Larchwood Care Homes (North) Limited

Appleby

Inspection report

Military Road
North Shields
Tyne and Wear
NE30 2AB

Tel: 01912579444

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This unannounced inspection took place on 2 August 2016. We last inspected the service in October 2014. At that inspection we found the service was not meeting Regulations 13 of the Health and Social Care Act (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and relates to the management of medicines.

Following our inspection in October 2014, the provider sent us an action plan to show us how they would address our concerns.

We undertook this full inspection to check that they had followed their plan and to confirm that they now met legal requirements in all areas.

Appleby provides residential and nursing care for up to 55 people, some of whom are living with dementia. At the time of our inspection there were 37 people living at the service.

The service had a registered manager 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 the provider had made positive changes and now met the current regulations in regard to the safe management of medicines. Medicines were stored and administered safely, and people received their medicines as prescribed.

We found people were safe at the service. The building was clean and well maintained, no trip hazards were noted, risks were assessed and staff were trained in safety, emergency and safeguarding procedures.

The service had sufficient staff on duty and they were supported and well trained. Staff recruitment and staff disciplinary processes, as far as possible, protected people from harm.

People received support to ensure they had enough to eat and drink and if they were identified as being at risk of malnutrition or dehydration, suitable monitoring systems were used to maintain their health. Referrals were made to health care professionals in a timely way when required and people were supported with a range of health care services to maintain good health.

The Care Quality Commission (CQC) is required by law to monitor the operations of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have the ability to make their own decisions and to ensure decisions are made in their 'best interests'. It also ensures unlawful restrictions are not placed on people in care homes and hospitals. In England, the local authority authorises applications to deprive

people of their liberty. We found the provider was complying with their legal requirements.

People were supported by staff that were kind, caring and respectful and knew them well. People were treated with dignity and respect. Staff understood people's needs well and helped them to choice how they went about day to day activities or choosing what they wanted to do.

Complaints had been handled appropriately and in a timely way.

The registered manager and provider had a robust quality assurance system in place and sought feedback from people, their relatives and other visitors to consistently monitor the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's medicines were now managed safely and appropriate arrangements for the recording, safe administration, safe keeping, using and disposal of medicines were in place.

People were safe and protected from harm. Staff knew what action to take if they suspected abuse was taking place.

Risks to people had been identified and risk assessments were centred on the needs of individuals.

There were sufficient numbers of competent staff to ensure that people had their needs met promptly and safely and the provider followed safe recruitment practices when employing new staff.

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink and were supported where necessary.

Staff and managers had received suitable training and were supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were seen to be warm, compassionate and sensitive when supporting people in their care.

People's privacy and dignity was respected by staff. People were supported to maintain relationships that were important to them.

Staff knew the people they were caring for and supporting,

including their personal preferences, interests and personal likes and dislikes.

Is the service responsive?

Good

The service was responsive.

People using the service and their relatives were involved in the development of their care plans and these were personalised to meet their individual needs.

There was an activities programme in place which met people's social needs.

The provider had a policy for people using the service and others, about how to make a complaint if they needed to.

Is the service well-led?

Good

The service was well-led.

The registered manager promoted strong values and a person centred culture that was visible at all levels of the service.

Staff told us that morale was good and they were proud to work for the service and were continually supported and developed to provide high quality personalised care.

Quality assurance systems were in place to continually monitor the service provided and ensured that people were at the heart of the service.

Appleby

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 2 August 2016 and was unannounced. The inspection was carried out by three inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed other information we held about the service, including the notifications we had received from the provider about the outcome of deprivation of liberty applications, police incidents, safeguarding concerns, deaths and serious injuries.

We contacted the local authority commissioners and safeguarding teams for the service; Healthwatch; the clinical commissioning group (CCG); the infection control lead and the food, health and training coordinator from the local trust; the local fire authority and a community matron for the service. We used their comments to support our planning of the inspection.

We spoke with 11 people who used the service, although not everyone could fully communicate with us; and three family members/carers. We also spoke with the registered manager, the deputy manager, two senior care staff, six care staff, the activity coordinator, the chef, one member of kitchen staff, the administrator for the service and the maintenance person. We observed how staff interacted with people and looked at a range of records which included the care and medicine records for six of the 37 people who used the service, six staff personnel files, health and safety information and other documents related to the management of the home.

Good

Is the service safe?

