Anchor Trust

Ashcroft Nursing Home - Bradford

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
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?	Requires Improvement

Overall summary

Ashcroft Nursing Home provides accommodation and personal care for up to 72 older people at any one time. The home is spread over three floors and set in its own grounds. On the date of the inspection, 12 November 2014, 54 people were living in the service.

At the last inspection in May 2014 the home was in breach of Regulation 9, Care and Welfare and Regulation 22, Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We undertook this inspection to check the required improvements had been made.

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

Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People spoke positively about the care received in the home and said improvements had been made over the last few months. We found the home now employed more staff which meant they could provide a consistent level of staff for each shift. Staffing levels were now sufficient to meet people's individual needs.

We found improvements had been made to the level of care and support provided. Care managers were in place to oversee care on each of the units and they reviewed people's care and support to ensure it was meeting their needs. Although we found improvements had been made to the care and support people received, we found the care people received was not always robustly documented. For example charts monitoring people's fluid intake were poorly completed on the nursing floor and records of the topical medicines people received were not always consistently documented.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

People were protected from abuse, because staff had received appropriate training and understood the actions needed to protect people. Risk assessments were in place which considered the risks to each person and how to manage those risks in order to keep them safe.

Medicines and the premises were managed safety.

The home was meeting the requirements of Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made and the conditions of the authorised orders were followed to ensure any restrictions of people's freedom were kept to a minimum. Staff understood the requirements of the Mental Capacity Act (MCA) and we saw evidence the act had been followed, which helped to ensure people's rights were protected

People spoke positively about the food on offer and we saw people were given sufficient choice. Staff understood people's individually nutritional needs in order to provide appropriate support.

People who used the service and their relatives told us that staff were kind and considerate. We observed care and saw staff treated people well. It was evident that staff understood the people they cared for which helped them to provide appropriate care.

A range of activities and social opportunities were on offer which included a regular activities programme run by the activities co-ordinator, trips out and links with the local community. People spoke positively about the activities on offer.

The service had a robust improvement plan in place, and we saw evidence this had helped to achieve a range of improvements to the service over the last few months. A range of audits and other checks on the quality of the service were undertaken to allow the service to continually improve. However, further improvements were required to the quality assurance system to drive improvement in the completion of care records. The service needed to ensure that all improvements were completed and these were sustained over time before we could be assured that the service was well led.

Summary of findings

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. People were protected from the risk of abuse. Staff understood safeguarding and how to identify and raise concerns. Safeguarding incidents were thoroughly reported and lessons learnt put in place to protect people from harm.

Where risks to people's health, safety or welfare were identified, risk assessments were put in place to protect people from harm. These were regularly updated as people's needs changed. Staff understood the key risks associated with the people we asked them about.

Staffing levels were sufficient to meet people's individual needs. Since the last inspection, more care staff had been recruited and more staff were now on duty. We found call bells were answered promptly and staff were visible

Is the service effective?

Good

The service was effective. The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The home was meeting the requirements of DoLS, appropriate applications had been made and the conditions of the authorised orders were followed. Staff understood the requirements of the Mental Capacity Act (MCA) and we saw the act was followed in assessing people's capacity where decisions needed to be made.

Staff were provided with a range of mandatory and specialist training. Staff we spoke with understood the topics we asked them about indicating the training was effective. Staff understood the people they were caring for which helped ensure effective care was provided.

People told us the food was good and they were given sufficient choice. Systems were in place to ensure people were provided with food which met their individual needs.

Is the service caring?

Good

The service was caring. People and their relatives all said that staff were kind and considerate and treated them with dignity and respect. This was confirmed by our observations on the day of the inspection, which showed staff were attentive, listened to and respected people.

Care plans considered people's life history and what was important to them. This showed staff had taken the time to understand people which helped them deliver personalised care and support.

Advocacy services were available and we saw evidence people had been appropriately supported to access advocacy services to ensure they were provided with support where decisions needed to be made.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Records detailing the care people had received were not consistently documented. For example food and fluid charts were poorly completed on the nursing floor and records of people's pressure area care and application of topical medicines was not consistently completed. This meant the service could not always provide evidence people had received appropriate care.

