially those people with dementia, could they tailor one to one activities to the person's likes and dislikes.

People living at the home told us that staff supported them to remain as independent as possible. They also told us that they liked this, as it meant they had control over their care and support. One person told us, "I can move where I want and go for a river walk if I tell them first. I've got my own phone line too so I can ring my family", they continued, "I have a wash with help for my back. I don't have a shower at the moment as I can't get water in my eyes" Another person said, "They encouraged me to stand and how to balance so I can use my walker slowly." We were also told, "They let me do what I can manage when I am showered." One person agreed with this and went on to say, "I do appreciate being encouraged, and they [staff] do listen to what I say." We observed a staff member who supported one person with their lunchtime meal and encouraged them to do as much as they could themselves. The staff member supported the person by cutting the food, but then encouraged the person to use the fork to continue eating. The staff member did not rush the person in any way, but enabled them to independently eat their meal with staff on hand if they needed it.

We spoke with people regarding their involvement in planning their care. Most people we spoke with said that their family dealt with this for them, however confirmed they had a care plan. One person told us, "I have seen my care plan, and they get in touch with my sister, as she helps me." Another person agreed and told us, "My son has a lasting power of attorney and runs my situation [management of care package], the office talk to him, and he will chat to the nurses about me too."

The home ran a system called 'resident of the day'. This is a system where each day a person is spoken to individually about all aspects of living at Braeburn Lodge. A recent quality audit showed that this had lapsed whilst there was a change in management. We spoke with the regional director who confirmed these were now being completed. This scheme supported staff to undertake reviews with people at the home. The manager confirmed that in the last month all care reviews had been undertaken within the residential unit and were on a rolling monthly programme. In the dementia unit the new senior was working through each individual record, and only two were outstanding in the nursing unit. The manager also confirmed that some records needed a thorough review as they were sometimes inconsistent, and a recent quality audit

had also shown this. The manager told us that they were working with senior staff to ensure this took place.

We reviewed the records of three people who lived at the home. We saw that reviews had systematically taken place and records had been updated. We saw in these records that people who wanted to be involved in their care planning were. Where a person had nominated a family member or friend to support with care planning, we saw that this had also taken place. We concluded that whilst there were some records still to be updated people were involved with formal care planning and day-to-day care planning. Staff were committed to involving people and ensuring their care reflected their wishes.

People told us that they had their privacy and dignity respected and upheld. One person told us, "They [staff] always knock and close my curtains when it is time for help." Another person said, "They [staff] knock and wait for me to say 'come in'." We were also told, "I get good privacy when I want to be left alone" and another person said to us, "They [staff] knock even if my door is open."

We observed staff throughout the day and they always knocked before entering a room and announced who they were. Staff were discreet when asking people if they required any help. We reviewed people's daily care notes and these had been recorded in a polite and courteous manner.

Good

Is the service responsive?

Our findings

People told us that they had choice in the things that they did. One person told us, "I am unsteady on my pins and I am a bad sleeper so like to get up about 8.30am so they come when I am ready." Another person said, "I like a bath and I can have one more or less when I ask." Someone else agreed and said, "I can plan my bedtimes, and choose my clothes and what to do." One person wanted a living space that was similar to the home environment they had left. They told us, "They [staff] moved me into this larger room and it is like the space I had at home." Another person told us that they liked a lie in and staff respected this. They said to us, "I had a lie-in today as I had the best night's sleep ever. The staff woke me up in the end but I said I did not want a shower today as I was still tired." Another person living at the home confirmed that they were asked if they preferred a male of a female staff member to support them. They said, "They [staff] did ask me [if I preferred male or female care staff] and I said I preferred females, that is respected."

We reviewed people's care records and saw that people's likes and dislikes were recorded. These included preferences such as the choice of carers; food and drink; times they liked to go to bed and get up, and even how many pillows they preferred at night. We saw that these records were detailed and up-to-date. A staff member we spoke with told us that they found the records useful and thought they contained the right amount of detail for them to meet a person's individual needs.

