HC-One Limited

Ferndale Mews

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

Our inspection took place on 10 and 11 January and was unannounced.

Ferndale Mews is a care home located in the Ditton area of Widnes, close to local shops, pubs and St. Michael's church. The home provides care for up to 34 older people with dementia. The building is a two storey purpose built home on the same site as Ferndale Court Care Home. All the bedrooms are single with en-suite facilities.

At the time of the inspection a registered manager was in place. 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 that people and their relatives were positive about the care provided at Ferndale Mews. The management had acted on feedback received about the quality of the care and had implemented an action plan. People, relatives, staff and other professionals reported that the service had recently improved. We found that people were well cared for in comfortable surroundings.

The service was safe. There were sufficient numbers of suitably qualified staff to meet the needs of people living at the home. There had been a focus on the recruitment of new staff and the use of agency staff had reduced. New unit leaders had been introduced and staff told us that the organisation of the home had improved.

Staff knew the importance of keeping people safe and appropriate procedures and systems were in place to prevent people from harm and abuse. Staff had received training about protecting people from abuse and harm. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

The home was undergoing significant refurbishment which was near to completion. The environment was conducive to the needs of people living with dementia.

We found that staff were knowledgeable and well trained. They received a thorough induction when they began their employment with the home and on-going training updates. Further face to face training had been planned. We observed that staff engaged in positive conversations and demonstrated skill in supporting people living with dementia.

People's consent was gained before any care was provided and the requirements of the Mental Capacity Act were met.

People and relatives had previously raised concerns about the quality of the food. A new chef had been employed and improvements were being made. The provider was continuing to monitor.

We saw that people were treated in a kind and caring manner. We observed that staff were skilled and patient, treating people with dignity and respect. People were able to make choices about the way they were supported.

The provider had introduced new documentation and people's care plans were being re-written. We found that the majority of care plans were person centred and detailed. The registered manager had highlighted through audits that some of the care plans needed to be reviewed and improved and action was being taken to address this. Daily charts were not always completed fully or at the time that the care was provided.

We found that there were some activities taking place but that these needed to improve. The registered manager already had plans to make these improvements.

There was a complaints procedure in place and people knew how to complain.

People knew who the registered manager was and felt able to raise any concerns with him. Staff told us that they felt well supported. We saw that regular team meetings were held, as well as supervision meetings to support staff. There were comprehensive quality assurance processes in place and people's feedback was sought about the quality of the care. The provider demonstrated that they were acting on feedback received to make improvements.

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.

There were sufficient staff to meet the needs of people living at the home.

Appropriate recruitment procedures were followed to prevent the risk of unsuitable staff being employed to work at the home.

Staff received training in safeguarding and understood their responsibilities to protect people from harm.

Individual risk management plans were in place to keep people safe and actions needed to minimise risks to people's safety had been identified.

Is the service effective?

Good

The service was effective.

Staff had an awareness of the need for consent and understanding of the Mental Capacity Act 2005. The Deprivation of Liberty Safeguards were being applied appropriately to people within the home.

Staff spoken with had the knowledge and skills needed to carry out their roles effectively. Staff received a thorough induction and regular training updates.

A new chef had been employed and improvements were being made to the quality of the food.

Is the service caring?

Good

The service was caring.

People told us that the staff were kind and caring. We observed that people were well cared for.

People were treated with dignity and respect.

Staff respected people's wishes and preferences and people

were involved in decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were being transferred to new documentation. Some were detailed and person centred, but not all were consistent.

There were some activities in place but these needed to improve.

There was a complaints policy in place and people told us that they would feel able to make a complaint. We saw that any complaints were appropriately responded to.

Is the service well-led?

Good

The service was well-led.

Staff said they felt well supported and worked as a team.

People and relatives were encouraged to give their feedback about the service.

The home had effective quality assurance systems in place to monitor and make any improvements.

Ferndale Mews

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 checked 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 10 and 11 January 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors on the first day of the inspection and one adult social care inspector on the second day. The service were aware of our visit to conclude the inspection on the second day.

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. Prior to the inspection we reviewed this and other information we held about the service. We looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. We contacted the local authority contracts and quality assurance team to seek their views and we used this information to help us plan our inspection.