Care was responsive to people's changing needs. We saw evidence that care packages were regularly reviewed and changes made following changes in people's health and welfare or on advice from visiting health professionals.

People spoke positively about the activities on offer. We saw a range of activities and social opportunities were available including trips out and links with the local community such as schools and churches. This helped to provide people with meaningful activity and social contact.

Is the service well-led?

Requires Improvement

The service was not consistently well led. Systems were in place to drive improvement within the home and we saw evidence that the quality of the service had improved in a number of areas since the last inspection. However, further improvements were required to the quality assurance system to ensure action was taken to address the issues we found with the quality of care documentation. The provider would also need to evidence that the improvements made to the service were sustained over time; before we were assured that the service was well led.

Audits were in place which monitored the quality of care people were provided with. Where issues were identified action had been taken to address and improve outcomes for people.

A clear staffing structure was in place and staff were aware of their responsibilities and how to raise issues or concerns. Staff spoke positively about the registered manager and told us how the culture had changed for the better recently, they felt more able to raise concerns and suggest ideas for improving the quality of care.

Ashcroft Nursing Home - Bradford

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, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 12th November 2014 and was unannounced. The inspection team consisted of three adult social care 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.

We used a number of different methods to help us understand the experiences of people who used the service. 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 with us. We spoke with 13 people who used the service, seven relatives, nine members of staff, the newly appointed registered manager and the regional support manager. We spent time observing care and support being delivered. We looked at nine people's care records and other records which related to the management of the service such as training records and policies and procedures.

We did not ask the provider to complete 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. Before the inspection, we reviewed all the information we held about the provider. We contacted the local authority safeguarding team and local healthwatch organisation to ask them for their views on the service and if they had any concerns. As part of the inspection we also spoke with two health care professionals who regularly visited the service.

Is the service safe?

Our findings

All the people we spoke with told us they felt safe in the service and nobody raised any concerns with us. For example one person said, "Oh yes I feel safe" and another person said "They are very good to me."

People who used the service were protected from the risk of abuse. Staff demonstrated a good understanding of safeguarding and how to identify and report abuse. We saw staff had received training on the subject, and safeguarding was an agenda item on staff meetings to ensure the topic was frequently discussed. We looked at how safeguarding incidents had been managed. Risks were escalated appropriately depending on the severity of the concern, for example some incidents had been investigated by the regional manager or the safeguarding and governance officer. Where concerns were identified, the local safeguarding agency had been correctly informed. Investigations contained clear lessons learnt/ recommendations to reduce the risk of re-occurrences and keep people safe.

Risk assessments were in place which assessed the risks to people associated with their care, such as falls, nutrition and skin integrity. Risk assessments were updated monthly and where risks to people were identified, plans of care were put in place to reduce the risk to people. This helped to keep people safe. Staff understood the key risks to the people we talked to them about and the strategies and intervention necessary to keep them safe.

At the last inspection we found there were not sufficient quantities of appropriately skilled and experienced staff. Previously the service had a number of vacancies and struggled to get enough staff to consistently cover shifts. There was also a large use of agency staff, who did not always know people and their individual needs. The service had put in management plans to address this and at this inspection we found improvements had been made. In terms of care workers, we saw the home had successfully recruited and was now fully staffed. We looked at rotas which showed staffing levels were now consistent and there was a marked reduction in agency staff. Staff we spoke with were familiar with people and their needs. The home was still using some agency nursing staff but they had block booked individuals from the agency, to ensure the same staff were used who were familiar with people's needs. We spoke with an agency nurse who demonstrated a good understanding of the people they were caring for indicating these procedures were effective. The home was in the process of recruiting six further nurses to eradicate the use of agency staff altogether. Rotas showed that nursing hours were carefully planned and consistently provided. The staff we spoke with confirmed that the staff group was now more consistent and settled. The consistency of staff allowed staff to better understand people's individual needs.

