Nicholas James Care Homes Ltd

Charles Lodge

Inspection report

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Date of inspection visit:
18 December 2018

Date of publication:
18 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 18 December 2018. Charles Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Charles Lodge is situated in Hove, East Sussex. It is one of a group of six homes within the south of England owned by the provider, Nicholas James Care Homes Limited. Charles Lodge is registered to accommodate 27 people. At the time of the inspection there were 22 people accommodated in one adapted building, over three floors. Each person had their own room and access to communal bathrooms. The home provided accommodation for older people and those living with dementia.

The home had a registered manager. A registered manager is a 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The management team consisted of the registered manager and a deputy manager. An area manager regularly visited the home to conduct quality assurance audits and to offer support to the management team.

Before the previous focused inspection on 12 October 2017, we had received information that an incident had occurred. One person had sustained a serious injury. This is subject to a criminal investigation that is still ongoing and is being dealt with outside of the inspection process. As a result, the inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. The previous inspection on 12 October 2017 and this unannounced inspection, on 18 December 2018, examined those risks.

At the previous focused inspection on 12 October 2017, the home was rated as 'Requires Improvement' and we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions of Safe, Effective and Well-led to at least good. This was because assessments of the environment had not always identified risks to people's safety. Accidents and incidents had not always been analysed to ensure that any changes required to people's care, were made. Records did not always contain sufficient guidance for staff and did not always accurately document their practice. When people had a health condition that had the potential to affect their decision-making abilities, an assessment of their capacity, to consent to certain practices had not been completed. Appropriate applications to the local authority to deprive people of their liberty had not always been considered.

At this inspection, on 18 December 2018, improvements had been made. The provider had reviewed their processes in relation to the management of risk and the guidance that was provided to staff within records. They were no longer in breach of the Regulation as they had made improvements to their processes with regards to mental capacity assessments and their oversight of Deprivation of Liberty Safeguards (DoLS).

Further improvements were needed however, in relation to assessing people's capacity, to ensure that the changes made continued to be embedded in practice for all decisions related to people's care. People were not always supported to have maximum choice and control of their lives. The policies and systems at the home did not always support this practice.

The provider's aims of creating a home-from-home environment were shared amongst the staff team and implemented in practice. People told us that they felt comfortable and at ease. People, their relatives and staff were involved in decisions related to the running of the home. They told us that their views and suggestions were listened to and respected and that they felt able to raise concerns about their care. Quality assurance processes ensured that the service people received met their needs and preferences and was effective.

The provider and registered manager saw the importance of partnership working. They worked with the local authority and external health professionals to ensure people received coordinated care. There was shared learning between the provider's other homes and regular meetings helped ensure that good practice was shared.

People told us that they felt safe. They were protected from abuse and discrimination. Sufficient numbers of skilled staff ensured people's physical and emotional needs were met. Risks to people's safety were identified and mitigated. Infection control was maintained.

People's needs were assessed and reviewed on an on-going basis. They received personalised care and were actively involved in discussions in relation to it. People were supported to maintain their health. They had access to medicines, which were managed safely, and received support from external healthcare professionals when required. People were complimentary about the care they had received and the effect this had on their health. One person told us, "I don't think I could have found anywhere better, since I have been here all my readings are correct, they were all over the place in hospital". People could plan for their end of life care to help ensure their comfort was maintained and their wishes were respected.

Staff were kind and caring. People were supported sensitively and their privacy and dignity were maintained. Positive relationships had developed between people as well as with staff. Compassionate and thoughtful interactions were observed and staff took time to interact with people. Staff were mindful of supporting people in a way that met their needs. When people displayed signs of apparent anxiety, staff took time to listen to them and offered distraction techniques. People were calm and settled after their interactions with staff. One person told us, "They listen to me, what I need".

People had access to sufficient quantities of food and drink to maintain their nutrition and hydration. People told us they enjoyed the food and they were provided with choice.

