Acorn Lodge Limited

Acorn Lodge Care Centre

Inspection report

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Date of inspection visit:
05 April 2016
06 April 2016
07 April 2016
08 April 2016

Date of publication:
02 June 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 5, 6, 7 and 8 April 2016 and was unannounced on the first day. We told the registered manager we would be returning over the next few days. At our previous inspection on 17 January 2014 we found the provider was meeting the regulations we inspected.

Acorn Lodge Care Centre provides accommodation for up to 98 people who require nursing or personal care. At the time of our inspection 95 people were living in the home.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People and their relatives told us they felt safe using the service and registered nurses and healthcare assistants had a good understanding of how to protect people from abuse. Staff were confident that any concerns would be investigated and dealt with. All staff had received training in safeguarding adults from abuse and had a good understanding of how to identify and report any concerns.

People's risks were managed and care plans contained appropriate and detailed risk assessments which were updated regularly when people's needs changed. Staff worked with all people across all floors to ensure they were aware of the needs of each person. The service had a robust recruitment process and staff had the necessary checks to ensure they were suitable to work with people using the service. Sufficient numbers of staff were employed to keep people safe and meet their needs.

People who required support with their medicines received them safely from staff who had completed in-depth training in the safe handling and administration of medicines, which was refreshed annually. Staff completed appropriate records when they administered medicines and these were checked after each medicines round on the same day to minimise medicines errors.

There was a comprehensive induction and a six month probation period for new staff. Staff members also took part in a training programme to support them in meeting people's needs effectively. New staff shadowed more experienced staff before they started to deliver personal care independently and received regular supervision from management. They told us they felt supported and were happy with their input during the supervision they received.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff were aware of the importance of asking people for consent and the need to have best interests meetings in relation to decisions where people did not have the capacity to consent. The provider was aware when people had restrictions placed upon them and notified the local authority responsible for assessment and application.

Staff were aware of people's dietary needs and food preferences and provided support to those who required it during mealtimes. People had regular access to healthcare services as a GP visited six times a week and recorded information in a visit book. Registered nurses and healthcare assistants told us they contacted other health and social care professionals, such as occupational therapists and speech and language therapists, if they had any concerns about people's health. We saw evidence of this in communication books and people's care plans.

People and their relatives told us staff were kind and compassionate and knew how to provide the care and support they required. All staff understood the importance of getting to know the people they worked with and showed concern for people's health and welfare in a caring manner.

People were spoken with and treated in a respectful and kind way and staff respected their privacy and dignity, and promoted their independence. People were also supported to access independent advocates where necessary. Where appropriate, people and their families were involved in decisions about end of life care and staff were aware of respecting people's wishes and providing support at a sensitive time.

People were involved in planning how they were cared for and supported. An initial assessment was completed from which care plans and detailed risk assessments were developed. Care records were person centred and developed to meet people's individual needs and reviewed if there were any significant changes. People and their relatives were actively encouraged to express their views and were involved in making decisions about their care and whether any changes could be made to it.

People were supported to follow their interests and encouraged to take part in a range of activities to increase their well-being and reduce social isolation. Those who were unable to take part in group activities had plans in place to receive one to one support. There was evidence that cultural requirements were considered when discussing this and making sure these needs were met.

People and their relatives knew how to make a complaint and were able to share their views and opinions about the service they received. The provider listened to all complaints and made sure people were confident their complaints would be taken seriously. There were also surveys in place to allow people and their relatives the opportunity to feedback about the care and treatment they received.

The service promoted an open and honest culture and the registered manager and senior staff team were transparent in their discussions with us during the inspection. Staff spoke highly of the atmosphere at the service and the support they received from management. Staff were confident they could raise any issues or concerns, knowing they would be listened to and acted upon.

There were effective quality assurance systems in place to monitor the quality of the service provided and understand the experiences of people who used the service. The registered manager followed a monthly, quarterly and annual cycle of quality assurance activities and learning took place from the result of the audits. However the registered manager failed to notify the CQC about a safeguarding incident which is a legal requirement of the provider's registration.