We used a number of different methods to help us understand the experience of people who used the service. During the inspection we spoke with six people who lived at the home and six relatives/visitors, to seek their views. As most people living were living with dementia at Ferndale Mews, they were unable to tell us about their experiences, therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We interviewed staff including the registered manager, residential unit manager, one nurse, four care staff, one senior carer, the administrator and the maintenance person. We also spoke with the operations director at the end of the inspection. During the inspection we spoke with one visiting health professional, as well as contacting another health professional over the telephone to seek feedback.

We reviewed three people's care records and inspected other documentation related to the day to day management of the service. These records included three staff files, staff rotas, quality audits, meeting minutes, complaints records, supervision records and maintenance records. We toured the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people in the communal areas, such as the lounge and dining room.

Good

Is the service safe?

Our findings

Relatives who we spoke with were complimentary about the care provided and felt that their relatives received a safe service. One relative told us they felt their relative was "very very safe." at Ferndale Mews.

We found that the registered manager and staff understood their responsibility to keep people safe. We saw from the records that staff had been provided with safeguarding training. Staff were able to tell us about the provider's safeguarding policies and procedures and knew what to do if they suspected that a person was at risk of abuse. The staff we spoke with understood the various forms of abuse. One member explained to us about situations where it had been necessary to report safeguarding concerns and someone else commented, "If I saw anyone being mistreated, I would tell." We saw that the provider also had a whistleblowing policy and staff knew that there were contact numbers available in the staff room for a whistleblowing helpline.

We saw that the registered manager kept a file in place relating to when safeguarding referrals and care concerns had been made to the local authority and notifications sent to CQC. We saw that the outcome of these were recorded and dealt with appropriately.

The registered manager told us that he had focused on staffing levels and the recruitment of staff since coming into post around 12 months ago. There had been a recent reorganisation within the staffing structure, with a newly appointed clinical lead and unit manager on the ground floor. The home had been through a period where it had been necessary to use agency staff to cover shifts. These are staff who are employed by a separate organisation which provides staff to any service which requires them. The recruitment of nurses had been particularly difficult. However the registered manager told us that they had undertaken a recruitment drive and the staffing had improved more recently. Staff commented "We had a lot of agency staff and it has got better, we've had a lot of new starters".

During the inspection we found there were sufficient staff to meet people's needs and provide personalised care. There were 17 people living within the residential unit and we saw that there were two care staff and one senior carer on duty, additionally there was a member of staff who supported a person on a one to one basis. The nursing unit also supported 17 people and there was one nurse and four care staff on duty from 8am until 8pm. We checked the staffing rotas which confirmed these staffing levels were consistent, although the numbers had occasionally fallen below these numbers when staff had been off sick. The registered manager explained that staff sickness levels had also impacted on staffing levels and the organisation was following their policy with regards to the management of staff sickness.

We saw that the provider used a staffing tool to calculate the number of staff required and this was dependent upon the needs of people living at the home. Staff told us that there were enough staff to meet people's needs, comments included "Most of the time there is enough staff" and "The staffing is okay." We observed that staff responded quickly so that people did not have to wait for support or assistance. Staff were very visible around the home at all times. Staff told us that they believed the consistency of the current

staff group had helped to improve communication with relatives and visitors. People were more familiar with a stable staff team.

We saw that staff employed by Ferndale had been through a thorough recruitment process before they started work to ensure they were suitable and safe to work with the people who lived at the home. We looked at three staff records which showed that all necessary checks had been carried out before each member of staff began to work within the home, including a full employment history check and Disclosure and Barring Service (DBS) check. The DBS is a national agency that checks if a person has any criminal convictions. Through this recruitment process the registered manager was able to check that staff were suitable and qualified for the role they were being appointed to and not putting people they care for at risk.