We saw staffing levels were sufficient to meet people's needs. Staffing levels had been increased since the last inspection as part of the provider's action plan to ensure people's needs were met. During the day there were now five care workers on both the residential and nursing units, which was an increase from the four on each floor at the last inspection. Our observations concluded that there were sufficient staff for example to ensure call bells were answered promptly and the staff we spoke with told us they felt there were enough staff and they were under less pressure now. Two care managers were now in place to oversee care on each of the units and staff told us this had been beneficial in better organising the units. There were sufficient quantities of ancillary staff such as cooks and cleaners and an activities co-ordinator was employed to provide meaningful activities for people. People who used the service, their relatives and staff all confirmed that staffing levels had improved, for example one relative told us, "It's getting better – there are more staff and not so many new staff. It's changing for the better."

We found medicines were safely managed and administered. Medicines were administered by trained nurses or care staff with the appropriate training. Staff checked medication prior to administration to ensure people were receiving the correct medication. We looked at medication administration record (MAR) sheets. Records were maintained for medication which was not taken and the reasons why. We saw that the medication records did not have any gaps in the signatures, showing that medication had been given correctly and on time. We saw that where medicines needed to be administered before meals this was the case. We asked staff about the safe handling of medicines to ensure people received the correct medication. Answers given demonstrated that the staff member knew of the correct procedure. Appropriate procedures were in place to ensure medicines were ordered on time and safely disposed of.

Is the service safe?

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The giving of the medicine and the balance remaining was checked by two appropriately trained staff.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given. Staff demonstrated a good understanding of the protocols.

We saw one person was receiving their medicines covertly. We scrutinised the persons care records to determine whether the giving of these medicines was within the legal framework as described in the Mental Capacity Act 2005 (MCA). The covert administration of medicines was taking place in the context of existing legal and good practice frameworks and as such was protecting the person concerned and the care home staff administering the medicine.

In a second person's care records it was recorded they received their medicines covertly. Whilst we saw evidence of a mental capacity assessment the authorising letter from the GP only made reference to disguising the taste of the medicine to make it more palatable. Nowhere in the letter did it mention covert medicines. We witnessed medicines being administered disguised in juice. The member of staff asked the person if they would like to take their medicines and the person clearly consented, therefore on this occasion the medicines were not given covertly. This meant there was a discrepancy between the homes interpretation of the GP's letter as stated in care plan documentation and the practice we witnessed. However, we saw no evidence this had resulted in harm to the person. We spoke with the regional support manager who said they would, without delay, seek clarification.

The premises were safely managed. A "handy man" was employed who managed the maintenance of the premises and conducted safety checks for example on water temperatures, fire equipment and lifting equipment. A maintenance log book was in place for staff to report issues and we saw evidence these were promptly actioned to keep the premises safe. We looked around the building and found the premise was homely, for example people's room were full of personal possessions. There was adequate communal space for a range of activities and eating and drinking. The décor was tired in a number of areas of the building such as the corridor on the residential floor, but we saw plans were in place to refurbish these along with adapting additional space to make it more suited to the people's needs.

We looked at four staff files. We saw robust recruitment procedures were in place. This included ensuring a DBS (disclosure and baring service) check and two references were obtained before staff commenced employment. Staff attended a formal interview and completed a competency assessment before being offered a position with the organisation. We spoke with three new members of staff who confirmed they had to await the relevant checks before they started work which showed the recruitment procedures were being consistently applied.

Robust disciplinary procedures were in place and we saw evidence that where concerns had been identified about staff members appropriate action had been taken to keep people safe.

Is the service effective?

Our findings

People told us they received good care and support and that staff carried out their duties effectively. People's comments included; "They are good here and there is plenty to eat" and "We are looked after very well. If you want anything just ask."

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. We were told that two people using the service were subject to authorised deprivation of liberty and a further five applications had recently been made. Our scrutiny of people's care records demonstrated that all relevant documentation was completed. The registered manager and regional support manager demonstrated a good understanding of the safe application of DoLS. We saw evidence of best interest meetings held with family members and health care professionals where people using the service lacked capacity to make their own informed decisions. This showed the correct procedures had been followed to protect people's rights.

The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions where appropriate. We saw these were valid and completed properly. Staff understood the need to ensure DNACPR forms accompanied people to hospital. Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes or their best interests.