People had access to an environment that met their needs. Communal areas, as well as private spaces, enabled people to spend time on their own or with others. Adaptations to the environment and facilities, to meet people's specific needs, had been undertaken.

People were not socially isolated. Planned group activities, as well as one-to-one interaction between people and staff, enabled people's social needs to be met. People were observed to be having fun. They were laughing, smiling and enjoying the interaction and stimulation that was provided.
People were encouraged to be independent. One person enjoyed helping staff with the household chores. Others independently accessed the local community.

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 home was safe.

There were sufficient numbers of staff to ensure people's needs were met.

Staff understood the signs that might indicate people were at risk and they knew how to keep people safe.

Risks were assessed and measures taken to mitigate risks. Improvements were made when there had been learning from incidents.

Medicines were managed safely to ensure people's health was maintained.

Infection control was maintained.

Is the service effective?

Requires Improvement

The home was not consistently effective.

Although improvements had been made since the previous inspection, in relation to supporting people in accordance with the Mental Capacity Act 2005, these needed to be further embedded in practice.

Staff had the appropriate skills and experience to meet people's needs.

People were supported to maintain their health.

People had sufficient amounts of food and drink to maintain their nutrition and hydration.

Is the service caring?

Good

The home was caring.

People were supported by kind and caring staff. Staff knew people well and took time to interact with them.

People were respected and they led dignified lives. They could make their feelings known and these were listened to and acted upon.

People's skills and experiences were respected. They were supported to maintain their independence.

Is the service responsive?

Good

The home was responsive.

Person-centred care ensured that people's needs and preferences were known and respected. Care was tailored around people's needs.

People were supported to plan for their end of life care. Staff respected peoples wishes if they had chosen not to discuss this.

People were provided with opportunities to comment or complain about the care they received.

Is the service well-led?

Good

The home was well-led.

The provider's aims were shared by the staff team who strived to implement these.

People, their relatives and staff were encouraged and able to be involved in the running of the home.

Quality assurance processes helped ensure that the systems and processes were effective.

Partnership working helped provide shared learning and good practice.

Charles Lodge

Detailed findings

Background to this inspection

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

Before the previous focused inspection on 12 October 2017, we had received information that an incident had occurred. One person had sustained a serious injury. This is subject to a criminal investigation that is still ongoing and is being dealt with outside of the inspection process. As a result, the inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of the risk of falls. The previous inspection on 12 October 2017 and this unannounced inspection, on 18 December 2018, examined those risks.

The inspection team consisted of one inspector 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. In this case the expert-by-experience had experience of older people's services.

Before this inspection we looked at information we held, as well as feedback we had received about the home. We also looked at notifications that the provider had sent us. A notification is information about important events which the provider is required to tell us about by law. We used information the provider sent us in the Provider Information Return (PIR). A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Before this inspection we communicated with the local authority for their feedback. During our inspection we spoke with six people, two relatives, four members of staff, the registered manager and the area manager. We reviewed a range of records about people's care and how the service was managed. These included the individual care records and medicine administration records for four people, two staff records, quality assurance audits, incident reports and records relating to the management of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed the care and support people

received as well as the lunchtime experience and the administration of medicines.

Good

Is the service safe?

Our findings

At the previous focused inspection on 12 October 2017, an area identified as needing improvement related to the management of risks within the environment. Regular audits of the environment had failed to identify potential hazards and therefore appropriate measures had not always been taken to ensure that the environment was safe. Once this had been identified, the registered manager had taken immediate action to ensure people's safety. Accidents and incidents that had occurred had been recorded. When there had been changes in people's needs because of the incidents, action had not always been taken to ensure that people's care plans or risk assessments were up-to-date and reflected changes in their needs. By not doing this the registered manager had not ensured that staff were provided with appropriate guidance to inform their practice and minimise the chance of reoccurrence.

