Cepen Lodge Limited

Cepen Lodge

Inspection report

West Cepen Way
Chippenham
Wiltshire
SN14 6UZ

Tel: 01249481729
Website: www.brighterkind.com/cepenlodge

Date of inspection visit:
25 October 2017
26 October 2017

Date of publication:
05 December 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

At the last inspection on October 2016 we found breaches of legal requirements. We asked the provider to take action to make improvements on record keeping. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found improvements were made.

Cepen Lodge Care Home provides residential care for up to 63 older people. The first floor is designated for people with a diagnosis of dementia. At the time of the inspection there were 60 people living at the service.

This inspection was unannounced and took place on 25 and 26 October 2017.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that staff were not always signing medicine administration records (MAR) for medicines administered. MAR charts were audited daily but the audit record showed staff were not signing medicines records for medicines administered. Procedures were in place for staff that consistently failed to sign medicines records.

Procedures on the administration of when required medicine (PRN) was not in place for all PRN medicines. For example, a PRN protocol was not in place for the treatment of angina attack. We noted that for some people the instructions for the application of topical creams were not clear.

Care plans were mainly person centred and we found consistent use of terminology which showed a respectful manner. In places the information in the care plans was not cross references and not consistent with the area of need.

People said they felt safe. The staff we spoke with said they had attended safeguarding of abuse training. They knew how to identify abuse and were clear on the procedures for reporting their concerns.

Assessments tools were used to identify risk and action plans were developed on how to minimise the risk to people. The staff were clear on the actions in place to manage the identified risk. For example lowering beds for people at risk of falls. Falls audits included the preventative measures and lesson learnt from the event. We saw from the audit the number of falls had reduced from the preventative actions taken.

Intervention charts in place followed risk assessments and were well completed. 24 hour fluid charts detailed people's individual fluid intake target and were totalled throughout the day. Where people did not have enough to drink the information was passed to staff during handovers. A member of staff said the

introduction of the monitoring fluids had improved people's health.

Incident and accidents reports were completed. An online incident reporting system was used by staff to record accidents and incidents. The reports were investigated at provider level for patterns and trends and the registered managers received feedback on the analysis of accidents.

The number of staff on duty reflected the duty rota. We saw staff available at all times. Staff took their time with people and care was not observed to be rushed. However, staff said there was staff sickness. Action was being taken by the registered manager to manage sickness and absences.

Staff told us the training was good. There was mandatory training set by the provider which staff said they had attended. There were opportunities for vocational qualifications. Staff said during their one to one supervisions they discussed concerns, the people at the service and performance.

Staff knew the day to day decisions people were able to make. People's capacity to make decisions about their care and treatment was assessed with accompanying best interest decisions in place for specific decisions.

The people at the service had support with their healthcare needs. People were registered with a GP and had access to other specialist's healthcare professionals such as district nurses and Speech and Language Therapists (SaLT).

The dietary requirements of people were being met and people said they enjoyed the food.

Staff greeted people by name and knocked on bedroom doors before entering. They close bedroom doors before delivering personal care. Staff knew people well, interactions were not rushed and they knew how to reassure people when they became distressed.

The complaints procedure was kept in a welcome pack in people's bedrooms. Complaints received were investigated and resolved to a satisfactory level.

Staff said since the last inspection there had been improvements. They said they worked well together and there was good team spirit. All staff spoke well about the registered manager and said they were approachable.

Formal systems were in place for assessing, monitoring and to mitigate risks relating to the health, safety and welfare of people who used the service. There were clear processes that ensured the delivery of care met good practice guidelines, legislation and the values of the organisation as well as those of the home. Where shortfalls were identified action plans including medicine errors were in place on how outcomes were to be met.

.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines records were not always signed for medicines administered and procedures were not always in place for medicines to be taken when required (PRN).

Risks identified were assessed and action plans were developed on minimising the risk. Members of staff were knowledgeable on actions necessary to reduce risks.

There were sufficient staff to support people and we observed that staff were visible and available to people.

People said they felt safe and were able to describe what safe meant to them. Staff knew the types of abuse and the responsibilities placed on them to report abuse.

Is the service effective?

Good

The service was effective.

Staff enabled people to make choices. People's capacity to make complex decisions were assessed and best interest decisions were taken where people lacked capacity.