Our findings

People told us they felt safe at the service and relatives felt the same. One person said, "I feel very safe here." Another person said, "Why do you ask that, of course I am safe…..look at her [staff member]…she would not hurt a fly."

We found that the staff understood their responsibilities to keep people safe and the reporting processes relating to safeguarding were good. The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the service. Staff told us they had completed safeguarding training and the records we saw confirmed this. Staff understood, and could describe the types of abuse people may experience and told us how they would keep people safe. One staff member said, "I would make sure the person was safe and then I would report my concerns to the manager. The manager would then inform the local authority."

The registered manager told us that each bedroom door had a door alarm which was activated when people were in their bedrooms and would sound if the door was opened. They told us that where people had been assessed to manage their own bedroom door key, a new lock was put in place. One relative told us that their family member had trouble with other people entering their room. They suggested they would like to see self-locking doors. We brought this issue to the attention of the registered manager who said he would look into this issue.

We saw that where any safety hazards had been identified, measures were put in place to minimise any risk. For example, the outside garden area had a shallow pond which the registered manager had identified as a potential hazard of drowning. Gates had been placed on either side of the garden to stop people with dementia related conditions from walking into this area by accident. The registered manager told us that plans were in place to fill in some of the pond to further reduce the amount of water in it and we saw a risk assessment had been completed to minimise the risk further.

The registered manager had ensured that other risks identified were assessed, including those relating to individuals and those in general. People had been risk assessed against issues in connection with poor nutrition, those at risk of falls, those at risk of choking and those who preferred hot drinks. This meant that the provider tried to minimise the risk of harm to people by taking additional precautions. General risk assessments had been completed, for example, a recent one was completed for sunburn and dehydration. This described how staff could minimise the risk, by people wearing loose clothing and wearing sun cream and ensuring refreshments were regularly given.

Accidents were recorded, reported and monitored by the provider for any trends forming. We saw that where people had a number of concurrent falls, then referrals had been made to other healthcare professionals to receive additional support. Accidents were reported to people's representatives in a timely way and the analysis detailed, for example, times, how the accident occurred and the outcome. This included if the person had to receive emergency treatment in hospital which helped staff to monitor if any

notifications were required to be sent to the Commission for any fractures people may have had. The registered manager also completed an accident investigation report which further ensured that all appropriate actions had been taken.

Checks were completed on fire safety measures, this included the completion of fire drills, checks on all fire equipment and the completion of a fire risk assessment, with all actions included having been completed. People had personal emergency evacuation plans (PEEPs) in place. PEEPs are documents which are given to the emergency services, should the need arise, in the event of a fire or flood or other emergency evacuation situation. These forms help emergency staff ensure that the correct level of support is provided to people, for example, those in wheelchairs or those with limited mobility.

The building was well lit, with hand rails in all areas. Each entrance to stairwells and lifts had a numeric keypad ensuring all doors remained locked. We saw the service employed a maintenance person who carried out and recorded routine safety checks of the building and various equipment at frequencies set out by the provider. For example, water temperature checks and checks on the safety and suitability of bed rails. These were up to date and signed off by the maintenance person. One member of staff told us, in regard to the building and the equipment, "You can see a big improvement since [registered manager] came and I have seen a lot of different managers. It's definitely worthy what he is doing….if I need anything, I get it. [Registered manager] will get anything because he knows it's for the benefit of the home."

The above showed the provider endeavoured to provide care safely and in a safe environment, although we noted that the provider had outstanding actions on their five year mains electrical installation to complete. We asked the registered manager about this and they told us they had asked the provider to complete this work and showed us evidence that this was the case. During the inspection, the registered manager contacted the provider who confirmed work had now been authorised to be completed. The day after the site visit the registered manager sent us a copy of the 'purchase order' which had been sent to the contractor to confirm work was to be completed.

We noted that the décor in places was in need of an update. One relative told us that the, "Whole home could do with decorating." The registered manager explained the refurbishment plans that were due to take place within the service and these included changes to the upper floors of the service, in terms of the room layouts which would allow people more room and new spaces to move around in. It also included painting and decorating of the areas that were 'tired' and a refurbishment of the upstairs medicines room.

Staff confirmed, as did our own observations, that there was enough equipment for people to use. For example hoists and other mobility supporting equipment. Everyone who required the use of hoists for transferring had their own sling. This ensured that transfers were completed safely. One staff member said, "We have everything we need." One person told us, "No problems with equipment, they [staff] have it all here."