At this inspection, on 18 December 2018, it was evident that improvements had been made. The registered manager had reviewed their procedures. Audits continued to be undertaken of the environment to ensure that it remained safe and potential hazards were identified and measures taken to ensure improvement. Accidents and incidents that had occurred had been recorded, monitored and analysed to identify trends. Measures were in place to assess the risk of falls and action had been taken to mitigate potential risks. One person, had experienced several falls. Staff had identified this and had arranged for the person to see their GP. Another person had been referred to the falls prevention team. The person wore a small sensor alarm on their clothing to alert staff if the person fell. Lessons were learned and information from the analysis of accidents was used to inform staff's practice and supporting documentation. For example, risk assessments and care plans were updated to reflect the change in people's needs following an accident.

People told us that staff made them feel safe. Comments from people included, "There are plenty of staff, staff are very good" and "If I ring my bell they don't usually take long to answer it". A relative told us, "They are supported well by staff. They have always felt safe here. They lack confidence and staff have always encouraged them".

People were supported by staff that were suitable to work with them. Appropriate pre-employment checks had been made before staff started work. Their employment history and references were obtained. People had access to sufficient staff to meet their needs. When people called for staff's assistance they received this in a timely way. Consideration of staff's skills and levels of experience were made. New staff were allocated to work alongside existing staff to ensure that they were supported to have a good awareness of people's needs. New staff told us that they valued this and it provided them with someone who they could seek support and advice from. They told us that this ensured that they knew how to care for people according to their needs and preferences to assure their safety.

Staff had completed safeguarding adults training and knew the signs that could indicate people were at risk of harm. Staff were aware of their responsibilities to safeguard people and told us what they would do if they had concerns about people's safety. The allocation and deployment of staff meant that there was always staff within communal areas to ensure people were safe. Staff were mindful of potential situations that could occur when people displayed behaviours that challenged others. There was a low number of

altercations between people. Staff were available and on-hand to offer distraction techniques and interact with them to help occupy their time. When altercations had occurred, staff had recognised that this had the potential to affect people's safety. The registered manager had considered this alongside their safeguarding procedures and had made a referral to the local authority to assure people's safety.

Staff worked alongside people and their relatives when devising care plans and risk assessments. Consideration of people's preferences ensured that they could continue to enjoy pursuing their pastimes in a safe way. For example, when people wanted to enjoy trips outside, risk assessments had been undertaken to ensure that suitable measures were in place to assure their safety.

Medicines were managed in a safe way. Trained staff, who had their competence regularly assessed, administered medicines and had clear and appropriate guidance to inform their practice. People told us that they had access to medicines when they needed them. Observations showed that people's consent was gained before staff offered support. They were asked if they required 'as and when required' medicines. Their right to refuse medicines was respected. People had access to regular GP visits where their medicines were reviewed and discussed. Audits conducted by the management team ensured that medicines continued to be managed safely. Information about people's health and the medicines that were prescribed, was readily available should people transfer to other settings, such as when they were admitted to hospital. This helped to ensure that people's care was consistent.

People had access to equipment that was safe. Equipment was regularly checked to ensure people's safety. Regular checks of the environment took place. Personal emergency evacuation plans provided guidance to staff about how to support people to evacuate the building safely in the event of an emergency.

Infection control was maintained and the home was clean. Staff used personal protective equipment when supporting people with their personal care needs. They disposed of waste appropriately to minimise the risk of cross-contamination. Staff had access to food hygiene courses to ensure that they demonstrated safe practice when supporting people with their nutrition and hydration.

Requires Improvement

Is the service effective?