We looked at the ways the home managed risks to people. We saw individual risk management plans were in place to keep people safe and actions needed to minimise risks to people's safety had been identified. For example, we saw that risk assessments were carried out when people were at risk of falling. Where the risk of falling out of bed had been identified for one person, a specialist bed with crash mats at the side of the bed, to reduce the risk of injury should a fall occur, had been provided. The registered manager told us that all of the bedrooms within the building were equipped with a movement sensor, which was used to try and manage risks as effectively as possible. These sensors were linked to pagers carried by the care staff and alerted them when people where mobilising. Carers told us that the system was very effective and enabled them to be responsive to people's needs. Comments included "If an alert goes off we go and check on people, staff can be responsive." The registered manager believed that the use of the movement sensors had helped to reduce the amount of falls that people experienced within the home. We discussed the potential impact of these sensors on people's liberty, especially if they were unable to consent to these. The registered manager told us that these could be turned off where they were not necessary. He advised that he would ensure that information about the use of sensors in people's best interests was recorded in their care records.

Accidents and incidents were also reported. The registered manager maintained an incident and accidents folder which contained any incident forms which had been completed by the staff. These were reviewed to identify ways of reducing risks to the person as much as possible. A monthly falls meeting was held and within these meetings fall audits were reviewed. The registered manager told us that where necessary people were referred to the falls service for extra support and guidance. We reviewed the incidents and accidents folders but saw that there were more falls recorded in the folder than had been identified on the audits. For example in November 2016 the audit identified that two falls had occurred, although there were four records of falls. We discussed this with the registered manager who advised us that this may been have due to an issue with regards to the inputting of information into the computer system and that he had subsequently received training in how to do this correctly. Despite this we found that the number of falls occurring at the home was relatively low and the home were proactive in attempting to mitigate against the risk of falls. We heard staff discuss with a relative about appropriate footwear for a person to reduce the risk of them falling.

We looked at the administration and recording of medicines. We spoke with the unit manager who had been administering medication. They demonstrated a good understanding of the safe handling of medication. Medicines were stored safely in line with requirements in locked trolleys and in a room with a separate controlled drugs cupboard. Room and fridge temperatures were recorded daily. Most medicines were dispensed in monitored dose blister packs. All storage was neat and tidy. All staff with responsibility for administering medicines had received the appropriate training and undertook regular medication competency assessments. Medicine audits were carried out on a monthly basis to ensure the records were properly completed.

The administration of medicines was recorded including the administration of creams as part of people's personal care We reviewed the medication administration records (MARs) of four people. We found some minor short falls in the recording of medicines administration. For example we noted that medication instructions had been handwritten on one of the MARs and had not been signed or countersigned to confirm the recorded instructions were correct. However MARs confirmed people received their medicines as prescribed.

Some prescription medicines contain drugs that are controlled under the misuse of drugs legislation; these medicines are called controlled medicines. We inspected the controlled medicines register and found all medicines were accurately recorded. Arrangements were in place to ensure consistent administration of medicines prescribed to be given 'as required'.

The provider demonstrated that risks to individuals and the service were managed so that people were protected. We saw that a fire risk assessment had been completed December 2015 and was now due for review, the operations director told us that this review was planned. Each person had a personal evacuation plan which showed the support that they would need in the event of a fire. A home emergency plan was also in place in the event of an emergency which required an evacuation of the home. The home employed a maintenance person, who we spoke with. We saw from the records that he completed various daily, weekly and monthly checks to ensure the safety of the premises was maintained. These included water temperatures, bed rails checks, electrics and other equipment. We saw that health and safety meetings were held on a regular basis.

In the main the home was clean and free from unpleasant odours. However we found that an area within the first floor dining room was not visibly clean. We also found that the area was cluttered with various items, which could make it difficult to clean effectively. We raised this with the registered manager who told us that domestic staff had been affected by staff sickness, but the home was being supported by a sister home. The dining room was due to be decorated the following week as part of the home's current refurbishment plan. The registered manager arranged for the area to be deep cleaned the following day. We also pointed out to the registered manager that we had noted an opened tin of food which had not been stored appropriately in the fridge. He agreed to address this straight away.

Good

Is the service effective?

Our findings

People and their relatives said "I've no complaints" and one relative described the home as "Brilliant."