We identified one breach of the Regulations in relation to notifiable events. You can see what action we told the provider to take at the end of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff had a good understanding of how to recognise and report any signs of abuse and protect people from harm.

Detailed risk assessments were in place to identify the areas of risk and to reduce the likelihood of people coming to harm. They were routinely reviewed annually and additional reviews were conducted if any significant changes occurred.

The provider took appropriate steps to ensure robust staff recruitment procedures were followed and there were sufficient staff to meet people's needs.

People received their medicines safely. Medicines were administered and recorded by staff who had received relevant medicines training which was refreshed annually.

Is the service effective?

Good

The service was effective.

People received care and support that met their needs and reflected their individual choices and preferences. Staff received the training and supervision they needed to meet people's needs and were passionate about their jobs.

Staff understood their responsibilities in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were supported to have a balanced diet, which took into account their preferences as well as medical and cultural needs.

Staff were aware of people's health and well-being and responded if their needs changed. People had regular access to a GP and other health and social care professionals, such as occupational therapists and speech and language therapists.

Is the service caring?

Good

The service was caring.

We saw that staff treated people with respect and kindness, and promoted their dignity and independence. People were encouraged to personalise their rooms to their liking and they told us staff were kind and compassionate.

People, and their relatives where applicable, were informed about their health and well-being and were actively involved in decisions about their care and support, in accordance with people's own wishes.

The service assisted people to access independent advocates. They also supported people and their families during end of life care.

Is the service responsive?

Good

The service was responsive.

Care records were detailed and personalised to meet people's individual needs so staff knew how people liked to be supported. The information was easily accessible for staff and updated if there were any significant changes.

People and their relatives knew how to make complaints and said they would feel comfortable doing so. The provider gave people and relatives the opportunity to give feedback about the care and treatment they received.

Is the service well-led?

Requires Improvement

Not all aspects of the service were always well-led.

The provider did not meet the Care Quality Commission registration requirements regarding the submission of a notification about a safeguarding incident, for which they have a legal obligation to do so.

People and their relatives told us that the service was well managed and the registered manager was committed, kind and approachable. Staff spoke highly of the management team and felt they were supported to carry out their responsibilities.

There were regular audits and meetings to monitor the quality of the service and identify any concerns. Any concerns identified were documented, discussed and acted upon.

Acorn Lodge Care Centre

Detailed findings

Background to this inspection

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

The inspection took place on the 5, 6, 7 and 8 April 2016 and the first day of the inspection was unannounced. We told the registered manager that we would be coming back over the next few days.

The inspection team consisted of one inspector, a pharmacy inspector, a specialist professional advisor in the nursing care of older people 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 service. The expert by experience had experience in the care and support of older people who use regulated services, including the onset of dementia.

Before the inspection we reviewed the information the Care Quality Commission (CQC) held about the service. This included statutory notifications of significant incidents reported to the CQC and the report for the last inspection that took place on 17 January 2014, which showed the service was meeting all the regulations that we checked during the inspection. We contacted the local authority safeguarding adults team and used their comments to support our planning of the inspection. The provider also submitted a provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 12 people using the service, 13 relatives and 26 staff members. This included the registered manager, the head of care, the administrative manager, five registered nurses, one senior healthcare assistant, nine healthcare assistants, two activities coordinators, the chef, one kitchen assistant and four domestic assistants. We also spoke with two health and social care professionals who were visiting the service at the time of the inspection. We looked at 11 people's care plans, 15 staff recruitment files, staff training files, staff supervision records and audits and records related to the management of the service.

Some people living at the service were not fully able to tell us their views and experiences so 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 carried out these observations during different parts of the day.