Our findings

At the previous focused inspection on 12 October 2017, the provider was found to be in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because when people had a condition that had the potential to affect their decision-making ability, the registered manager had not always ensured their capacity was assessed in relation to specific decisions about their care. CCTV had been installed within the communal areas of the home. The registered manager had used this to monitor people's whereabouts to assure themselves of people's safety. Consideration of people's ability to consent to this had not always been made. When people were subject to continual support and supervision from staff, and were unable to consent to this, consideration of the necessary procedures to follow had not always taken place. After the inspection, we asked the provider to take action to make improvements to the processes around assessing people's capacity. At this inspection, the registered manager and provider had reviewed their processes and this action had been part-completed. The provider was no longer in breach of the Regulation. However, further improvement and embedding in practice, is needed.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The provider had implemented a new electronic care-planning system. Records showed that when people had a condition that had the potential to affect their decision-making ability, staff had assessed people's capacity in relation to specific decisions. Discussions with people, or others involved within their care, had taken place and were clearly documented within the new system. Further improvement however, was needed to ensure that this process was followed for all decisions relating to people's care. For example, records showed that staff had asked some people's relatives to sign consent forms for people to have the flu injection. The registered manager had not considered assessing people's capacity prior to doing this. Some relatives who had been asked to give their consent, did not always have the legal authority to be the sole-decision maker in relation to decisions about people's healthcare. This was fed back to the registered manager who explained that they would act to ensure this was remedied. This is an area of practice in need of improvement.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. When people were subject to continuous support and supervision from staff and were unable to consent to this, appropriate applications to the local authority had been made. Some people's DoLS authorisations had conditions associated to them. This meant that staff needed to ensure the conditions were met to comply with the DoLS authorisation. Records showed that staff had supported people in accordance with the conditions of their DoLS.

People continued to have faith in staff's abilities. Staff were supported and encouraged to undertake courses that the provider felt were essential to their roles. New staff were supported to undertake a thorough induction as well as shadow existing staff to ensure that they had appropriate skills and knowledge to support people according to their needs and preferences. Staff undertook additional courses to meet people's specific needs. This included a course about dementia care. This helped staff to understand what people might experience and enabled them to support people in a considerate and appropriate way. Observations of interactions between people and staff demonstrated that staff were mindful of how best to interact and engage with people who were living with dementia. Links with external healthcare professionals and private training providers enabled staff to have access to current good practice and to develop within their roles.

Staff told us that felt well-supported. They had access to regular supervisions and appraisals that enabled them to discuss their roles and reflect on their practice. Feedback was provided to staff during these times and they were supported to consider additional learning and development opportunities.

Consideration was made to ensure that people's holistic needs were assessed. People's physical and emotional health had been assessed and staff worked hard to ensure that people were supported appropriately to meet all their needs. People continued to be supported to maintain their health. They had access to medicines when they needed them and staff worked in accordance with best practice guidance to ensure people received appropriate care. Staff were responsive when there were changes to people's health. Timely referrals to external healthcare professionals ensured that people were provided with appropriate treatment and coordinated care. One person told us about the improvement to their health since residing at the home. They told us, "I don't think I could have found anywhere better, since I have been here all my readings are correct, they were all over the place in hospital".

People had access to a 'homely' environment and told us that they felt comfortable and at ease. Communal areas provided people with opportunities to engage and interact with others. If people preferred their own company, they had access to their own rooms so they could spend time alone or entertaining their relatives and visitors. The registered manager acknowledged the importance of creating a welcoming environment and had made efforts to ensure the home met people's preferences and was well-presented. Efforts had been made to meet people's specific needs. Signs were displayed to inform people of the location of bathrooms to aid their orientation.

People had access to sufficient food and drink that met their needs and preferences. People were provided with choice and staff respected their wishes. One person told us, "Plenty to eat that's good. I like salads and chef makes these for me". Snacks and drinks were available outside of meal times. These included soft drinks, fruit, sandwiches, cakes and biscuits. Observations showed that people were reminded and encouraged to have sufficient amounts to drink. People could choose to enjoy their meals in the main dining room, the conservatory, the lounge area or in their own room. People's preferences were respected. For people in the dining room, a sociable and relaxed atmosphere had been created. People enjoyed shared conversations with people sitting at their table or with staff, who took time to have conversations with them. Consideration was made about encouraging people's appetites. Cooking smells that came from the food being prepared in the kitchen, helped people who were living with dementia, to know that it was time for a meal and supported them to be ready to eat.