We observed staff caring for people throughout our visit, and saw that they asked people where they wanted to go and what they wanted to do. Care staff did not carry out any care or treatment without first explaining the process to the person and wherever possible, obtaining their verbal consent. All staff with whom we spoke had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff we spoke with had a good understanding of these subjects. This meant that staff understood how to protect people's right to make their own decisions wherever possible.

People said the food was good and they had adequate choice. For example one person said "We are very lucky the food is always excellent and well cooked." Another person said, "The food is very good and there is always a choice at mealtimes. I look forward and enjoy every mealtime." A third person said, "It's all right. The meals are fine and you tell the girls if you're not happy." We observed the breakfast and lunch time meals in the home. Staff were patient in explaining choices to people to aid their understanding. Food was served in an unrushed manner in a pleasant atmosphere. People were asked if they had enough food, for example we saw one person was served a second breakfast following their request. People were given a choice of two lunchtime meals. We observed an alternative meal was made for one person who did not like the two choices available, showing the food service was flexible in order to meet people's needs. People who had difficulty recollecting what each meal consisted of were shown both choices to enable a visual prompt of what the choice was. We saw people received the assistance they needed and staff gave this assistance in a sensitive and dignified manner. However we noted one case where the help a person required to eat as demonstrated in their care plan was not followed. We saw that although the person should have been assisted to eat with a tea spoon a fork was used. Throughout the day we saw people were encouraged to take drinks and snacks such as biscuits and cakes and fresh fruits.

We saw food dietary record sheets were completed on a weekly basis for everyone who used the service. The record sheets showed people's dietary needs and preferences, any special dietary requirements and any food allergies they might have. We saw the record sheets were used by staff at mealtimes to ensure people received the correct meal. We spoke with the chef on duty and they had a good understanding of individual people's dietary needs which helped to ensure they were met. The chef confirmed that the catering staff worked closely with the nursing and care staff to make sure people received sufficient to eat and drink.

Where people were at risk of dehydration or malnutrition this was identified through the nutritional risk assessment process and control measures put in place. This included seeking professional advice and fortifying food. As part of this some people's food and fluid balance was recorded to ensure they were eating and/or drinking sufficient quantities.

Staff reported training was good and provided them with the necessary skills to undertake the role. The staff we spoke with had a good understanding of the topics we

Is the service effective?

asked them about indicating the training system was effective. We saw training consisted of a mixture of face to face and e-learning training and was tailored to individual staff's role and responsibilities. This included moving and handling, health and safety, dementia, fire, food safety and infection control. Induction training was in place, this included new staff shadowing more experienced members of staff for a two week period to help them develop the required level of skills and knowledge. We saw evidence this had been completed for new starters. Where agency nursing staff were used, an agency induction was completed to ensure they knew the correct ways of working. Specialist training such as pressure area care and palliative care was given through health professionals and plans were in place to provide challenging behaviour training in December 2014.

Staff demonstrated a good understanding of people's healthcare needs and the support they required. For example we observed staff assisting a person who required their entire oral intake via a syringe. We saw that the assistance took place in an unhurried and patient manner with constant dialogue from the care worker giving encouragement and praise to prevent the risk of choking. Care plans were in place which provided staff with guidance on how to meet these healthcare needs. Where specialist advice and input was required, we saw evidence the home referred people to health professionals such as district nurses, dieticians and their advice recorded for staff to follow. For example where a person had been identified as having swallowing difficulties, a referral had been made to a speech and language therapist and district nurses were regularly consulted regarding catheter care. We spoke with a visiting health professional who told us the service was good at following their advice and contacted them appropriately and pro-actively to ensure that appropriate care was provided. They told us that overall the care was good and had recently improved. People confirmed to us they had access to a range of health professionals such as chiropodists and GP's.

Is the service caring?

Our findings

People and their relatives said staff were caring, kind and compassionate. For example one person said, “The girls are kind. I’m happy.” Another person said, “I could have not chosen a better place to live, the home is clean and comfortable and the staff are friendly and always there if you need them.” A relative told us, “The staff are marvellous, really accommodating. They go the extra mile and are really good with mother. They involve me in everything, ring me all the time.”