The senior staff member on the dementia unit told us that after they had reviewed a person's records, they then told staff about any changes. This was so staff were aware of any new care needs or changes to a person's existing care requirements. They also explained to us that they were using the care records alongside a new monitoring system to ascertain changes in people's needs. For example one person on the dementia unit was often very tired in the afternoons and therefore did not want to interact with staff. The senior amended the hourly observation chart so that staff had to record whether a person was 'awake' or 'sleeping' at night rather than recording 'checked'. The senior identified that this person was consistently up in the night. This meant staff could determine why the person was up at night and amend care provision to support this person back to bed. This person now slept better and was more responsive when engaging with staff in the afternoons.

People led very active lives and they were supported to maintain hobbies and interests. Staff encouraged people to be involved in organised activities but also respected those people that wanted to entertain themselves.

We received very positive feedback regarding access to activities. One person told us, "I have got my patio door so I go out for a walk around, I like garden walks to help my legs. I go upstairs for activities sometimes and staff come with me." Another person said, "We had an outing to the pantomime in Peterborough on the minibus which was fun" they continued, "At Christmas, the local nursery and two schools came in to sing to us a few times and a group from the church, I heard more carols than I have for quite some time!" Another person told us, "We go out on alternate weeks for fish and chips as it is so popular, we have two groups on the go. We sometimes go in the far lounge for Tai Chi, he is very good and keeps us moving, he is booked fortnightly now." A relative confirmed and said, "[To person living in the home] you have quite a few things

to entertain you, don't you? You have got singers in tomorrow. The fish and chips trip is so popular they have two groups now, that get rotated, don't they?" To which the person with them responded positively.

The home employed a dedicated person to manage the activities. There had been some recent changes to the activities team, and more events are now up and running for people to join in. We spoke with the activities coordinator about their role. They explained how they spent time with people living at the home to decide what activities they liked. They gained this feedback at the 'resident meetings' that were held regularly. The activities coordinator also asked for opinions after new activities had taken place.

The activities coordinator showed us the current timetable and explained that there was a pictorial version for people living with dementia, which we observed. The activities coordinator was able to tell us about people who were either cared for in bed or did not like to join group activities. They explained these people's likes and dislikes to us. For example, one person liked to have a massage on their hands and arms. This person also liked a popular musical band and liked to watch their music videos. The home had sent a message via a social media site to the lead singer of this band to ask if they would record a message for this person.

People were supported to maintain their religious beliefs. One person told us, "They have the church service here." We asked the activities coordinator about this and they explained that they had links with two churches, who regularly visited. One church had also told staff they could contact them outside of working hours if a person wanted support. The activities coordinator had made this referral at times when people or their family had requested it.

This showed us that staff were responsive to meeting people's individual needs and to ensuring that they had access to their hobbies, interests and religions and were able to maintain active and varied experiences.

People told us that they knew how to make a complaint, but that they had not had cause to. One person said, "I have no complaints", another person agreed, "We have had none to make [complaints]." We were also told, "I am very aware of what is good and would speak up if I was unhappy with anything."

There was a complaints policy available to people and staff felt confident to act on issues if they were raised to them. The home had received formal complaints in the past year. However we viewed records and these had all been dealt with in a timely manner and to the satisfaction of the complainant.

Good

Is the service well-led?

Our findings

People we talked with spoke positively as to how the home was run. They also told us that the manager was new, but that the manager had been visible in the home. One person told us, "It is very well run", and another confirmed and said, "I had a short chat with [manager] and they seem pleasant." One other person agreed and said, "I have met [manager] and they are very determined and they fight my corner [regarding my care package]."

When asked if people would recommend the home the response was also positive. One person said, "I would recommend this place to anyone" with another person agreeing, "I could not have gone to a better place." We were also told by someone, "It is 100% better than the other homes I have been in."