Staff had the knowledge and skills needed to carry out their roles. There were arrangements in place to support staff to meet the responsibilities of their role. Staff attended training set by the provider as mandatory and had opportunities for personal development through one to one supervision.

People's dietary requirements were catered for

Is the service caring?

Good

The service was caring

People were treated with kindness and with compassion. We saw positive interactions between staff and people using the service. Staff knew people's needs well and there was a calm and friendly atmosphere.

People's rights were respected and staff explained how these were observed.

Is the service responsive?

Good

The service was responsive.

Care plans were mainly person centred support plans but some needed to be cross referenced to ensure information was accurate and up to date.

The registered manager investigated complaints and responded formally on the action to be taken to resolve complaints.

Is the service well-led?

Good

The service was well led.

There was strong emphasis on continuous improvement. The views of people using the service were gathered. Quality assurance systems were in place and where shortfalls were identified there were action plans on meeting these standards.

Staff were aware of the values of the organisation. They said the team worked well together.

Cepen Lodge

Detailed findings

Background to this inspection

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

This inspection took place on 25 and 26 October 2017 and was unannounced on the first day of the visit. The registered manager was aware of our visit on the second day.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed all of the information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

The inspection was carried out by three inspectors and an Expert by Experience. We spoke with 13 people about their experiences of care and treatment and to three relatives visiting family members at the time of the inspection visits. We spoke with the regional manager, registered manager, deputy manager and eight members of staff including the activities coordinator. We wrote to five health care professional for their feedback about the service and one responded.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included six care and support plans, staff training records, staff duty rosters, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices for part of the day.

Requires Improvement

Is the service safe?

Our findings

Medicines were not consistently managed safely. Medication Administration Records (MAR) charts were not always signed to show the medicines administered. Staff reported that while there were medicines errors these had reduced since the last inspection. A member of staff said there were internal audits to "pick-up" errors. Another member of staff said they were expected to check the MAR charts at the end of the shift to ensure staff had signed the records. They said where signatures were missing staff were to record their findings in the "drug administration error" record and staff responsible were contacted to correct their errors. Staff said the registered manager reviewed the drug administration error records on each unit daily.

Procedures were in place for some medicines to be administered when required (PRN). The protocols for pain relief detailed the direction, the intervals to be administered and maximum dose in 24 hours. However, PRN protocols were not devised for one person prescribed with medicines to improve sleeping patterns and for the treatment of angina attacks. We noted that for some people the instructions for the application of topical creams were not clear. We saw that the deputy manager had requested the GP and the pharmacist that medicines prescribed had accurate directions on their application.

The deputy manager told us the medicine procedures in relation to omissions and errors were updated recently. They said consideration was also being given to having specific staff for witnessing the signing the MAR charts. they told us that where staff made medicine errors a reflective log had to be completed which included an account of the incident and the consequences of their action. The updated procedure also detailed the disciplinary actions to be taken for one or more medicine errors. For example, one to one supervision were held for the first medicine error, a re-assessment of the staff's competency for the second error and for the third error disciplinary action was to be taken.

We saw transdermal patch application records were used on where to apply patches as the same site should not be used continuously and should be varied.

A person self-administered medication including insulin. We saw there was a completed "self-medication application" form completed to ensure the person's competence. The person, GP, registered manager and a team member were involved in reaching the decision for self-administration of medicines which the person signed.

Medicine care plans detailed the actions staff must take for safe handling of medicines. These actions were for staff to follow GP instructions, they must be trained to administer medicines and must sign records to show the medicines administered. Staff administering medicine received medicine training. Staff told us team leaders and senior carers administered medicines. This meant the staff administering medicines had attended medicine competency training.

People told us they felt safe living at the home and it was the staff that made them feel safe. One person explained that for their first shower a staff member waited in the bedroom to ensure she didn't 'fall. The hand rails and seat made me feel safe and so now I can take a shower on my own". Another person said "I

feel safe. If I need help I push this button and they mostly come".