We observed care on each of the three units of the home. We used the Short Observational Framework for Inspection (SOFI) to observe interactions and activities in the service. People were treated with dignity and respect. We saw staff interacted positively with people who used the service regularly asking them if they were ok and providing them with an appropriate level of interaction. We observed staff exerting a calming influence on people. For example, where people were displaying restless or agitated behaviour, we saw staff giving positive, thoughtful reassurance. We saw staff trying to distract people who became distressed with calming activities such as playing their favourite music and throughout our inspection staff were engaging with people on a one-to-one basis.

We saw staff had time to interact and chat with people and we saw good interactions from all staff groups for example the handyman, activities co-ordinators and receptionist all worked well together to provide personalised care and support to people.

People appeared very comfortable and all were well dressed and clean which demonstrated staff took time to assist people with their personal care needs. People spoke positively about the level of care and support provided by staff, for example one person told us, "I have new shoes on today and a new warm jumper."

People’s care plans showed how people liked to spend their time and how they liked to be supported. The plan also showed what people or their relatives had told staff about what provoked their anxieties and inappropriate behaviours. This meant that care could be provided in a sensitive way to avoid anxiety for people. Care plans focussed on the need to promote personal independence and dignity. The life history sections enabled care staff to engage in meaningful reminiscence therapy with people which may help those with dementia. People had communication plans in place which detailed how staff should communicate effectively with them and we saw staff had the skills and knowledge to provide personalised level of communicative support.

The care staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people’s dignity, privacy and independence. For example by always knocking on doors before entering their private accommodation, by encouraging people to make choices about their daily lives and always addressing people by their preferred names.

We found varied mechanisms were in place to listen to people and their relatives. People said they felt involved in the care and were invited to resident meetings and care plan reviews. Care plan reviews contained people’s comments and we saw these had been used to update care plans which showed they had been listened to. There were also comment books located on each floor to allow people to comment on their experiences in the home.

We saw people had access to advocates as required. We were told that one person had been appointed with an Independent Mental Capacity Advocate as defined in the Mental Capacity Act 2005. Whilst the person could not speak with us about the appointment it was clear that it was relevant as they had no-one who could be appropriately consulted when making a decision and they did not have the capacity to make that decision alone. The registered manager had information to enable them to support people who used the service to access advocacy services if needed.

Health and care services are legally required to make ‘reasonable adjustments’ for people with dementia under the Equality Act (2010) to ensure equal and fair treatment and promote independence. We saw that the provider had installed a passenger lift to enable greater freedom and mobility within the home. We saw that one person had the need to be seated with their legs elevated and the provider had made available a reclining chair with a leg elevator. One room had specifically been equipped with a ceiling mounted hoist to meet an individual’s specific needs.

Appropriate care planning had been put in place for those approaching the end of their lives. This included liaison with health professionals and anticipatory medicines put in

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place so they could be administered when the person required them. During the inspection we had the opportunity to talk with End of Life Educator for Care Homes who supports care home management and staff to achieve the Gold Standard Framework (GFS) in end of life care. They told us the registered manager and staff were working toward the award and were very enthusiastic about the training provided. The GFS ensures that people receive the best possible end of life care.

Is the service responsive?

Our findings

Clear care plans were in place to assist staff to delivering appropriate care. These included detailed pre-admission assessment documents which showed people's needs were assessed before they moved to the service. Care plans were then developed in areas such as personal care, skin integrity and moving and handling. These contained clear information to allow staff to meet people's individual needs, for example how to safely manage their urinary catheter. We observed that care plans contained specific information regarding the level of support people needed. This included information and guidance which related to the management of long term conditions, such as dementia, that affected their physical health, mood and behaviour. The care plans provided staff with clear guidance to follow when giving support and care. In some cases they identified triggers and warning signs to help staff recognise early signs of behavioural issues or deterioration in people's health and well-being. We saw evidence care plans were updated when people's needs changed for example staff had identified that one person was unable to communicate pain verbally anymore, so guidelines had been changed to assist staff.