The manager had only been in post for a few weeks; however we observed that they already knew staff and the people living in the home. Staff who we spoke with told us that they felt that they could approach the new manager at any time. One staff member told us, "[Manager] is approachable and listens [to me]." The activities coordinator confirmed and said, "Yes, I love working here, everyone is supportive." Staff also told us that if they felt they could not speak to the manager about a specific concern there were systems in place for them to report these concerns outside of the home. There was a clear line of accountability for staff and processes in place for when the manager was not available. There was on going recruitment for new care staff at the time of our inspection visit, with seven new people due to start. Barchester Healthcare had also started recruitment for roles to support the manager in the day-to-day running of the home.

We saw from records that there were regular team meetings which gave staff the option to add to the agenda. The activities coordinator told us that they felt team meetings were useful and that the management team listened to their ideas. The manager had put steps in place to manage supervisions and appraisals in the future; this was because a recent audit had stated that this needed to be improved. However, we observed observational supervisions during the inspection visit and staff confirmed they could seek support at any time.

People living at the home told us they were asked their opinions about the home and we saw that regular 'resident meetings' took place. The home also operated a 'resident of the day' scheme which meant their thoughts and opinions were sought as well. One person confirmed, "They had a meeting with us." Another person told us, "There have been two meetings since I have been here, you see things happen after." The activities coordinator told us that during a 'resident meeting' they were asked to change the way they advertised the activities. Originally they were advertised on a Monday. People felt this did not give them time to review the list, and families felt they could not organise visiting so that their relative was free to go to the activity. People asked for it to be distributed on a Friday, which is now done. People and their relatives find this much more helpful.

The manager had a number of audits that they used to track the quality of the care provision. Barchester Healthcare also carried out unannounced audits undertaken by a member of their staff not situated at the home. We saw that the audits included, but were not limited to, a wide range of areas, for example,

safeguarding; accidents and incidents including falls; medicine management; care record reviews; infection control; supervisions and training for staff; nutrition; activities and the overall maintenance of the home.

At the time of the inspection visit the manager was only beginning to address issues raised within these audits, as they were new to the home. The manager told us that they had started with issues that they felt were the most important. For example, the manager in their first few weeks had focussed and addressed the stabilisation of staffing. Additionally they met with people who lived at the home, to understand their individual care needs.

We reviewed the audits and found that they included areas of improvement that we had. There was also a corresponding action plan was in place. The manager was able to explain to us what steps they had taken so far, and the plans to continue the improvements. For example, we found that individual food and fluid diaries were not consistently completed. We also saw that two care records had some information missing about the activities people had undertaken, or reviews were not clear in the text of a care record. We saw that a recent audit had picked up all of these areas. The manager was able to explain that they were looking to train staff as to why a person had their food or fluid monitored and how to complete a record. We were told that there was a current review of all care records so that records were better completed and consistent.

At the previous inspection visit on 25 November 2015, we felt that accidents, incidents and falls were not always appropriately followed up. This was because there was no mechanism to monitor accidents and incidents. We saw at this inspection visit that this had improved. We saw that falls had been regularly assessed by the manager and people had been referred to the appropriate healthcare professional to minimise risks of falls. We saw that audits highlighted when specific equipment was needed to support people and that this equipment was in place. We concluded that audits were effective at identifying risks and issues. We felt that the management team were aware of the changes needed and had started to work towards these. There were still elements of improvement needed; however there was an action plan in place to achieve this.

There was a business continuity plan and risk register in place for the service. This meant the manager had effective processes in place in case there was a disruption to the running of the home. The manager told us that a large amount of the quality assurance for day-to-day care was done in an informal manner, which included observations, which enabled the manager to act in a responsive manner. The manager was aware of the key challenges that the service could face in the future, and explained how they would manage these.

The service had submitted all the relevant notifications, to the Care Quality Commission, that they were required to do and had policies and procedures in place to manage quality care delivery and health and safety.