We observed staff completing two medicine administration 'rounds' with people. People received their medicines as prescribed and all medicines were in stock at the time of the site visit. One person had refused their medicines and the staff member on duty respected their decision and placed the unwanted medicines in a medicines 'pot' which they placed on top of the medicines trolley. When the staff member went to give medicines to people out of sight of the medicines trolley, we saw that it was left unlocked at times and also with the refused medicines left in the pot. We noted however, that the staff member asked another member of staff to 'watch' the trolley; which they did. Although no harm was caused to anyone, this posed a potential risk, as the member of staff 'watching' could have been called away by another person or had to react to an issue arising. We spoke with the registered manager about this, who addressed it immediately with the

member of staff concerned.

Three people were receiving covert medicines. Covert medicine is the administration of any medicine in disguised form. We checked people's records in connection with this action and established that GP's had confirmed this as an appropriate action to take and in the person's best interests. Staff on duty told us, "If they did not take it like this, they would not take it at all and they need it."

Disposed medicines were dealt with effectively and returned to the pharmacist for destruction. Medicine administration records (MARs) were fully completed with no gaps and included information on people's allergies and how they would prefer to take their medicines. Various codes were printed on the MARs and were used to record if people had refused or were unable to take their medicines for any reason. We noted that the code on the MARs did not match the code that staff used. We discussed this with the registered manager who explained the system they used worked well. We noted that there had been no errors or issues, and medicines had been given appropriately and recorded if not administered, albeit with the different code.

We recommend that the provider follows best practice guidelines in safe medicines management.

One relative said that they felt there were plenty of staff. One person told us, "Yes dear, always seem to be plenty of staff." Dependency assessments had been completed and matched with staffing levels to ensure that there were enough staff on duty at all times. Staff told us, "Staff levels are really quite good and we have time to interact with the residents" and "I have worked in other places and I can honestly say that there is enough staff work here….pretty good really."

Staff told us that they had completed a range of checks before they started work. One staff member told us, "I had to get my DBS done and have one-to-one training and group training." We saw this recruitment process included references and checks made through the Disclosure and Barring Service (DBS). The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable staff from working with people who required care and support. We saw that staff were monitored by the registered manager during their probationary period and the registered manager told us if needed, this period would be extended to ensure that staff were suitable before their employment was confirmed as permanent. Nurse PIN numbers were checked to confirm they were suitably qualified and registered to carry on with their nursing roles. All nurses and midwives who practise in the UK must be on the Nursing and Midwifery Council (NMC) register and are given a unique identifying number called a PIN.

We checked the finances of people who lived at the service. People's money was stored together within secure arrangements at the service and all receipts were available where people had spent money. For example, hairdressing, chiropody or for any toiletries purchased.

Good

Is the service effective?

Our findings

People thought that the staff were effective at supporting their needs, and relatives confirmed this. One relative told us staff are good at "diffusing challenging situations". After the site visit, the registered manager provided us with evidence of one person who had returned to the home environment after receiving effective care and support from the service.

Staff confirmed that they had completed a range of training and records and other information we saw confirmed this. One staff member told us, "Constantly doing training. Do extra stuff, like visual awareness and deafness training." Another member of care staff confirmed that training which used to be on line e-learning, was mostly done face to face now. A further member of staff confirmed that training was "very good" and said, "The last one I did was dignity and respect."

Training in key areas as well as more specialist training specific to meeting people's diverse needs was evident in the records and from our observations. This included for example, training in behaviours that challenged, palliative care, verification of death, moving and handling, dementia and food hygiene. Staff had also completed varying levels of recognised qualifications in health and social care.

We saw evidence that staff observations were carried out, including in connection with medicines, infection control and general care. Medicines competency checks included, for example, observations of how staff dealt with the application of topical creams. Random night time checks were also completed on the care given by night staff. Where staff were not meeting minimum standards, an action plan had been put in place. This meant systems were in place to check that staff were following the correct procedures to make sure that people received safe and effective care.

Staff confirmed that they received regular supervision sessions from their line managers and that yearly appraisals were completed. Staff personnel records that we checked confirmed that regular support sessions had taken place, including clinical supervision for nursing staff. This included yearly appraisals with staff. This meant there was a system in place to support staff to deliver effective care and treatment.

Staff confirmed that handover meetings took place and that they were relevant and passed on information about each individual. One staff member said, "We know who we are responsible for." This showed that staff communicated well with each other for the benefit of the people who lived at the service.