However, the completion of records relating to people's care was inconsistent. We were provided with assurance through talking to staff that people were receiving appropriate care but this was not always consistently documented. On the residential floor, we found evidence people's continence and personal care was clearly documented, this showed people received regular checks and care was offered where appropriate. However, in one person records, their skin integrity care plan said they should receive two hourly pressure relief, but this was not being robustly documented. We also found pressure relief was not always documented on the nursing unit of the home.

In another person's records we found staff were meant to apply creams to their legs twice a day. Through discussions with staff, we were provided with assurance that this was happening but the completion of records indicating this had taken place was poor with no entries recorded on some days.

On the dementia unit, one person's care records said their legs should be kept elevated following advice from the district nurse. We observed that their legs were not elevated. Discussions with staff revealed that they encouraged leg elevation but the person refused to comply. However, this was not being robustly documented within the person's daily records or elsewhere.

Food and fluid balanced charts were in place where people were at risk of malnutrition and/or dehydration. We saw they were inconsistently completed, for example on the residential floor they were completed well, with fluid amounts tallied to monitor whether people were drinking enough. However, on the nursing unit we found the fluid intake charts completed by staff for some people who were at risk of not drinking sufficient fluids did not always contain accurate and up to date information. For example, the fluid intake chart for one person showed they had only taken 320mls of fluid in a 24 hour period. The records for another person showed they had only taken 360mls of fluid in a 24 hour period even though the day report for the same period stated they had taken a good diet and fluid intake with encouragement. This matter was discussed with the registered

manager who said they were confident that both people had received sufficient fluids but care staff had failed to complete the charts correctly.

In another person's care plan the information provided was not always accurate or up to date. For example, we saw the person was being treated for a pressure ulcer. However, the grade of the ulcer was recorded differently in different sections of the care plan. The manager acknowledged the care plan required updating to reflect this and to provide staff with accurate information and guidance. This was done during the inspection.

The quality of entries in daily records was also inconsistent with some staff writing very little. We were therefore not able to establish from some reports how the person had spent their day or if care and treatment had been provided in line with the care plan in plan. We brought the matter of poor record keeping to the attention of the registered manager who said they would immediately address these issues through training and supervision of staff.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We saw evidence people were weighed in line with the requirements in their care plans. This was audited monthly so management could assure themselves that people were

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being weighed on timed and look for any trends. We saw appropriate action was taken following the identification of weight loss, for example referral to the dietician or doctor, so that the cause could be investigated.

Care plan reviews were up-to-date, we saw the home worked to a planner to ensure that reviews were completed on time and all relevant areas of care were reviewed. Reviews clearly showed the involvement of people /and or their relatives and showed changes to people's care had been made. Where appropriate health professionals were involved in the review for example psychiatric nurses into emotional and wellbeing care plans. This helped to ensure they contained sound clinical advice to allow staff to provide responsive care.

We saw documented staff handovers took place. This allowed information on people's changing needs to be transferred from one shift of staff to the next and helped to ensure responsive care.

People's social needs were considered through the care plan process and a range of activities provided for them. People mostly spoke positive about the activities for example one person said they went the extra mile and took them to see their husband in another care home as well as taking them out for meals. Another person told us, "We play games and they fetch you in a wheelchair. I like reading and there's a library downstairs." One male resident told us activities were geared towards women, we saw the activities co-ordinator was aware of this and had plans to develop more male orientated activities. We saw staff tried to include everyone in activities for example by going around all the communal areas and asking people if they wanted to join in. We observed the activities co-ordinator in the main lounge playing games with people who were very engaged in the activity and clearly enjoying it. It was obvious that there was a good relationship in place.

We spoke with the activities co-ordinator who had a clear commitment to continuous improvement of the activities on offer. They showed us how they had instigated more trips out of the home , started a breakfast club to improve social interactions and plans were in place to develop this and one to one work with residents further through their network of volunteers. Plans to refurbish the building were based around providing more space for bespoke activities and the co-ordinator told us this would further improve the quality and variety of activities available.