The staff we spoke with said they had attended safeguarding of vulnerable adults training and the training matrix confirmed staff had attended this training. Staff knew the types of abuse and the expectations on them to report allegations of abuse. The registered manager told us all staff attended training and procedures to protect people from abuse were accessible to staff. They told us "staff have ownership of the allegation and are able to report suspicions of abuse to the local authority. I would prefer staff discuss it with me first but they don't need to wait for me before they report an allegation of abuse. There are issues of confidentiality and for staff that report abuse I give feedback to a level that is acceptable. It's on a need to know basis."

Risks were identified and action plans were developed on how to manage risks. The staff we spoke with knew the measures in place to minimise and monitor the risks identified. The training matrix showed staff had attended training to support people to stay safe. For example, people at risk of malnutrition and moving and handling. A member of staff said for people at risk of malnutrition food and fluid charts were completed as well as monitoring people's weight.

Risk assessments were in place for people with mobility needs. The risks associated with supporting one person with transfers were identified in the risk assessment. For example, unpredictable reaction and stiffness. Also detailed were the number of staff and the equipment needed for each movement. For another person their risk assessments stated "walks independently holding to handrails and staff hands. The action plan stated staff were to ensure the person wore appropriate footwear and corridors were free from obstacles. Staff said there was guidance on how to support people with mobility needs and people were enabled to take risks safely. It was stated "we want to give them [people] their independence. We don't want to take it away from people. We will look at the risk to minimise it. It's all about allowing them to keep their capabilities".

Risk assessments were in place for people with a history of falls. The risk assessments identified poor balance as the cause of the falls for one person and to prevent falls the action plan was for staff to ensure beds were at the lowest position, crash mats were to be placed against the bed and staff were to check the person regularly. We saw for some people beds were at the lowest position and crash mats were against the beds. A member of staff told us the preventative measures in place. For example, sensor mats were used in bedrooms for people at risk of falls and snacks between meals were offered to people at risk of weight loss

The staff had a good understanding of prevention and management of difficult behaviours. A member of staff told us some people displayed complex behaviours and staff completed antecedents, behaviour and consequence (ABC) charts to identify triggers.

Staff attended Positive Behaviour support training. Care plans were not developed for one person on how staff were to manage difficult behaviours. The staff documented the triggers that showed to staff one person was becoming anxious and needed reassurance. For example, lack of sleep, frustration and "likes to be left alone". The distraction techniques were for staff to be patient and to invite the person to participate in activities. The care plan for another person stated "refused assistance" from staff with personal care and for staff to persist with offers of assistance. Staff were to be patient and were to "go at the person preferred pace" as the person would eventually agree to personal care. The review of the care plan stated the person preferred male carers and staff were to prompt and encourage the person to accept support with personal care.

For another person the capacity care plan dated July 2017 stated that at times "verbal and physical

challenging behaviours" were presented at times which "mostly occurred when being assisted with personal care. XX will hit our pinch and shout at staff". The personal care plans dated September 2017 did not include how staff were to manage difficult behaviours during personal care. The registered manager said the person no longer presented with aggressive or violent behaviours during personal care.

Risks at service level were identified and managed. Accidents and incidents involving people were documented. The provider used an online system for incident and adverse events reporting. A member of staff told us that an incident such as a fall would be recorded in the care plan, they would make an online entry of the accident, write in the daily review of care and inform the GP of the fall.

Personal emergency evacuation plans (PEEPS) were in place on how staff were to support people to leave the property safely in the event of an emergency. Individual PEEP detailed the person's understanding and their reaction to fire alarms. Where people needed support the equipment and number of staff needed was detailed.

There were sufficient numbers of staff on duty to meet the needs of people. The deputy manager told us there was "a senior carer or team leader on each floor and on each shift". The staffing levels on the units reflected the staff on duty. The staff rota showed there were 13 staff on duty each day deployed to work across three units. For example, on the first day of the inspection a senior and two care assistants were on duty on the ground floor and on the first floor there was one senior and three care assistants. At night there were two seniors and six care staff awake in the home.

Good

Is the service effective?

Our findings

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

People were empowered to make complex decisions. A member of staff told us "If people are not able to make long term or complex decisions mental capacity assessments were completed and best interest decisions made". We saw mental capacity assessments for care and treatment were in place for people with cognitive impairments. For example, one person living with dementia was not able to understand information about living at the home. The best interest decision reached with relatives and staff was for the person to live at the service. Deprivation of Liberty Safeguards (DoLS) applications to gain authority for the person to remain at the home was requested.