When people required support to eat and drink, staff were sensitive to their needs. Staff reminded people of their food choice, explained what they were doing and ensured that people were supported at their preferred pace. Observations showed that the chef was a visible presence in the home. People enjoyed interacting with them. A relative told us, "The chef often goes up to see my relative to see if they enjoyed

their food and ask if they had cooked it right for them. They are interested in my relative's culture".

Good

Is the service caring?

Our findings

People and their relatives consistently told us that staff were kind, caring and compassionate and our observations confirmed this. Comments from people included, "Staff are very kind. Sometimes they go out of their way to make you happy" and "They listen to me, what I need". A relative told us, "Staff are very respectful, and treat my relative with respect. They know them so well".

A warm, friendly, welcoming and homely atmosphere ensured that people feel at ease and at home. People were treated with respect. Staff were mindful of people's life experiences. Information about their life history, which included their employment and family-life, had been gathered and supported staff to know people well. Staff were observed taking an interest in people's lives and experiences. Staff and people had a good rapport with one another. People enjoyed conversations with staff about their families and things that they had enjoyed doing throughout their lives. One person, who was living with dementia, was confused about where they were. The person asked staff if they were on a boat. Staff took time to sit with the person and engage in conversation with them. They spoke to the person about the holidays they had enjoyed on cruise ships. This interaction calmed the person and they were observed to be less-anxious and disorientated as a result.

Another person, who was living with dementia, was showing signs of apparent anxiety. They were worried about their relative and were visibly upset. Staff demonstrated patience and understanding. They explained that the person's relative was okay and that they would be visiting later in the day. Despite the person asking staff the same question multiple times, staff responded to the person as if hearing their requests for the first time. Staff were aware of the impact offering distractions could have on the person to allay their anxiety. Staff acknowledged how helpful the person was to them. They asked them if they could assist with any household chores. The person responded well to this and enjoyed some banter with staff. They then assisted staff to fold serviettes in preparation for the lunchtime meal. The person was reassured by their interactions with staff and was seen smiling and thanking staff whilst they were occupied with the task.

People were treated with dignity and their privacy was maintained. When people required assistance with their personal care needs, staff were discreet and mindful of supporting people in a sensitive manner. Staff knocked on people's doors and waited for a response before entering people's rooms. Personal information about people's care needs was stored in locked cabinets and offices to ensure that their confidentiality was maintained.

Positive relationships had developed between people as well as with staff. People enjoyed conversations with one another whist sitting with each other over lunch or within the communal lounge. People could have visitors and relatives at any time and told us that their guests were made to feel welcome. People had access to telephones so that they could maintain contact with people who were important to them.

People were involved in decisions that affected their lives and the care provided. They were involved in discussions about their care so that when their care needs were reviewed these reflected the person's current needs and preferences. As part of some people's DoLS authorisations they had access to paid

representatives who could support them to ensure their needs were communicated and their rights promoted. People could also have access to advocacy services if they required assistance to make their needs known. Leaflets advising people of this were displayed. An advocate can support and enable people to express their views and concerns, access information and services and defend and promote their rights.

People were encouraged and able to remain independent. People could independently mobilise around the home and were able to choose how they spent their time. Some people independently accessed the local community to enjoy visits to the local shops, restaurants and pubs.

Good

Is the service responsive?

Our findings

People received personalised and responsive care. People were central to their care and fully involved in the planning and on-going review of it. Staff considered people's social and emotional needs, as well as their physical needs. These were assessed before people moved into the home and on an on-going basis. People and their relatives were actively involved in continued discussions about their care needs as well as their preferences. People told us that they felt able to talk to staff and the registered manager if they had any concerns about their care. Regular reviews ensured that people continued to receive care that met their needs. One person told us, "I was involved in my care plan. I sat down with staff". A relative told us that staff had adapted the way they supported their relative, as well as their accommodation, to ensure that their changing needs were acknowledged and met. They told us, "We were involved in our relative's care planning, we are updated all the time on changes". A new electronic care planning system was in the process of being implemented. Although the current paper-based system met people's needs, the provider wanted to continually improve the process and had introduced this change.