The provider had a complaints policy in place which identified the procedure to be carried out when a complaint is received. Time scales were attached to each complaint denoting how quickly the complaint should be acknowledged as being received and a timeframe for completion of the investigation and response. We looked at two complaints received in the last five months and saw they had been appropriately handled and responded to within the timescales in the policy. People and relatives we spoke with said the registered manager was good and they had confidence they would deal with any issues raised.

Is the service well-led?

Our findings

The home had a registered manager in place who registered in September 2014. Staff and people who used the service spoke positively about the new registered manager and said they were, "Hands on" and they felt they could go to them with any problems or concerns. Staff told us morale had picked up in the service recently and they felt better supported. For example one staff member said, "There's been a real improvement in staff morale since [registered manager] came and staff are much more willing to help."

We found effective systems were in place to drive improvement within the home. A service improvement plan was in place which the provider was working through to improve all areas of care and support. The improvement plan provided a structured format to action improvements over set timescales. A number of improvements had been implemented such as increased continuity of staff, new equipment, more accurate care plans and an improved dining experience. Further improvements were planned such as to the premises and the implementation of a dependency tool to monitor and assess staffing levels. Staff told us they felt the standard of care had improved, for example one staff member said, "Improved lots over the last few months we have regular meetings to see where we are at, and address points." Relatives we spoke with also told us the standard of care had improved.

We also saw that the number of complaints about the service had reduced, further indicating that the service had improved; for example 12 complaints were received about the service in the first five months of 2014 and only two complaints over the five months immediately prior to the inspection.

Clear lines of reporting were in place. On each unit, care workers reported to a senior carer and a care manager was in place who oversaw the organisation of each unit. Care managers also covered shifts each week which allowed them to experience any issues first hand. A registered manager was in place and there was a clear escalation procedure to senior management. We saw staffing structures were clear and were provided to staff on induction so they were aware of the lines of reporting. Management were available at weekends and there was a clear on call procedure out of hours to ensure decisions were made appropriately in relation to care and support.

Support from specialists within the organisation such as dementia, safeguarding and service improvement were available and we saw evidence they had input into monitoring performance and overseeing action plans.

The registered manager and senior care staff undertook a range or regular audits as part of a system to assess and monitor the quality of care provided. For example care plans were regularly audited. These looked at a range of areas such as monthly weights, timely care plan review and involvement of health professionals. Audits in other areas such as the dining experience, manager's spot checks, and medication also took place as part of the quality assurance system. There was evidence these audits had identified a range of issues such as with completion of documentation and we saw evidence that actions had been put in place to address issued identified. The provider also undertook audits and inspections of the service. This was often with specialist input such as from the "care and dementia lead" to help to ensure high standards of care were maintained.

Although improvements had been made in a number of areas, further improvements were required to the quality assurance system to ensure that action was taken to address the care documentation issues we found. Alongside addressing these issues, the provider would need to provide evidence that the range of improvements made to the service were sustained over time to provide us with assurance that the service was well led.

A robust incident management system was in place and there was analysis of incidents to learn lessons. Incidents were analysed monthly for themes and trends. Information on incidents and complaints was analysed by the regional manager to provide appropriate monitoring of the home.

Mechanisms were in place to seek the feedback of people who used the service. The registered manager told us the provider was in the process of conducting the annual resident/relative survey which asked people how satisfied they were with the standard of care provided. We saw this was complimented by smaller surveys which had been done periodically throughout the year, for example we looked at a survey from August 2014, most respondents were very positive about the care rating it as good or excellent. Where issues had been identified such as lack of varied activities, we saw actions had been taken.

Periodic resident and relatives meetings took place to seek the feedback of people who used the service. We looked at

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recent minutes and saw people had been fully informed about improvements in the home activities and a consultation had been held on the refurbishment work. “You said we did” information was in place providing people with feedback about how the home had listened to them. This showed people had been involved in decisions in relation to the running of the home.

A range of staff meetings took place which provided a mechanism for performance issues to be discussed and staff to air their views. We looked at the minutes of a recent staff meeting which showed safeguarding, DOLS, MCA and dignity were discussed with staff. Team leader, management and quality meetings also regularly took place and we saw care performance was discussed at these meetings to drive improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information as an accurate record was not always maintained in relation to the care and treatment provided to each service user.