Mental capacity assessments were completed by GP's where Do not attempt Resuscitation (DNAR) orders were in place. The GP had recorded in the DNAR orders the rationale for the decision to allow natural death and detailed the individuals such as relatives and staff involved in the decision. We saw relatives had declined screening investigation for one person who lacked capacity. The deputy told us the relative had lasting power of attorney (LPA) for care and treatment. However, LPA documents were not in place at the home. The deputy manager contacted the relatives who agreed to provide the registered manager with the appropriate orders that gave them the legal powers to act on behalf of their family member.

Care plans in place instructed staff to support people to make decisions. The care plan for one person stated the person was able to make choices from the visual options shown. Staff were knowledgeable about the day to day decisions people were able to make. A member of staff said people made decisions about their clothes, activities and meals." Another member of staff said "We can't assume people lack capacity" and gave examples on how people were supported to make decisions. For example, supporting people to make choices from visual options also staff asked people "what they would like to wear?"

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Deprivation of liberty authorisations had been sought for people subject to continuous supervision.

New staff had an induction when they started work at the home. A member of staff said their induction prepared them for their role and included shadowing of more experienced staff .

Systems were in place to ensure staff had the skills needed to meet the responsibilities of their roles. The

training matrix provided showed staff had attended mandatory training set by the provider. A member of staff told us "training is good" and they were process in place to ensure staff were aware of refresher training. They said internal trainers were "supportive". Another member of staff said the training was good in particular "face to face" courses as it promoted more discussions.

The registered manager said the aim was for staff to have six one to one supervisions per year including an annual appraisal. There were group supervisions as well and two one to one session focused on personal development. Staff said one to one supervision was with their line manager or registered manager. A member of staff said at their one to one supervisions they discussed concerns, the people at the service and their performance.

People's dietary requirements were catered for at the home. People told us they were able to choose what to eat and drink. Another person added "The food's good, we choose what we want from the menu (they pointed to the menu on the table)". People were able to choose at meal times where to eat their meals and those that eat in their rooms made their choices the day before. We observed staff members visiting people in their bedrooms during the afternoon and assisting them to make choices. One staff member encouraged "Are you sure you don't want any breakfast? What about a slice of toast and marmalade and a cup of tea?" The person responded positively and agreed to order breakfast.

The nutrition care plans included people's likes and dislikes and the support needed from the staff such as "cutting food to finger size". Staff had documented that one person had a "good appetite and liked snacks." The action plan for this person included the adapted equipment used by the person to eat their meal independently. For example, plate guards and adapted cutlery. For another person the action plans was for the meals to be fork mashable.

The chef told us they were kept informed about people's nutritional requirements. They said the menu was generated annually according to the seasons by a catering company but they were able to adapt the menus to suit people's preferences. The whiteboard in the kitchen detailed people's specialists diets which included high calorie and vegan diets. Also recorded were known allergies and where Speech and Language Therapists (SaLT) were involved the type of textured diets to be served.

People were supported with ongoing their healthcare. One person told us the registered manager was to visit to discuss pain management with them. Another person explained "the optician came and now I have free glasses". A member of staff told us there was "good working partnerships" with the GP. They said the GP came to the home weekly and staff prepared a list of people who needed or wanted a visit from the GP. People had access to other community specialists such as community nurses and Speech and Language therapists (SaLT).

A GP with regular contact with people at the home told us "there has been a great improvement in the management of referrals to us. The number of late requests for visits have reduced, routine reviews have been appropriately saved for weekly visits and urgent visits have been appropriately requested." They said following consultation with the registered manager staff now record the advice given to them during visits. It was stated "I am glad to see that all staff now have notebooks and on my last visit wrote down any changes or advice." We saw GP visits were recorded and included was the purpose of the visit, the advice given and outcome of reviews.

We saw some signage and other adaptations to promote people's independence. A member of staff told us memory boxes that contained specific items and belongings were installed outside bedrooms. Memory boxes helped the person living with dementia recognise their room. Another member of staff said as the

home was not a specialist service and the organisation approach was "same care and same rights. The approach used was according to the needs of people. It's more about stimulation as opposed to changing the home."

Good

Is the service caring?