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. We saw evidence that where people lacked capacity to make particular decisions for themselves, that their family, staff and other healthcare professionals had been involved with the decision making process, including records of multidisciplinary meetings and records of any best interests decisions.

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 is 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. The registered manager had submitted and had approved, 25 DoLS applications to deprive people of the liberties, with others waiting for approval.

We noted that for some people, advance care planning assessments had been put in place. These are documents indicating what care people would prefer at a time in the future when they lack the capacity to make particular decisions about their care themselves. For example, the document included questions, 'Do you have a will?' and asked where the person wanted to be cared for if their health deteriorated.

Kitchen and care staff were aware of the dietary needs of people who lived at the service. One member of care staff told us that information was available about people's allergies and what they liked and did not like to eat. They said about kitchen staff, "They make cakes for people who are diabetic." Another staff member told us that there were a number of people with complex diabetes and kitchen staff ensured that they tailored meals to suit their requirements. Kitchen staff told us, "One person does not like 'white' food, such as eggs or potoates….so we have spoken with [person] and their relatives and now we make what they like." People who were at risk at malnutrition had been assessed and were continually monitored to ensure any weight loss was quickly recognised and actions put in place. The chef told us that the main meal of the day was at night and this had worked well. They said, "From lasagne to steak pies to cakes and scones…all homemade even the chips!"

The chef recognised the various needs of people, and gave us an example of one person who they prepared 'finger foods' for. The chef described how the person liked to walk around the home and how they had prepared suitable food for them to carry with them, for example, chicken goujons or sausage rolls.

We observed lunch time on both floors of the service. Menus were displayed and tables were laid out with brightly coloured table mats and plates. Staff explained that the brightly coloured table mats and plates helped those with a dementia related condition or a visual impairment distinguish their plates and meals more easily.

People had no complaints about the food that was prepared for them. Comments included, "I like my grub, it's good"; "Have a try, it's nice" and "It's champion." Staff were overheard saying, "You're doing really well pet [local term of endearment]"; "Are you going to try eating it yourself?" and "I'll cut it up for you." A staff member told us, "There is enough food to feed an army." Staff checked with people if they were enjoying their meals and all confirmed they were. One person said to a member of care staff, "Everything is fine by me." One person was observed enjoying a fruit crumble and stated, "Mmmmmm" in acknowledgment that they were appreciating it. We noted that people who received pureed meals received them in a way which could have been improved with regards to their presentation. We spoke with the registered manager about this and they told us they were about to participate in nutrition training and would look into this as part of that training. We saw that one person who now received pureed food had gained weight according to a family member.

Staff and people confirmed that a range of refreshments were made available to them, including milkshakes, tea, hot chocolate and a range of juices. We noted that people who were at risk of choking received support from specialists and also had the use of prescribed thickener which we found in an unlocked cupboard in an upstairs kitchen area within the dining room. We brought this to the attention of the registered manager, who told us he would address this immediately to ensure that people did not

access the thickener accidentally.

All of the people living at the service had their weight monitored and recorded, including monitoring of food and fluid intake, particularly for those people who where more at risk of malnutrition or dehydration. People's weights were also used to identify the setting required on specialist air flow mattresses used to support people while sleeping or resting. Air flow mattresses minimise the risk of pressure ulcers by providing alternating pressure.

People's health needs were monitored and actions taken to ensure they were met. A relative told us, "The staff keep me fully informed about what has been happening, if [Person's name] has been unwell or a bit under the weather. Their health care needs are well attended to." Another relative told us that the nurse would speak with them about any little thing and were very quick to pick up on any changes that may indicate an underlying health issue. Records we saw showed that people had access to a range of healthcare professionals which included dentists, chiropodists and GP's. We noted one person had been seen and their care plan reviewed by their GP after concerns around inflammation of their skin. One member of staff said the community nurse visited the service twice a week and said, "She is brilliant, we are well supported from a health care point or view."

The service had been adapted to support people in wheelchairs and others with mobility needs. We also saw adapted taps in sink units which automatically turned off when people had finished running the water. Parts of the service had signage which helped people who were living with dementia to orientate themselves around the building. The garden area had been paved in a way which allowed easy access for people with limited mobility. Reminiscence boards were in place to support people with memory loss and to help people recall past experiences.