We looked around the home and found the environment to be conducive to the needs of the people who lived there. The home had undergone a refurbishment plan, which was near to completion. A coffer bar area had been created, along with a new kitchen/dining area and a cinema screen had been installed into one of the lounges. A reminiscence room was being completed and the upstairs dining room was due to be decorated the following week. New furniture was on order and there was also a newly installed hair salon. Rooms were bright and decorated to a good standard. People had been encouraged to bring in personal items from home and many rooms were personalised. We saw that attention had been given to the environment to support people living with dementia. For example toilet doors were painted bright yellow, to enable people to identify them more easily.

Staff spoken with had the knowledge and skills needed to carry out their roles effectively. New staff completed an induction which was based on the Care Certificate. This certificate has been developed by national health and social care organisations to provide a set of nationally agreed standards for those working in health and social care. Staff told us that they had completed an induction and this had included working alongside more experienced staff, until they were confident and competent to work unsupervised. We saw that staff worked through a comprehensive workbook within their probationary period and were assigned a mentor to offer advice and support.

We examined training records which were recorded electronically. These demonstrated that training was provided through e-learning, as well as face to face training sessions in subjects such as moving and handling and fire safety. The e-learning covered a number of areas including safeguarding, The Mental Capacity Act (MCA), equality and diversity and health and safety. Staff told us that they undertook training and we saw that people were in the main up to date with their training. Some staff commented that they did not always find that e-learning was the most effective type of learning for them. The registered manager told us that he had identified areas where staff could benefit from further training and had planned some face to face sessions using the new cinema screen. Staff had also been supported by some training sessions from the local later life memory service.

Staff demonstrated skills in supporting people living with dementia. We observed that staff engaged in positive conversations and saw an example where a member of staff distracted a person with skill and humour when they became anxious about whether they should pay for their lunch. We saw another example where a staff member supported a new person to the home who was worried about returning home. The staff member spoke reassuringly and supported the person to explore the building, which effectively calmed the person.

We spoke with staff and asked them about staff supervisions and annual appraisals. Staff told us that supervisions were conducted by the registered manager or clinical lead. These meetings were arranged

twice a year or more often if required and provided staff with the opportunity to discuss any issues. We saw evidence of these meetings in the three staff files that we looked at, these files also identified that performance and capability issues were addressed and managed as appropriate.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We discussed the requirements of the MCA and the associated DoLS with the registered manager, who was aware of these requirements and showed us that policies were in place. We saw that the manager had a monitoring form to record those people for whom a DoLS application had been made. At the time of our inspection, DoLS applications had been made for all of the people living at the home and they were awaiting assessment by the supervisory body (the local authority).

Staff demonstrated an understanding of the MCA and that decisions may need to be made in a person's best interests. We saw that mental capacity assessments had been completed appropriately and recorded in people's care plans. The records also demonstrated that staff understood the principles of the MCA. We saw that consent and capacity to consent were taken into account within each of the care plans. For example staff had recorded in one person's care plan that the person was able to understand simple instructions and that staff should attempt to gain consent for personal care. Where people were unable to provide consent due to not having the capacity to do so, staff were clear that best interest decisions should be made. One staff member advised us that she had requested a best interest meeting regarding a person's care needs to ensure that their health was maintained but also to ensure that their wishes were taken into account. Other comments included "Some people lack capacity but we still ask people questions and give them choices."

Meal times were a pleasant experience for people. There were clean table cloths and tables were laid out nicely with flowers. Drinks of squash and water were available for people. We undertook a SOFI (Short Observational Framework for Inspection) during lunchtime within the residential unit. We observed that people received the appropriate level of support from staff. During this time we saw that carers were available at all times and provided sensitive support to people. A member of the catering team also supported the staff and served lunch from a heated trolley. We saw that people were able to choose where they would like to eat their meals, with some people preferring to eat in the lounge or their bedroom.

The registered manager told us they had employed a new chef at the home and he had been asked to focus on the quality of the food. Recent feedback from people and their relatives had highlighted that the quality of the food could be improved. A further "food for thought" survey had been issued and the responses were currently being collated. The registered manager told us that a new menu was due to be implemented which had been developed by the organisation for its nutritional content. There was a choice of food available at lunch and tea and alternatives were also available. We saw that new daily menus had been delivered and these were due to go out into the dining rooms. Feedback during the inspection highlighted that the amount of food provided was sometimes insufficient to always enable people to have a choice. Staff told us that on occasions people may change their mind but there wasn't always enough food prepared to allow for this. We shared this with the registered manager who told us that he would address this issue.