Our findings

People felt they mattered. Staff listened to people and spoke to them appropriately and in a way they were able to understand. We saw one person ask a member of staff "where's my handbag?" The staff member responded "is it in your room? Would you like me to get it for you or would you like to come with me to find it?" We saw the member of staff leave and return with the handbag. We saw people's birthdays were celebrated. The chef showed us they had baked a cake for one person whose birthday was on the day of our visit. We also saw where staff had decorated their bedroom door with "Happy Birthday" signs.

During the activity session one person asked "can I sit there, I don't want to upset anyone, and I'm not one of the gang". The coordinator re-assured the person and helped them to the seat and got them a cup of tea. The person was soon engaged in conversation with the other people at the table.

People were treated with kindness and compassion. Staff told us they introduced themselves to the person and always approached people with a smile. A member of staff said for people new to the home "I introduce myself to people and explain my role. I gain information about their background, I sit and talk to them and I comfort and reassure them." Another member of staff said "I like to adopt good relationships with people. We treat people as if they were a member of our own family. It's what we expect for our own relatives. I like a welcoming happy smiley environment and the worst thing would be for everybody [staff] to be miserable. I would question the care where staff looked miserable." The registered manager explained a member of staff had accompanied one person to visit their nearest living relatives in France. The staff member that had accompanied the person said "It's the most fulfilling thing I've ever done in my life. The relatives had gathered lots of photos and videos of the family and they all looked at them together. When we were coming back I had to turn my back, it was so emotional".

We saw positive interactions between staff and people using the service. We observed a staff member assisting one person to leave their bedroom. The member of staff said to the person "Come on, you hold my hand" and the person took their hand but their walking was difficult. Another staff member came to assist the member of staff and both tried to get the person to stand tall but eventually lowered them to the floor and placed a pillow under her head. The senior staff member came to the staff's assistance and asked "did she fall" to which the response was "no we lowered her to the floor" and together reached the decision to use a mobile hoist to assist the person from the floor. The senior took the hand of the person and reassured her "It's alright we'll get a wheelchair and take you to the dining room, don't worry". We observed three staff members very gently hoist the person to a sitting position "so as not to scare her". The senior staff member was constantly reassuring the service user throughout and asked the other staff member to encourage the person to drink fluids.

The registered manager told us there was an organisation expectation that registered managers speak to five people each day to "find out how they are." They said the five people were consulted about their care and where needed action was taken. This registered manager also said "I listen to people and I have a daily walk around the home. I am involved in the activities of the home for example residents and relatives meeting and people come to the office."

People were supported to express their views and to make decisions about their care and support. The Recreation and Activities coordinator told us they assisted people to make group decisions. They said at residents meetings a "flip chart was used for people to suggest ideas of activities. All things [activities] mentioned were then condensed into a plan". For example, communion, quiz nights.

People's rights were respected by the staff. The Equalities Diversity and Human Rights procedure was based on four principles which included the values of the organisation, the types of discrimination and accountability. The training matrix showed staff had attended "Equality, diversity and human rights" training. We saw a staff member knock on the bedroom door of one person and greeted them by name and asked "are you coming down to lunch?" The staff member then closed the room door and assisted the person to get dressed. A member of staff gave us examples on how people's rights to privacy and dignity were respected. They said before entering people's bedrooms they knocked on bedroom doors and waited for an invitation to enter and personal care was undertaken in bedrooms with the doors closed and curtains closed.

Good

Is the service responsive?

Our findings

People were supported to make decisions about their wishes for their end of life. The care records for one person on end of life pathway was based on their personal care, continence and nutrition needs. However, care records were not clear on the decisions reached regarding the priorities of care. There was little evidence on the discussion between people, their relatives about their wishes and priorities for their care. We noted that only five staff had attended End of Life training.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to End of Life planning.

People received care that was responsive to their needs. A member of staff said care plans were developed and reviewed by the senior. They said the seniors ensured the information was accurate and "reflected a person centred approach". Another member of staff said care plans included people's known allergies, their likes, dislikes and preferences.

Care Plan documentation related to people's health and physical needs as well as their mental, emotional and social needs. For example, the mobility care plan for one person detailed their medical diagnosis, the medicines prescribed and how their mobility needs affected them. Their preferences included "likes to do things on her own". Staff were to support the person by giving them directions, they were to offer assistance in the morning when their mobility was more restricted and obstructions were to be removed from pathways. The eating and drinking care plan for another person stated the person was able to eat their meal without assistance, they "preferred small portions, chooses to have breakfast in their bedroom and staff were to "cut food where needed".