One person had a health condition that affected their mobility. Staff understood this and were responsive to the person's needs. They ensured that the person had access to their medicines before they were supported with their personal care needs. This meant that the person's symptoms were minimised, they were comfortable and their mobility was improved.
People's individuality was recognised and promoted. People wore clothes of their choice. Some people wore jewellery and carried handbags. People could furnish their rooms with ornaments from home and items that were important to them. This helped to maintain people's identity.

Staff promoted people's diversity and supported people according to their preferences and culture. Consideration of the type of food people could or could not eat within their cultures was known and respected. A relative told us, "The staff helped my relative to celebrate Chinese New Year".

People's diversity, in relation to their health conditions, was acknowledged and efforts had been made to ensure people could have equal access to the facilities and environment. Guidance from the Alzheimer's Society, 'Making your home dementia friendly', advises that Dementia may affect how well people can tell the difference between dimension and colours. It advises to use bright and contrasting colours to help people see things more easily. Brightly coloured toilet seats had been installed in the bathrooms and provided people with a contrast in colour. This supported people's cognitive abilities and enabled them to continue to remain independent when accessing the bathroom facilities. A notice board was displayed. This contained information on the day, date, season and the weather. This provided support to people to aid their orientation to time and place.

Staff knew people well, they took time to get to know the person and what their lives were like before they moved into the home. This helped staff to understand what people might enjoy doing. Activities coordinators ensured that people had access to sources of stimulation and interaction to occupy their time. People were not socially isolated. They could choose where they spent their time. Some people preferred to spend time in their rooms, listening to music, watching television or reading. Technology, such as electronic

devices were used by people or staff to access the internet or listen to music. People told us that they were happy that they could choose what they did. Planned group activities and external entertainment were provided. Observations showed people enjoyed taking part in chair netball and target practice as well as being entertained by an external singer. Efforts were made throughout these activities to actively engage people in conversations and discussions that were of interest to people. One person enjoyed asking other people questions and an impromptu quiz took place. People enjoyed taking part in this and were seen to be laughing and smiling whilst joining in. Staff were mindful of enabling people to maintain their skills. This included encouraging people to take part in physical exercises and movements as well as prompting people to keep their own scores when taking part in the group activities. This helped to ensure that people's cognitive abilities were recognised and encouraged. One person told us, "I enjoy the quizzes they put on and I like to read". An impromptu 'singsong', instigated by one person, but who were joined by others, took place after people had finished their lunch.

As well as planned group activities, staff recognised the value in one-to-one interactions. They took time to talk with and listen to people. Dementia UK states, 'The use of dolls can bring great benefit to some people with a diagnosis of dementia, particularly those in later stages. It involves making a doll available to the person to hold or to sit with'. Some people, who were living with dementia, enjoyed holding and comforting soft toys or dolls. Staff took time to communicate with people about their 'babies'. Observations showed one person enjoying jokes with a member of staff about how they had used to feed their own babies.

Technology was used to ensure people received timely care and support. People were provided with a call bell so that they could call for assistance from staff. For people who were unable to use a call bell, due to their capacity and understanding, regular checks were undertaken to ensure people's safety when they were in their rooms.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in full, in line with section 25 of the Health and Social Care Act 2012. Services must identify record, flag, share and meet people's information and communication needs. Staff ensured people's communication needs had been identified at the initial assessment and formed part of their care plans. These documented the best way to communicate with people. Information for people and their relatives, if required, could be created in such a way to meet their needs and in accessible formats to help them understand the care available to them. Larger print information had been provided to people. The provider's statement of purpose was provided in larger font so that people who had a visual impairment could access and read this. Photographs of food had been displayed showing people the available choices for that day.