Records demonstrated that people's weights were monitored and actions taken if people were at risk of losing weight. During the inspection we saw that one person had refused breakfast and that staff ensured that they continued to offer food on a regular basis in case the person changed their mind. Staff had good knowledge of people's individual support needs and preferences around food and drink. We spoke with a carer who had a clear understanding of the support that people required, she knew for example who required a diabetic diet and that one person required finger foods.

People living at the home had access to a range of health professionals. The registered manager and staff at Ferndale Mews sought support from outside health care agencies, for example the local later life memory service undertook a weekly visit to the home to help ensure that the correct care and support were provided to the people living there. The registered manager told us that he believed that links with other organisations were important to promote good practice. He informed us that the home benefitted from support from the local medicine management and care home liaison team. We saw from people's records that advice was sought from a range of professionals including dieticians and speech and language therapists. We also spoke with a visiting health professional who felt that the staff appeared knowledgeable about the people that they were visiting and provided good information in a helpful manner.

Good

Is the service caring?

Our findings

People and relatives we spoke with told us that staff and management were very caring. One person said, "They are very kind and very caring." Relatives told us "You're made to feel welcome" and "It seems to be a happy environment."

We found that the atmosphere in the home was calm, relaxed and sociable. During the inspection we observed how well staff interacted with people who use the service. We heard that staff were kind and caring in the way that they approached people. We observed one carer supporting a person and they demonstrated great patience. The carer spent time sitting with the person and their approach effectively calmed and reassured the person. The staff we spoke with understood the importance of providing support in a compassionate manner. One staff member commented "I treat people like they are my own family."

There were a number of thank you cards and compliments about the service available to read. Some of these were very complimentary about the care that people had received. One comment included "We are so grateful for the dignity and compassion you have shown." Relatives and visitors spoken with told us that they were able to visit at any time and were made to feel very welcome.

It was evident that positive caring relationships had built between staff and people. We saw that staff were laughing and joking with the people. One person and their visiting relative told us how one of the carers was "their favourite". We spoke to staff to see how well they knew the people living in the home and they demonstrated that they had a lot of knowledge about the people and their likes and dislikes. They were able to tell us about people's individual care needs. For example a staff member clearly knew people's specific dietary needs. Another member of staff was able to tell us about a person's preferences and that they sometimes liked to get up later in the morning. We spoke with a visiting health professional, who advised us that the staff seemed to know the residents "very well."

We found that staff ensured that people's dignity and privacy were maintained. People were treated with respect. We observed that staff knocked on people's bedroom doors before entering and ensured that doors were closed when carrying out personal care. A relative explained how staff had ensured that their relative was supported to wear their best clothes for a recent trip out. We observed that people were well presented and smartly dressed, for example one person liked to wear a shirt and tie and staff had supported him to dress in this way. Staff told us that maintaining dignity was promoted by the management. Where any issues had been identified regarding staff approach, we saw that this was appropriately addressed by the management. A member of the management team told us "We would pick up on staff if they didn't treat people with dignity."

We found that people were given information in a way that they were able to understand. For example, we saw that a member of staff offered a person living with dementia a choice at lunch time because the person found it difficult to understand the choices available. The staff member brought the choice of food available to show the person which helped them to understand and make a choice. Information and advice was available in written format at the entrance to the home and on notice boards. This included information

about how to make a complaint and how to provide feedback on the home. A residents' guide was available, although within a recent residents' and relatives' meeting some people highlighted that they had not received this guide. We spoke with the relative of a person who had recently moved into the home, who told us that staff had been very helpful and had provided them with lots of information.

Information about people living at Ferndale Mews was kept securely in a locked office to ensure confidentiality. We saw that staff took active steps to maintain people's confidentiality. There was a white board in the office where information about people was recorded by staff. This board was covered by a blind when not in use, to ensure that information could not be easily viewed through the office window.

Requires Improvement

Is the service responsive?