Staff said there was a verbal handover about people's current needs when they arrived on duty. Daily reports included information about people's daily routines, tasks completed and how people spent their day. Where appropriate intervention charts were used to ensure people were supported to be re-positioned according to their care plans and risk assessments. Food and fluid intake chart were completed for people whose weight staff monitored. On the day of our inspection, a person had been offered food and fluid but these had been declined. Staff told us that at handovers they were instructed to encourage fluids for those people that were not going to reach their individual fluid intake target.

People's accessible information needs were assessed and action plans were developed on how they were to be supported with their communication needs. The care plan for one person with communication needs stated the person was able to verbally communicate but needed time to process the information. For another person the communication care plan stated the person was able to give single responses such as "yes and no" and expressed their wishes by vocal sounds. A member of staff said that some people living with dementia understood information in combination of verbal and written format.

People were supported to maintain relationships with those that mattered to them. Staff documented when relatives were made aware of important events, the discussions regarding the needs of their family member

and invitations to review meetings.

People were supported to take part in social activities. A person living at the service produced the newsletter and the October 2017 edition included "facts about October, upcoming activities, Birthdays and information about the staff." For example, the section for "getting to know the staff" included the profiles of two staff and the dining out section included restaurants within walking distance and favourite restaurants in the local area.

We observed the morning activity session "Arts and crafts". The activity co-coordinator greeted arrivals by name and asked them where they wanted to sit. She asked on arrival "Are you ready to do something?" One person told us "It's pretty damn good here, the food is nice and we do activities like puzzles and singing. We could have a lot worse". An entertainer was present in the afternoon and there was lots of singing. After the event one person said they felt tiered "after all that signing" and we observed them entered their bedroom singing "Kiss me goodnight sergeant major".

We saw completed "Wishing Well" forms in some care records. The people at the service and their relatives were able to complete the "Wishing Well" form and post it in the well. The staff said they "do their very best" to make the wish come true. We saw one person had identified in their "Wishing Well" a desire for afternoon tea and the photographs evidenced the activity.

The Recreation and Activities Coordinator told us the approach for people living with dementia was "about the person and not the dementia we [staff] adapt to the dementia." For example "one person has lost her sight we adapted the activity and they are still painting. It's the ritual of making a cup of tea not handing someone a cup of tea."

People we spoke with said the staff listened to their concerns. We saw the complaints procedure on display in the dining room and the contact details for people to confidentiality raise their concerns were included. The registered manager responded to complainants in writing detailing the outcome of their investigation along with the actions taken to resolve their complaints.

Good

Is the service well-led?

Our findings

At the previous inspection we found a breach of Regulation 17 Health and Social Care Act Regulated Activities Regulations 2014. We had found records did not provide staff with up to date information on people's intake of fluid. The provider wrote to us telling us how the legislation requirements were to be met. We found improvements had taken place.

The registered manager told us the procedures in place for reducing medicine errors. They said internal and external audits were taking place. The level of the audit depended on the errors and the regional manager carried out an audit of medicines on their monthly visits. Staff that made medicine errors had to complete a reflective log to explain why the error was made. At a recent team meeting staff were reminded not to disturb staff administering medicines. Staff were told to "respect the tabard" and not to interrupt staff administering medicines. The supplying pharmacist carried out an audit of medicines in August and September 2017 and no recommendations were made

A registered manager was in post. The registered manager told us "I treat staff with respect. I don't want staff to dread coming to work. We will put things right as a team. We put it right together. I tell them what I expect and ask them to change" and "if this doesn't happen then they are performance managed." The staff said the registered manager was approachable, fair and was a good leader. A member of staff said the registered manager had "helped them with advice and appreciated the qualities of each staff member." Another member of staff said the registered manager had gained the trust of the staff overtime. They said there had been many previous managers (including registered managers) and staff had lost confidence in the leadership of the home.