In the garden area, various sections had been adapted to particular themes. For example, in one section of the garden it had been adapted to look like a seaside area. Another area of the garden contained scented flowers to activate the senses, particularly with people who were living with dementia. The registered manager explained to us that they had utilised information from the Stirling University as a guide for best practice around dementia when designing the garden and other areas within the home.

Good

Is the service caring?

Our findings

Comments from people included, "Staff are really nice"; "They are a good bunch, very kind" and "I would not swap the staff for any others, they are very very caring and kind to me." Comments from relatives included, "Staff are very friendly, helpful and supportive"; "I have never seen them [staff] inpatient…never."; "It's much more than adequate, this is as good as it gets."

We visited one person with the nurse who was on duty at the time. The person presented their feet for a rub and the nurse duly obliged. The person said, "I get well looked after." During observations we overheard care staff saying to people, "Your hair looks lovely" and "Can I help you sit more comfortably in your seat?" The comment regarding the 'hair looking lovely' was followed by lots of laughter from people and staff, as one male member of staff said, "I thought you meant my hair!" One person said to a member of staff, "Hello my darling." The staff member responded with, "Hello gorgeous." It was noted that people appreciated these interactions.

One member of care staff told us in regards to people at the service, "Just like a second family." Another staff member was observed giving one person a cup of tea and the person stroked the staff members face. The staff member reciprocated with a hug. A third member of care staff told us, "People can access the garden… it's so important…being indoors must be depressing but being out in the garden and seeing the bright coloured flowers really cheers them up."

During our interviews with staff, one person walked into the room we used. The member of care staff we were speaking with interacted extremely well with the person and escorted them to the lounge and ensured they had some refreshments. They were reassuring and encouraging, which the person responded well to.

Staff knew people well. One staff member explained how one person loved music and this was used to help them calm down when they were in a low mood. Another staff member explained how one person liked to cuddle their 'baby', which was a doll dressed in baby clothing. The staff member explained that the person was comforted by the rocking movements of trying to get the 'baby' to sleep.

Discussions with all members of the staffing team confirmed that they knew how to promote people's dignity and show people respect. They all mentioned that they had received staff training in this area. One staff member said, "We make people feel comfortable and close doors." One staff member explained how they covered people when performing personal care duties and said how important it was for the person. We overheard one staff member showing respect to one person as they whispered, "I'm just going to wipe your nose."

People appeared well presented, although we noted that not everyone was wearing slippers or other footwear. We spoke to the registered manager about this and he told us that people were encouraged to wear footwear, but that they recognised how difficult it was for some people to maintain this due to their health condition or behaviour. He noted our comments and said he would look into the matter to ensure staff were doing all they could, which he assured us they would be.

One relative told us they had been fully involved with the care planning of their family member who had lacked the capacity to make a specific decision. They told us that the staff had involved them in a recent review of their family member's care and that particular changes had been made which they had fully agreed with.

Discussion with the staff revealed there were no people living at the service with any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010 that applied to people living there; age, disability, gender, marital status, race, religion and sexual orientation. We were told that some people had religious needs, but these were adequately provided for within people's own family and spiritual circles. We saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this.

People were encouraged to be as independent as possible. One staff member told us it was important to let people brush their own teeth, for example, rather than have staff taking over. We saw people being able to eat their meals at lunch time and one person was praised for getting an article of clothing back on after they had taken it off.

Good

Is the service responsive?

Our findings

Relatives and healthcare professionals that we spoke with expressed confidence that the registered manager and staff had the knowledge and skills needed to meet people's needs appropriately.

The provider was in the process of implementing new paperwork across the service and the registered manager was monitoring this to ensure it was done swiftly and fully.

People had an assessment completed before they moved into the service to ensure that the service was appropriate and could meet their needs. The assessment included, for example, a medical history, mobility needs, communication needs and any issues identified with behaviour that would possibly challenge the service. Once people had moved into the service, a full care plan and various assessments were put in place, including those in connection with nutritional requirements, mobility, behavioural and skin viability.

Care plans were centred around the individual person and included details of how staff could support people with their particular identified needs. For example, a behavioural care plan for one person had details of how staff should look for triggers, including, "boredom", "insensitivity", "misinterpretation of approach", "pain" or "infection." It was also recorded that the person's needs were, "To be occupied in meaningful activity." We located the person which the care plan related to and staff were following this by the actions they took and what the person was engrossed in doing. Issues had been identified regarding one person's mobility and we noted that the GP had been informed and staff were monitoring the situation. People's personal preferences were detailed in care records. One person who had personal care needs, had it identified on their records that they liked to be showered at night and liked to wear skirts and blouses as they would not wear trousers. People's care plans were reviewed regularly and this included involvement from the person where possible, relatives and other healthcare professionals. One staff member told us that people had "life history" books kept in their rooms which relatives had helped put together.