Residents' and relatives' meetings, as well as surveys, provided opportunities for people and their relatives to share their opinions. People told us and records confirmed, that people could speak freely and air their views. The provider had a complaints policy which was accessible for people to use. People told us that they were happy with the care they received. People and their relatives told us that they would feel comfortable raising concerns. When people or their relatives had done this, records showed that the provider had taken appropriate and timely action to deal with these. Suggestion cards and a suggestions box was displayed for people or their relatives to provide anonymous feedback.

People were provided with the opportunity to plan for their end of life care. The provider worked in accordance with the Gold Standards Framework. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives. Some people had chosen their preferred place of care, who they would like with them at the end of their lives and their funeral arrangements. Some people did not want to discuss this and staff had respected their wishes. Thank-you

cards, which had been sent by relatives of people who had passed away, acknowledged staff's caring attitude and the care that their loved ones had received.

Good

Is the service well-led?

Our findings

At the previous focused inspection on 12 October 2017, an area identified as needing improvement related to the guidance provided to staff to inform their practice. Records did not always contain sufficient detail to document staff's actions. At this inspection, improvements had been made. The provider had implemented a new electronic care planning system. This provided an opportunity to have more detailed records about people's health conditions and needs. The registered manager and staff were in the process of transferring hard-copy records to the new system. In the interim period, the registered manager had ensured that people's care plans provided sufficient information for staff. Records for one person, who was living with diabetes, showed that information about the signs and symptoms about high or low blood glucose levels had been included.

The provider's aim was to, 'Provide a happy, secure and home-from-home environment with warm and friendly staff, where making new and happy memories were a priority'. This was implemented in practice. There was a welcoming, homely and friendly atmosphere. People were central to the running of the home and involved in their care.

People, relatives and staff told us that they felt the home was well-led. Feedback about the management team was positive. A relative told us, "The manager is very good, we can talk to her about anything to do with our relative. They are always around we could not have done better than this home, we looked at a few".

Regular staff meetings enabled staff to be involved in decisions that affected the running of the home. Staff told us that their suggestions and opinions were welcomed and listened to. Regular formal supervisions and appraisals enabled staff to share their ideas and to receive feedback on their practice and development. Staff told us that they found these supportive and that they felt valued. One member of staff spoke about the registered manager and told us, "If we need it she'll help out. She is very good with the residents. I think she is a good manager. She is very understanding and very good with the staff too. That's the sort of person you need to run a home".

Regular residents' and relatives' meetings ensured that people could air their views and discuss any ideas or suggestions. Regular surveys were also sent to people to gain further feedback. Feedback was positive and praised the registered manager and staff as well as the care provided.

Quality assurance processes ensured a good oversight of systems and processes. Regular audits were conducted by the registered manager and the area manager. Action plans were devised when improvements were required. Records showed that when areas in need of improvement had been identified, appropriate action had been taken in a timely manner. The area manager told us that they had confidence that the home was well-led and that the systems and practices within the home, as well as the knowledge of the management team, meant that when the registered manager was not at the home, that it continued to run smoothly.

People told us and records confirmed, that the registered manager had demonstrated their awareness of the duty of candour CQC regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons'. Records showed that relatives had been kept informed of any changes to people's needs.

The provider had complied with the CQC registration requirements. They had notified us of certain events and incidents to ensure that we had an awareness and oversight of these to ensure that appropriate actions had been taken.

Links with external healthcare professionals and local authorities had been developed to ensure that people received a coordinated approach to their care and staff learned from other sources of expertise. The registered manager attended meetings with other registered managers from the provider's other homes to share learning and take on-board good practice. Findings from inspections were shared amongst the provider's other homes to help ensure that improvements that had been identified and any subsequent learning or changes to practice, were shared.