Some staff said that although the team "mostly worked well together" there was poor morale due to sickness. We found clear processes were in place for sickness absences and a member of staff with lead roles in personnel issues told us staff sickness was recorded and analysed. They said "back to work" interviews were held for those staff having "odd days". It was stated that although every effort was made to promote a supportive approach the staff were aware that following any sickness absence there was a discussion. Where staff were expected to be absent for long periods a risk assessment was developed. Action plans were then reviewed at the end of the sickness absence to ensure their "phased return" was effective. This member of staff also said there was an improvement in sickness absences.

Other staff said "everyone gets on well." A member of staff said "I love working here and we are a big happy family." The Recreations and Activities Coordinator told us "I engage with the team and I include them in the activity. Staff come back in the evening to help with activities which boosts morale."

There was open communication with people who use the service, those that matter to them and staff. A relative explained their family member had been living at the service for several years and "it has got better with this [registered] manager." The registered manager explained that there has been a very active and vocal relatives group, meeting monthly when they were concerns, especially about the quality of the food. The frequency of the meetings was moved to every two months following improvements and at the last

meeting the group indicated these could now move to every three months. The minutes of the relatives meeting held in October 2017 detailed the topics discussed which included the odours, staff absences and the dementia approach.

Team meetings were regularly held and were specific to the role. For example team meetings were held for catering, seniors and for care staff. Staff told us there were daily "stand up" meetings attended by heads of department and seniors. They said at these meetings staff can request assistance and ensures all staff were made aware of "what was happening. I feel positive about the home."

We looked at the minutes of the catering, senior and care staff meetings and at the catering meeting held in October 2017 the staff rota and tasks were discussed. The senior meetings focussed on reviewing care plans and re-structuring of the senior roles. At the care staff meeting the topics discussed included person centred plans, sickness absence and medicine rounds.

Arrangements were in place for assessing and monitoring the quality of the service. Audits to measure and review the delivery of care were effective and included medicines, infection control and care planning. The October 2017 report of the monthly visit by the regional manager included the actions taken by the registered manager to meet shortfalls identified. For example, medicine errors, 10% of care plans to be reviewed, training matrix to be updated and a review of accident and incident reporting.

Systems in place to improve, innovate and ensure sustainability. The registered manager told us about the steps taken to continuously improve the service. They said it was based on "what we can do differently". The promotion of training and developing relationships with external agencies that supported the staff to improve the care people receive. For example, commissioners, local hospices and community nurses. It was also stated "we don't accept the status quo. We look at a different way of doing things. We develop projects for staff to take responsibility".

The registered manager told about a variety of projects in progress and we spoke with some of the staff assigned with lead roles for their projects. The deputy manager and senior told us about the hydration project developed to improve people at risk of infections and included assessing people's fluid intake over 24 hours. We saw staff were recording people's fluid intake and totalled them at specific times of the day. The senior explained that at handovers staff were instructed to encourage fluids to those people who were not reaching their individual daily target. The 24 hour monitoring of fluid intake ensured staff took appropriate action throughout the day for those people who were not going to reach their daily target.

The deputy manager told us the number and management of falls was audited and a "falls project" was introduced. They said since then the number of falls had reduced. The registered manager said the lead staff of the project and relatives that had raised concerns about the number of falls their family members were experiencing were involved the "falls project". The initial analysis had identified that "more energy was needed in the prevention of falls and on how staff behaved when people fell." While there was acceptance that people fell there was a need for "accountability to change practice". The process for accidents and incidents had changed with the introduction of the "falls project" staff involved in an accident had a one to one supervision with project lead to gain an understanding of the incident and the actions taken. The falls analysis report we saw included the level of injury, the actions taken, details of the investigation and the lessons learnt. For example, there was a fall rated moderate injury, the staff had taken appropriate action and had contacted emergency service. A retrospective investigation had taken place following the person's admission to hospital and had identified that relevant agencies such as CQC were not aware of the notifiable incident. The lesson learnt was to improve communications.

Arrangements were in place to address improvements and the sustainability of the service. The registered manager said two further projects were to be introduced which included the wellbeing of staff and community access for people. The registered manager explained the benefits for people who had access to community groups and told us the project lead staff were going to evaluate how people were to access over 50 clubs in the community. There was a "Brighterkind" four point principle for staff to "flourish" and the registered manager had accessed six free counselling sessions for staff that wanted to talk about their problems and feelings in a confidential environment.