Following the inspection we spoke with four health and social care professionals who had worked with people using the service for their views.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe living in the home and when they were receiving their care. One person said, "I do feel safe here yes." Another person said, "I feel safe with them, they look after me well." Relatives we spoke with had no concerns about the safety of their family members. One relative told us they thought their family member was safe and said, "I leave my [family member] in their hands knowing they are safe and happy. It gives us peace of mind."

Staff had received appropriate training in safeguarding and were able to demonstrate how to keep people safe from the risk of abuse. Staff understood how to recognise the signs of abuse and told us they would speak to the registered manager or senior staff if they had concerns about a person's safety and/or welfare. Staff were aware that they could also contact other appropriate organisations with any concerns but felt confident any concerns raised would be dealt with by the provider. One healthcare assistant said, "This is their home and they should feel protected. I would never hide from a situation when somebody might be at harm." The registered manager showed us records of all the safeguarding training and it was refreshed on an annual basis.

There was a procedure to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs was carried out by the registered manager or another senior member of staff, which identified any potential risks to providing their care and support. A range of risk assessments were completed in relation to the environment, people's mobility and personal care support needs. Dependency assessments were carried out on a monthly basis covering areas including nutrition and individual support with feeding, continence care and skin integrity. The care plan contained details about the level of support that was required and detailed information about people's health conditions. The information in these documents included practical guidance for staff in how to manage risks to people. Healthcare assistants knew about individual risks to people's health and well-being and how these were to be managed. Records confirmed that risk assessments had been completed and care was planned to take into account and minimise risk. For example, one person had been assessed as being at risk of pressure sores. We saw the relevant assessments in place and it was observed that wound treatment assessments and notes reflected an effective treatment plan. Tissue viability input from a specialist community nurse was seen, as was dressing change regimes and information sharing with the agencies attending.

People told us that staffing levels were sufficient to meet their needs. One person said, "There are enough staff on to help you when you need it. If I use the call bell staff always attend." Relatives we spoke with confirmed that there were suitable numbers of staff around to meet their needs. At the time of the inspection there were 102 members of staff employed by the service, many of whom had worked for the provider for a number of years. The staffing numbers on the floors we observed were noted to be consistent and adequate for the care provided. The registered manager showed us a copy of the staff dependency tool and how the staffing ratio was worked out. We looked at the staff rota for the previous four weeks and the following week and saw staffing levels were consistent with those as described by the registered manager and the staff we spoke with.

Appropriate checks were undertaken before staff began work. The 15 staff files that we looked through were consistent and showed that the provider had robust recruitment procedures in place to help safeguard people. We saw evidence of photographic proof of identity and all Disclosure and Barring Service (DBS) records for staff were in date. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working in care services. There was also evidence that the personal identification code numbers of registered nurses were in date and the provider carried out checks every six months to ensure they were aware of the registration status of nursing staff. The provider asked for two references and people couldn't start work until they had been received. There was a recruitment checklist at the front of each file to make sure all relevant documents had been received before employment commenced. This meant that people were supported by staff who were suitable for their roles.

There were appropriate medicines policies and procedures in place. We observed medicines being administered one morning of the inspection. The nurses administering the medicines were observed to check with each person and follow accurately each step of the administration process. People confirmed that their individual requirements were met. One person said, "I do not have to worry, I get my tablets at the right time."

We checked how the service stored medicines, including controlled drugs and the safe disposal of medicines no longer required. Random checks of several medicines including controlled drugs were carried out and we found that the quantity in stock matched the records in the controlled drugs register. This provided additional assurance that people were receiving their controlled drug medicines as prescribed. We looked at a sample of 29 medicine administration record (MAR) charts during this inspection. All 29 MAR charts had the allergy status of the client recorded and 28 of the MAR charts had a picture of the client to assist staff in identifying the correct person during medicines administration. There were no gaps on the MAR charts that we looked at and there were records to explain why any doses of medicines had not been administered. MAR chart audits were completed four times a day by staff involved in medicines administration and senior staff also completed monthly medicines audits to check that medicines were being managed safely. We saw evidence that the audits picked up medicines issues appropriately.