One person who lived at the service had been assessed by the occupational therapist to get a bespoke chair. We saw from records that this was in the process of being sourced, but there had been a delay due to funding. The registered manager emailed us the day after the site visit to confirm that they would ensure that the person would have the chair provided for them soon and would let us know of the outcome.

One relative confirmed that "lots" of activities occurred at the service and said, "They [staff] take [relative] out which they like. They keep him interested which is good." Two activity coordinators worked at the service and promoted a range of activities. These included musical events, exercises, walks out with the activity coordinators, games and taking people shopping. One activity coordinator told us, "I also try and support them [people] to maintain their independence and maintain family contact. We have a post box so people can post cards or letters, so if it was someone's birthday we could send letters….it's just that correspondence and linking up with families and friends (meaning it's important)." We were told by staff, that one person had completed a sponsored walk to help raise money for charity. The activity coordinator told us, "I always try and think outside of the box"; "We are waiting for metro passes so we can get people on the metro"; "People go to the fish quay" and "A couple of [people] love gardening, so I have set up a

gardening club and a DIY club, we also have a photography session."

The service had links with local church networks to provide a service within the home every fortnight for anyone wishing to participate.

People had social activities care plans in place and a history of the person was recorded. From this information we saw that care plans contained details of what people liked to do, including for example, gaining comfort from animals that had visited the home. We saw from records of activities that had taken place that the service had been visited by miniature horses and reptiles. A staff member confirmed that the visit had taken place and said, "[Name of person] loved the horse that came." This showed that activities were tailored to support the likes of people who lived at the service.

Staff told us that many people went out into the garden area, including those who lived with dementia. One staff member said, "It's lovely out there for people to just sit and look at the pretty flowers and hear the birds singing." In the garden area we saw a large wooded hut, which was open and contained craft equipment and other items for activities to take place. One staff member told us, "People use this area in the warmer weather to make things and come and sit. The activity coordinator brings people out to do things with them."

Staff were able to spend time sitting chatting to people. We observed a staff member talking to one person about a motorbike they used to have and both staff and the person enjoyed this interaction. It was clear from the information we were given and from conversations with people and staff, that the registered manager promoted social inclusion and a full programme of activities to take place with people.

People were able to make choices about day to day living. One person told us, "I can choose what I have for breakfast, dinner and tea." A staff member told us it was important to enable people to choose and said, "I always promote [person's name] to choose her own clothes. I will show her what clothes she has and she will choose." We overheard one person being asked if they wanted to go out into the garden. They replied, "No, I'll just sit in here thank you." The staff member respected their decision and the person was left in peace.

There had been eight complaints made to the service during 2016, these were both written and verbal and we noted that the numbers of complaints had reduced from the previous year by half. Records of complaints, including information about meetings held with staff, fact finding investigations and collecting statements from any witnesses. We were confident that the registered manager had dealt with all complaints in an appropriate manner and in a timely way. People we spoke with knew how to complain and information to support them in the process was available, including in 'service user' packs and in the main reception area and other parts of the service.

We asked and received permission to view and report on the compliments made via thank you cards in the service. Comments included, "Thank you for the compassionate care you gave [person]"; "It was good to know she was happy and safe with you" and "Saying thank you will never express our appreciation."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. The registered manager was present and assisted with the inspection. He had worked at the service for just over a year at the time of inspection and had registered in August 2015. He had a background as a registered mental health nurse and had worked with people who had behaviour which challenged services within a residential setting for many years.

People who lived at the service told us they liked the registered manager and one person told us, "He helps us with all sorts of things." and "Yes, I like him, he's nice." Relative comments included, "Have seen [registered manager] out and about"; "[Registered manager] is on the ball with people in here….does a great job." Staff comments included, "Definitely doing things properly"; "[Registered manager] is really good. Quite laid back and puts in far more hours than he should"; [Registered manager] is brilliant, one of the best we've had. He does walk arounds….he knows people" and "Since [registered manager] came, we have worked really hard….he's a strong manager."