Our findings

Feedback received confirmed people were generally of the view that the service was responsive to individual needs. People told us, "It's a lovely place," and "I've no complaints"

The registered manager told us that the provider was in the process of implementing new documentation and staff were reviewing all of the care plans. The care records we reviewed included care needs assessments, risk assessments and care plans. We found overall that these reflected how people would like to receive their care, including their individual preferences. For example we saw in one person's records that staff had included that the person preferred to undertake some aspects of their own personal care. We also saw other preferences recorded such as, not liking a bath.

The care plans included information covering personal care, mobility, continence, communication, social activities, sleeping and rest and medicines. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care and the Malnutrition Universal Screening Tool (MUST). When risks had been identified, there were appropriate risk assessments in place that detailed the identified risk and the action that needed to be taken to minimise the risk. We saw that pressure relieving mattresses and cushions were in use where identified. We also found that the care plans included details of how to support people to communicate their choices and wishes, for example one person's records stated that they required options to be offered a few times to support them to make a choice. Other examples included offering someone the choice of clothing each day.

However, we found one care plan which was not as person centred and had not been reviewed as regularly as the others. The registered manager demonstrated that he was aware that certain care plans needs needed to be reviewed, especially within the residential unit. We saw that audits of the care plans had been undertaken and the issues identified during the inspection had already been identified by the management team. Actions were being taking to address these issues. Training was being planned to support staff with documentation and the completion of care plans.

Staff told us that a "resident of the day" system had been introduced, which meant that a member of the nursing staff was responsible to ensure that the person's assessments and care plans were reviewed and updated on a monthly basis, as a minimum.

Staff were knowledgeable about people's care needs and how people liked their care to be provided. Staff confirmed that they had read people's care plans and were kept up to date with any changes to people's care through a daily meeting. One staff member told us that during these handover meetings information was shared, for example about any new admissions to the home. She explained "We read out of a new person's care file today with the nurse."

Each person also had a person profile record, which was kept in their bedroom. This provided person centred information and included details such as what people enjoyed and "Important things about my

life."

We found that previous issues had been raised by some relatives about their lack of involvement with care plan reviews. We saw that the registered manager was taking action to address this. He had developed a folder to monitor the reviews undertaken and was ensuring that families were invited to take part in these reviews. We saw that letters of invitation had been sent out to relatives regarding upcoming reviews. Care plans inspected showed that relatives had been consulted with. Relatives spoken with told us, "They talked about his care when he first came in," and told us that they were kept up to date with any changes to their relative's needs. Comments included, "They tend to ring me with any changes" and "They have a review, I've seen the care plan and been involved."

We looked at documents in the bedrooms of the people living at the home. These included charts for positional changes, personal hygiene and bed rails checks. The majority of these were completed accurately but we found that there were some gaps in the recordings and one of the charts we sampled had not been completed at the time the care had been provided. For example we saw that a person required two hourly positional changes, a positional change had been recorded at 9.30am but there were no further record of another change when we reviewed the person's records at 12.50pm. The person's personal hygiene record had also not been completed on the morning of the inspection. Staff told us that the person had received this support and we observed that they appeared clean and comfortable, however this had not been accurately recorded in the person's records. We saw from recent staff team meetings that this issue had been raised and staff had been reminded of the importance of accurate recording. We discussed this with the registered manager who told us that he was monitoring the situation and addressing any staff performance issues.

We saw that there were some activities available to people but this was an area which needed to improve further. During the first day of the inspection we found that there were no activities taking place. Staff chatted and interacted with people but we saw that people for the majority of time sat in lounges with little to occupy them. On the second day, an outside organisation visited and people took part in an armchair exercise session. We saw that people were smiling and joining in with the singing. However, staff spoken with told us that they felt activities and stimulation for people living at the home could be improved. One person living at the home told us "There's not a lot going on." We discussed this with the registered manager who told us there were some social opportunities for people and we saw that the local rugby team visited the home on a weekly basis. The home also had access to a minibus and people occasionally went out on trips. People's religious and spiritual needs were assessed on admission. There was a local church nearby and the vicar visited the home to undertake church services.

The registered manager was already aware that work was required to improve the activities and had a vision of how he would like these to be developed in future. He told us that the new reminiscence room would be offer opportunities for stimulation when it was completed. There was an activities coordinator role within the home, but unfortunately the coordinator was currently absent from work. The registered manager told us that he had plans to extend the role to include activities during the evenings and at weekends.