Current fridge temperatures were taken each day but staff were not recording the minimum and maximum temperatures. We also saw some fridges had ice frozen to the back surface. We discussed this with the registered manager and they amended their recording charts during the inspection. A small proportion of people (less than 10) were being given medicines covertly in accordance with the care home medicine policy. Documentation was in place that had been signed by the GP, a staff member from the home and a pharmacist.

Infection control procedures were also observed to have been followed as staff were aware of the colour coding for gloves and aprons, wearing different sets when in people's rooms and when working in communal areas. This helped to minimise the risk of possible infection within the building. We saw how the laundry was managed to ensure there were no mix ups between floors and people had their own laundry tray with labels in their clothes.

Good

Is the service effective?

Our findings

People told us they were happy with the care they received from staff and felt they had the right skills and experience to meet their needs. Comments included, "The staff are well trained and the nurses are very reliable" and "The staff are terrific and do a great job." One relative told us they were very happy with the staff that cared for their family member and felt they were well looked after. They added, "They know how to look after my [family member] here, the care is wonderful."

When staff started work at the home they had to complete an induction programme within their probation period of six months. Staff had the opportunity to sign up for vocational qualifications in health and social care. These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and knowledge to carry out their job to the required standard. Staff that did not sign up to this were expected to complete The Care Certificate as the main part of their induction programme. The Care Certificate sets the standard for the fundamental skills and knowledge expected from staff within a care environment. Staff confirmed that they had completed an induction programme at the beginning of their employment that had included the opportunity to shadow more experienced staff until they felt confident. One senior healthcare assistant told us how they observed a medicines round during their induction, and then supported a registered nurse.

There was a comprehensive training programme that was delivered to staff as part of the mandatory induction. Modules included safeguarding, moving and handling, fire safety, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and first aid, and these were refreshed on a regular basis. The registered manager showed us their staff training matrix which covered all modules and identified when training had been completed. The training programme was carried out twice a year to make sure all staff received the training throughout the year. We saw that staff also received training which was specific to people's individual needs and that staff had completed training in a range of areas, including dementia awareness, falls awareness, continence care, dysphagia and pressure sore awareness. Staff we spoke with throughout the inspection spoke highly of the training available to them and how it improved their understanding of their role. One healthcare assistant told us how they got involved in the training sessions. They said, "We got to experience being in a hoist, being transferred, even trying the food thickener. When you experience it yourself, it helps you to understand how the person feels and you have a better idea of how to support them." Staff who were responsible for administering people's medicines had regular training and completed annual competency assessments. A registered nurse said, "The pharmacist gets involved in the training every year and we get the chance to discuss medicines concerns as a group."

We saw records that showed nurses and healthcare assistants had regular supervision and an annual appraisal system was in place. We looked at a sample of records of supervision sessions which showed staff were able to discuss key areas of their employment. Items discussed included safeguarding, training development, record keeping and any recent issues involving people they supported. One senior healthcare assistant told us they were able to discuss concerns they had recently when moving a person in their bed and how they discussed different techniques to help support that person. Another healthcare assistant said, "The supervision is excellent and I feel very supported. It's good they make sure that I'm doing the right

thing." We also saw registered nurses and senior healthcare assistants had regular medicines supervisions to make sure people received their medicines safely.

Staff understood the main principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS).

We discussed the requirements of the MCA with the registered manager and senior staff team and they demonstrated a good understanding of the process to follow where it was thought that people did not have the mental capacity required to make certain decisions. We saw records that showed best interests meetings had taken place and when mental capacity assessments had been completed. We saw a sample of DoLS applications for people who were under constant supervision and not free to leave the building for their own safety. The registered manager told us that they worked closely with the local authority and reviewing officers in order to identify any potential deprivation of liberty. The application and authorisation documents we saw were kept in a central log and folder, were in date and reflected in people's care plans.