Staff told us that morale was good and they worked well as a team. They told us that they felt supported as a team and that the registered manager's door was always open if they needed to discuss any concerns or issues they may have. Although there were no incentive schemes that staff were aware of, one staff member told us, "[Registered manager] praises you…it's nice….I feel appreciated. Deputies and seniors recognise your contribution and say thanks." However, one staff member, who wished to remain anonymous, told us that they felt bullied by several of the staff within the service. We noted that the staff member had not brought this to the attention of any line management prior to the inspection. We brought this to the attention of the registered manager who said he would look into this matter with staff in general and commented that staff were aware they should report issues to have them addressed appropriately.

We visited the staff room and found the registered manager had displayed various information articles to enhance staff knowledge and raise awareness. For example, there was a health and safety notice board and a manager's notice board. These had information about infection control, policies and procedures, information about how to join a trade union, when the next team meeting was and also a copy of a risk assessment in relation to the heat and weather. We also saw lists of training which had been booked for various staff members. One staff member told us that the registered manager put memos in the staff room in connection with the "company" business. This all indicated that the registered manager was open and transparent with information to his staff team.

Staff confirmed that surveys were sent out to families every three months and these were returned to head office who analysed them and sent the results back to the service. Staff also confirmed that the activities coordinators completed questionnaires with people who lived at the service in order to capture their views of the care provided. We saw a recently returned analysis which showed overall positive comments from people, relatives and staff. Comment included, "The manager is a very good listener" and "I do like the way the home is run now." This meant there was a process in place to obtain the feedback of those involved in the service.

Suggestions and comment cards were in place for people or visitors to comment on anything they would like changed or wanted to make staff aware of. Most comments were positive, including a comment from one family thanking the staff at the service for organising and joining in with a person's birthday celebrations. We also found one comment from a relative who had suggested better furniture should be purchased. The registered manager had seen this information and was investigating further.

Meetings took place for people and their families, although one relative asked if it was possible for the staff to communicate these meetings a little better and suggested sending a memo, although the same relative said that communications were "Spot on" with the registered manager.

Staff confirmed that team meetings took place regularly. One relative confirmed that nursing staff meetings also took place as they had "Seen them occur". Minutes of various staff meetings showed that staff discussed a range of topics, including for example, safeguarding, training, head injuries, documentation and had shared positive feedback.

When we spoke with different members of the staff team, they all knew what their areas of responsibility were and were able to explain these to us. For example, nursing staff told us that it was their responsibility, for example, to keep people's paperwork up to date, to complete particular audits and to complete daily checks on medicine administration records. One member of nursing staff said, "I love it – great working here. I like the interactions people have with staff. Thoroughly enjoying the role."

There were a range of robust quality assurance processes in place, including audits and checks on all parts of the service. These included, dining experience checks and financial, medicines and care file audits. Care file audits consisted of checks on people's records to ensure particular pieces of information were all in place, including personal emergency evacuation procedures, hospital information and personal profiles. We saw a care file audit on one person's records which noted that a 'social activities care plan' was not in place; we then saw that this had been actioned as completed. All of these checks were completed regularly and when issues had been identified, the registered manager had actioned these as part of their 'home development plan' and their 'to do' list. For example, it was noted that as part of the quality monitoring process it had been identified that risk assessments were poor quality and needed to be reviewed. We saw that the registered manager had ensured that these were now in place and this was marked as completed.

Staff had signed to verify that they had read and understood various policies and procedures within the service, including, for example, the disposal of sharps, smoking and various care techniques. They also signed to say they had read and understood how fire evacuation procedures would be carried out.

There had been recent visits from the local authority contracts and commissioning team and local clinical commissioning group (CCG) as part of their monitoring visits of care homes. Both of these monitoring visits showed that positive work was taking place within the service, one commenting that good interactions had been seen and good care planning was in place. Comments from all healthcare professionals were positive about the management that was now in place at the service. It was noted that due to the closure of another service in 2015, the registered manager had worked hard to open up a nursing unit and accepted admissions at very short notice. This was commended by commissioners at the time and demonstrated the well led culture of the team at the service.

Staff and management at the service work in partnership with other organisations. For example, the service had agreed to participate in the 'Health Foundation's Innovating for Improvement Programme: Creating Community Centred Care Project', which aims to improve the health and wellbeing in local communities.

The registered manager had sent notifications to the Commission as legally required by their registration. They were aware of the need to ensure new inspection reports were displayed on the provider's website and also in the service.