We found that the management acted on information received about the quality of the care. A residents' meeting had been held in September 2016 and representatives from the local authority's quality assurance team and Health watch attended the meeting. We saw from the minutes that a number of issues had been raised about the quality of the care. Some of these included concerns about the laundry, the quality of the food, communication, activities and input into review meetings by people's relatives. We saw that the provider had taken steps to address these concerns and had implemented an action plan. Relative feedback called "What you told us and what we have done" had been produced and feedback provided

about the actions that had been taken. Further relatives' meetings had been held and another meeting was arranged for January 2017. One relative told us that the care provided was "generally good" and that things "had gotten better since the end of last year."

The provider had a complaints procedure in place, which was on display in the reception at the home. We saw that the registered manager had a system for logging any complaints, which were documented with any actions taken to resolve them.

Good

Is the service well-led?

Our findings

We found that the service was well–led. People told us that they knew who the manager was and found that the management team were responsive. We saw that the registered manager was visible and accessible. Staff comments included "I always feel really supported at work" and "I'm happy to come to work."

We saw that suitable management systems were in place. The registered manager was registered with The Care Quality Commission (CQC) and understood his responsibilities. He was well supported by a wider team, including an operations director, clinical lead and unit manager. The registered manager was available throughout the inspection and engaged very positively with the inspection process. We found that the management team were friendly and approachable. Documentation was available on request throughout the inspection.

The registered manager told us that he had focused upon improving the experience of the people living at the home and aimed to continue to make further improvements to the quality of the care. It was evident that work had been carried out to improve the way that the home was organised and the recruitment of staff had been a priority. Staff were positive about the registered manager and told us they believed the home was being well managed. They said the management were very supportive and that the home was much more settled now the registered manager was established. Comments included "I love it here, the staff are fantastic, we're a really good team,"; "He (the manager) listens, if something needs doing he has pushed for it" and "It's a good unit and a good team. We work well and there's good communication."

People and their relatives were also very familiar with the management team. People spoken with said that they felt able to raise any concerns with the management and staff. One relative told us that they were had planned to see the manager on the day of the inspection and said they felt comfortable to raise any issues with him. The registered manager told us that he operated an open door policy and generally stayed at the home into the evening to enable visitors at this time to speak with him if necessary. His office was based in the reception area which meant that people could easily locate him.

The management at the home had processes in place which sought people's views and used these to improve the quality of the service. We saw that surveys had been undertaken including food surveys and relatives' feedback surveys. As discussed in the responsive section of this report, action had been taken as a result of feedback received.

The provider had an effective system to regularly assess and monitor the quality of service that people received. We saw that numerous regular audits had been completed by the registered manager and other staff. Audits were carried out in the areas of infection control, care records, medication and health and safety. We saw evidence that a monthly "key care indicators" report was produced, which reported on areas including infections, wounds, and weight loss. The operations director told us that a new dashboard system was being implemented in January 2017 which meant that that a more detailed and effective report would be produced to measure the quality of the care provided.

Each month a formal quality assurance visit was carried out by the assistant operations director (AOP).We saw records of the most recent visit whereby the AOP had completed a thorough audit of all areas of the home and assessed their performance. Areas audited included whether people looked well cared for and the quality of the staff interaction. We saw that this supported the registered manager to highlight any areas for improvement and actions plans were developed from these audits.

Various staff meetings were held, which included full staff meetings, health and safety meetings and falls meetings. The minutes of the full staff meeting in November 2016 showed that the topics discussed included standards of care, documentation, keyworker system and mobile phone policy. They demonstrated that the registered manager had set out his expectations of staff and included discussions around the quality of the care provision. Meetings had been held on a monthly basis. Staff told us that these were effective in addressing and discussing any concerns. One member of staff said, "We had a team meeting which addressed a lot of issues."

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. CQC check that appropriate action has been taken. Our records indicated that all notifications had been submitted appropriately in line with CQC guidelines. Although we noted that we had not received one notification for a DoLS authorisation, the registered manager's records suggested that one had been submitted. The registered manager was aware of his responsibility to inform CQC as required.