Staff told us they always asked for people's consent prior to providing personal care for them. One healthcare assistant said, "I always check with them and talk with them, tell them what I'm doing, making sure they are involved." Where appropriate, the views of people's relatives were sought when developing care plans. One relative said "I was involved with the care plan and did it together with my [family member]". We saw people's care records and consent forms had been signed by people to say they agreed to the care being delivered.

We observed lunch over the three floors during our inspection. Staff helped people to their seats and asked them where they wanted to sit. People could also have lunch in their room if they wanted to. Staff helped people put aprons on to eat their lunch, asking permission before they did so. The staff gave out cutlery and ensured that people who could not use knives safely did not get them. Staff seemed aware of people's preferences, who liked drinking water rather than juice, and which people needed to use beakers. Furthermore, staff were aware of people's lunch option, and then offered them a choice of rice or potatoes with it. The service was not rushed and people who required support from staff received it in a caring manner. One relative said, "I know they have involved a speech and language therapist (SALT). They are aware of his/her nutritional needs and are closely monitored when eating."

The home had been awarded a five star food hygiene rating at its most recent inspection. The top rating of five means that the home was found to have 'very good' hygiene standards. People we spoke with complimented the quality of the food provided and told us that they always had a choice of what to eat at every meal. We sampled the food over the course of the inspection and found it to be of good quality, fresh and ample in portion size. People's dietary needs and preferences were respected and catered for. We spoke with the chef, who had worked at the home since it opened. They could tell us in detail different people's food choices and how they catered to meet people's medical and cultural needs. Diabetic and soft diet choices were available, including Caribbean and African options throughout the week.

Registered nurses and healthcare assistants said they supported people to manage their health and well-

being and would always speak with the registered manager or senior staff if they had any concerns about the person's healthcare needs. The majority of people were registered with the local GP, who had been the home GP for 10 years. They were aware of the needs of the people in the home and visited the home six times a week. These visits were recorded in daily communication books and staff followed up on any actions required. The GP told us that the key to keeping people out of hospital was to visit every day to avoid a crisis. We saw information in people's care records where staff had made contact with a number of health and social care professionals, including occupational therapists, SALT's and dietitians. There were also systems in place for other specialist healthcare professionals such as dentists and opticians to visit and record their findings. One person told us they were really happy that the GP visited every morning. One relative told us how staff were very committed to helping people. "My [family member] has had less infections since moving in here, has great access to a GP and if there are any concerns, appointments are booked."

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care they received at the home and spoke positively about the staff who supported them. Comments from people included, "The staff are very kind here, you can have fun with people here" and "Everybody is so nice here, they do a lovely job." Relatives were positive about the staff, one of them said, "They are all wonderful, very caring and my [family member] is in the best place." Another relative told us that staff were aware when people felt low. "When my [family member] is sad, they always sit and have a chat with him/ her, they understand him/her."

Throughout the inspection we observed positive interactions between people using the service and staff. Staff were always observed to be compassionate and interested in the needs of the people they supported. Whilst observing some activities people were very relaxed and comfortable with staff and we could see that people felt happy to express their wishes and felt at ease. During a cake baking activity, staff encouraged people to be as independent as they wanted to be and offered a variety of choices, communicating with them in a calm approach and respected their wishes if they did not want to get involved. One of the activity coordinators said, "I'm really happy if I can make a difference to their day, it's really important."

Staff knew the people they were working with and were able to give information about people's personal histories. Within people's care plans we saw personal fact files, life history, personal preferences, interests and achievements. We saw people's rooms were personalised and staff encouraged this. One person said, "The staff encouraged me to make my room feel like my own, which makes me feel good." One relative showed us their [family member's] room which had a number of pictures throughout, highlighting their family, friends and achievements. The registered manager said it was really important for staff to get to know people and build positive relationships with them. They told us, "We encourage relatives to visit and attend events and activities. The more exposure we have with relatives, the more we get to find out about the person." A registered nurse, who had worked at the home for 10 years said, "I know the people that live here like a member of family."

The people using the service and relatives we spoke with confirmed they were involved in making decisions about their care and were able to ask the staff for what they wanted. The registered manager told us when they carried out assessments and reviews they always made sure, where appropriate, a relative was present with the person. Once the assessment had been completed they would listen to people's preferences and find out how they wanted their care to be carried out. People were also supported to access advocacy services. Advocates are trained professionals who support, enable and empower people to speak up. This meant that where people did not have the capacity to express their choices and wishes or found it difficult to do so, they had access to independent support to assist them. Staff worked closely with an advocacy service and we saw records, where it was appropriate, where people had access to an Independent Mental Capacity Advocate (IMCA).

People told us staff respected their privacy and dignity. We heard positive comments about how staff were respectful to people when they worked with them and how people were encouraged to be as independent as possible. One person said, "Living here means that I can be really independent with help from staff." A

relative told us how pleased they were with how the staff treated their [family member] with respect. "They are aware of how to support him/her, they handle him/her with care and dignity. It gives us confidence." We observed staff knocking on people's doors and announcing their presence during our visit. People were asked if they wished to speak to us and if they were happy for us to see their rooms. All staff had a good understanding of the need to ensure they respected people's privacy and dignity. One person said, "The staff always have time for you, especially when I have my bath, they never rush." The registered manager told us that new staff were allocated to shadow a senior member of staff to ensure high standards were observed from the start of employment. Information from the most recent relatives annual survey showed that 29 relatives out of 30 thought their family member was treated with dignity and respect.

Staff had a good understanding and were able to explain what the process would be when people were reaching the end of their lives. The registered manager told us that people were involved in end of life planning as it was so important to be aware of people's and their relatives wishes. One relative told us about the discussion they had about end of life care. "I was involved, the discussion was in-depth, it included the GP and we were able to change anything if we wanted to." People who had made advanced decisions regarding end of life care had Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms in place and this was highlighted in their care plan. All DNACPR paperwork found was well written and demonstrated choice and relatives wishes where appropriate. The location of the document was sometimes difficult to find within care folders. After speaking with the registered manager about this it was changed during the visit to being more visible at the front. Staff demonstrated empathy and understanding when discussing people's end of life wishes and support needs. Where people had no family, the home made sure that a member of staff was present so people would not spend their last moments alone.

Good

Is the service responsive?

Our findings

People told us they were happy with their care and support and that they felt involved when decisions were made about their care. Comments included, "If there are any problems, the staff do their best to sort it out for me" and "The staff work around me to accommodate my needs." One relative told us that they felt part of the team and was supported by staff when they came to visit their [family member]. Another relative said, "If I mention anything they respond. They are able to work like that which is reassuring." Health and social care professionals we spoke with said that staff were responsive to people's needs and had a good understanding of how to care for them.

We spoke with the registered manager and head of care about the process for accepting new referrals into the home. People could either be assessed on site or they would visit people at home or in hospital, whatever was easiest for the person and their family. Relatives were encouraged to be present at the pre-admission assessment and also during the initial assessment. People were allocated a registered nurse and they got a breakdown of their healthcare needs. The registered manager said, "People and their families are always involved and always included." New referrals had a full and complete assessment that included relevant risk assessments. This comprehensive and informative document was an excellent tool for staff to refer to when the person was admitted. We spoke with one of the senior healthcare assistants who told us that they worked according to the care plan with new people and spent time understanding how they liked to be cared for.

We looked at a sample of care plans for people living in the home. Detailed support plans were in place which covered areas including personal care, eating and drinking, mobility, social and emotional well-being, communication and nursing needs. The support plans were personalised and provided details about what was important for people. There was reference to people's wishes and how they wanted their care needs to be met. For example, we saw records where people had requested specific times of the day for when it was best to meet their personal care needs. We spoke with people who confirmed this and told us that staff would do their best to work around people's individual needs. One person, who had a social event on one of the inspection days, told us how their normal routine had been rearranged to facilitate their plans. Care plans were detailed and had been appropriately updated when there were changes and regular reviews took place, which meant there was an up to date record for staff about how to meet people's needs. For example, one person had received support from a tissue viability nurse to provide advice and treatment for a pressure sore. Detailed guidance was included for staff to support the person in the safest way. Care was well evidenced, well documented and tracked regularly. A registered nurse said, "It is important what information goes into the care plan so we know how to support each person. Management will chase us up if they don't think it is detailed enough."

The home supported people to follow their interests, maintain relationships and take part in activities of their choosing. We spoke with the two activity coordinators responsible for the activities and getting people involved. Each person had their own activities folder with a daily activity log of what people had done and quarterly meetings took place to speak with people about what they would like to get involved in, focusing on their physical and sensory needs and levels of engagement. Some of the activities offered throughout the

home included pet therapy, music therapy and baking, including special events throughout the year. The home had recently renovated one of the rooms into a themed East End pub where people could meet and socialise, or families could book out for social events. They had also just finished work building a new café where they were planning to hold afternoon teas for people. We saw that people were encouraged to get involved and staff were aware of the importance of this. We saw in one person's care records they had a social isolation risk assessment and information encouraged staff to involve them in activities. We saw staff involve this person in a music therapy session, despite their limited communication. Both activity coordinators were passionate about their roles, one added that, "It was a calling; I've always wanted to help people."

We observed one of the music therapy sessions during the inspection. Due to people's reduced mobility, the activity was carried out over each floor so everybody had the chance to participate. People who were unable to participate had the opportunity to have individual sessions in their rooms. About 15 residents attended the first group session and 16 for the second. Staff involved people by handing them percussion instruments and sang and danced with people who were able to. One person danced throughout each session. Staff told us that he/she 'came alive' when music was played. One relative said, "They always involve my [family member] in activities, they wheel him/her down to the music therapy and he/she loves it."

People were also supported with more specific cultural or religious needs. One relative told us that a church group come to visit once a week. The registered manager told us they had links with local churches and a nun offered Holy Communion on a monthly basis. We also saw records within people's care plans that allowed people to enjoy food that met their cultural needs.

People and their relatives said they were happy with the service and would feel comfortable if they had to raise a concern. One person told us that that they would not feel worried about voicing any concerns they had about the home. They added, "Because of the atmosphere here I would always feel fine about telling staff any concerns about someone or something." Another person said, "Even though I've only been here a short time, I'd feel comfortable asking staff about complaints or worries I had." Relatives also felt comfortable speaking with staff about any concerns and were confident that issues would be dealt with. One relative said, "I've never had any issues with my [family member] and their care. I love the staff and they work hard."

One way in which the service listened to people's experiences and concerns was through a monthly residents' forum. People were asked for their feelings about the care they received, the food, activities and any other business. We saw records from meeting minutes where people had suggested specific foods they would like to try. The chef was informed of the feedback and options were added to the menu. The home also tried to hold 'relatives and residents' meetings three times a year. We saw information within the minutes where people had brought up items to discuss and management had listened to it and acted upon it.

We saw records which showed there had been eight complaints in the past year. We looked through their complaints folder and saw the complaints records included details of the event, what action had been taken, if anybody else had been notified, for example, the local authority, and the outcome of it. We saw evidence where complaints led to supervision sessions being carried out or meetings being held which showed that people were actively listened to. One relative brought up an issue with us during the inspection. We discussed this with the registered manager who reacted positively about it and made plans to speak with the relative about it so they could find out more information and resolve the problem.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place who had worked at the home for over 10 years.

The registered provider is required by law to notify the Care Quality Commission (CQC) of important events which occur within the service. We saw records during our inspection about a safeguarding incident which should have been reported to us which had not been.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. We have requested that in future all notifications are sent to us in a timely fashion so that, where needed, action can be taken.

People using the service and their relatives were very complimentary about the service and their day to day experiences of staff and management. People told us they felt comfortable talking with the managers and that they were approachable and listened to them. Comments included, "I find everyone here very good, the staff are very nice people. Especially the manager, who is really nice'" and "I don't know what I'd do without them. I get great support." One relative told us that they were happy with how the home was managed. They added, "I can see that they are committed to people." Health and social care professionals told us that the management team were very approachable, efficient, communicated well and were confident any issues would be followed up.

Staff told us they were well supported by their management team and had positive comments about the management of the service. They felt that the provider promoted a very open and honest culture and knew about the whistle-blowing policy and felt comfortable talking with management. They said if they had any problems they could speak to the management team, even out of hours. One activity coordinator said, "They have an open door policy, they listen to our suggestions. I feel comfortable talking to them, they are here for the staff and residents." Comments from healthcare assistants included, "It's a really good environment, management will always help and respond quickly" and "We work like a team here. The manager is very supportive, approachable and understanding." We spoke with a member of staff who had left the home but decided to come back, citing the registered manager as one of the main reasons. They added, "No matter how busy she is, she is always able to attend to everyone. She's the best manager I've ever had."

The registered manager was aware of the challenges which faced the service and looked to find ways to overcome them. One of the challenges we discussed was maintaining and improving the standard of care within the home. They told us that everybody played a key role in achieving this. "It is important that we don't become complacent. We need to ensure our current values get embedded in the new staff." They added that they listened to all staff and wanted them to be part of the decision making process. They also highlighted how important it was to develop staff and encourage them to improve. There was an overall sense that the home was a good place to work. A number of staff we spoke with had worked there for over 10 years. One member of staff said, "I just feel at home here. When you feel appreciated it gives you a boost

and makes you feel wanted."

The registered manager had robust internal auditing and monitoring processes in place to assess and monitor the quality of service provided, which were carried out at daily, monthly, quarterly or yearly cycles. The registered manager had monthly meetings with registered nurses and senior healthcare assistants which covered areas such as care planning, administration of medicines, risk assessments and recording of incidents. Specific audits of care plans and medicines on each floor were completed on a monthly basis. The registered manager also carried out a quality monitoring monthly comparisons check, to see if they could identify any patterns in the service. They looked at a range of information, including hospital admissions, medicines errors, number of people with urinary tract infections (UTI's) and number of people who had pressure sores. They also carried out regular health and safety checks of the building, including the fire alarm system, call bells, water temperatures and the safe use of hoists. This information was included within the annual home audit.

All accidents and incidents were recorded and these records were kept within the home. Records showed that the registered manager analysed them so that any patterns could be identified and addressed, in order to reduce the likelihood of incidences reoccurring and promote people's safety. We saw incidents had been discussed at team meetings and saw evidence that when an incident or accident had been recorded, the relevant people had been notified and plans put in place to minimise the risk of it happening again. The registered manager told us that they found it useful to talk about incidents and accidents during group supervisions where they reflected and discussed what went wrong.

The provider sent out annual satisfaction surveys to people's relatives. We saw the results from the most previous survey in November 2015. 69 surveys were sent out and they received 32 back. The information received about the service was positive and areas that could be improved upon were highlighted with action plans in place. Of the 32 replies, 27 relatives said they were happy with the quality of care their relative received in the home.

The provider also carried out an annual employee job satisfaction survey as the registered manager told us it was important to understand how her staff felt about their roles and if there were any areas that could be improved. We saw results from the most recent survey carried out in January 2016 which highlighted that staff were happy in their roles and felt supported at work.

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 18 Registration Regulations 2009 Notifications of other incidents The registered provider had not notified the Commission without delay about serious incidents in relation to service users. Regulation 18 (1), (2) (e)