ADL Plc

Allambie Court

Inspection report

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Date of inspection visit:
22 February 2017

Date of publication:
05 May 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 22 February 2017 and was unannounced.

Allambie Court is registered to provide accommodation with nursing and personal care for up to 30 older people who are living with dementia. At the time of our inspection visit there were 23 people living in the home.

The service had a registered manager. 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.

The home was last inspected on 23 March 2016, when we found the provider was compliant with the fundamental standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, the home was awarded an overall rating of 'requires improvement'. This was because procedures and policies were not always followed to ensure people consistently received safe and responsive care. The provider's quality assurance checks did not identify when improvements needed to be made.

At this inspection, we checked to see if improvements had been made. We found some actions had been taken and improvements had been made, but there were still areas where improvement was needed.

People were comfortable with the staff who supported them and relatives were confident people were safe living in the home. Staff received training in how to safeguard people from abuse and understood what action they should take in order to protect people from harm. Risks to people's safety were assessed, and risk assessments were updated in response to incidents or changes in need. Staff knew how to support people safely. However, risk assessments were not always clear or detailed enough to ensure consistency.

Risks associated with fire or other emergencies required review, but the provider had already identified a number of measures required to improve people's safety in the event of fire.

People were supported with their medicines by staff who were trained and assessed as competent to give medicines safely. Medicines were given in a timely way and as prescribed.

There were enough staff to meet people's basic care needs. The provider conducted pre-employment checks prior to staff starting work, to ensure their suitability to support people who lived in the home. Staff told us they were not able to work until these checks had been completed.

The provider ensured staff had information on the level of support people needed with decision-making so

people were protected. The registered manager had a good understanding of the Mental Capacity Act, and the need to seek informed consent from people before delivering care and support. Where restrictions on people's liberty were in place, legal processes had been followed to ensure applications for legal authorisation had been sent to the relevant authorities. However, 'best interests' decisions were not always clearly documented and we could not be sure this requirement had always been met.

People had access to health professionals when needed and we saw the care and support provided in the home was in line with what had been recommended. Risks around eating and drinking had been assessed and staff ensured people received the support they needed to remain well.

Staff were respectful and treated people with dignity and respect. People were supported to make choices about their day to day lives.

Care planning and reviews took place, but there was not always evidence of how the views of people and their relatives had been taken into account. The service was not always responsive to the needs of people living with dementia, and the care plans in place did not contain sufficient person centred information to enable this to happen. Staff did not always take opportunities to engage with people and the support provided continued to be task focussed.

Relatives told us they felt able to raise any concerns with the registered manager. They felt these would be listened to and responded to effectively and in a timely way. Staff told us the management team were approachable and responsive to their ideas and suggestions. There were systems in place to monitor the quality of the support provided in the home. However, the registered manager had been unable to ensure issues identified through these systems had been acted on and the service improved.

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 needs had been assessed and risks to their safety were identified. Risk assessments had been updated to reflect changes in people's needs and staff knew how to reduce risks for people. However, risk assessments were not always sufficiently clear or detailed to support new or agency staff. Staff were aware of safeguarding procedures and knew what action to take if they suspected abuse. Medicines were administered safely and as prescribed by staff who were competent to do so.

Is the service effective?

Good

The service was effective.

People's rights were protected. Where people lacked the capacity to make all of their own decisions, the provider protected people's rights under the Mental Capacity Act (MCA) by assessing people's capacity and the support they needed with decision-making. Staff sought consent from people about how their needs should be met. However, where decisions had been made in people's 'best interets', there was not always clear information on how this had been done. People were supported by staff that were competent and trained to meet their needs effectively. People received timely support from health care professionals to assist them in maintaining their health.

Is the service caring?

Good

The service was caring.

People were supported with kindness, dignity and respect. Staff were patient and attentive to people's individual needs. Staff showed respect for people's privacy and talked with them in ways they could understand.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care planning and review took place when people moved into

the home and as their needs changed. However, it was not always clear how and if people and their relatives had been consulted and how information from them had been used to update care plans. This meant people were not always supported in ways that were focussed on them. Support remained focussed on tasks to be completed and was not always in line with what was needed to respond to the needs of people living with dementia. People had access to activities to support them to maintain and develop interests. People knew how to raise complaints and were supported to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People felt able to approach the management team and were listened to when they did. Staff felt supported in their roles which meant there was a culture of free and open communication between staff and the registered manager. Systems were in place to check the quality of the service provided, and to seek feedback from people, their relatives and staff to help the service improve. The registered manager found it difficult to find time to fulfil their role as registered manager, and had been unable to implement and monitor consistent improvements in response to auditing systems in place.

Allambie Court

Detailed findings

Background to this inspection

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

The inspection visit took place on 22 February 2017 and was unannounced. The visit was conducted by two inspectors and a nurse specialist advisor.

We reviewed the information we held about the service. We looked at information received from local authority commissioners. Commissioners are people who work to find appropriate care and support services for people and fund the care provided. We also looked at statutory notifications sent to us by the service. A statutory notification is information about important events which the provider is required to send to us by law.

We reviewed the information in the provider's information return (PIR). This is a form we asked the provider to send to us before we visited. The PIR asked the provider to give some key information about the service, what the service does well and improvements they plan to make. We were able to review the information as part of our evidence when conducting our inspection visit. We found it accurately reflected what we saw during our visit.

During our inspection visit, we spoke with three people who lived in the home. The people we spoke with were not able to converse with us fully, and so we also spent time observing interactions between people and staff. We also spoke with three relatives. We spoke with the registered manager, a member of nursing staff, and four care staff.

We reviewed six people's care plans, to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated to check how the provider gathered information to improve the service. This included medicine records, staff recruitment records, the provider's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

At our previous inspection in March 2016, we found risk assessments had not always been completed and had not always been updated to reflect changes in people's needs. This meant the provider could not be assured people were supported safely.

During this inspection we reviewed risk assessments for people living in the home and found some improvements had been made to ensure people were supported safely. Where people were at risk, assessments had been completed and guidelines were in place for staff on how these risks were to be managed. However, risk assessments remained generic and did not always link clearly to people's care plans. For example, one person had fallen on a number of occasions over the past few months. Hand written alterations had been made to the person's care plan to update staff on how best to support the person. However, these were not always dated and were not always legible. We discussed this person's risks with staff and they knew how to keep the person safe. For example, one staff member said, "[Person's name] has falls, and now has one to one support. We have to read the risk assessments." However, this was not reflected in the person's care plan. We discussed this with the registered manager. They assured us the care plan would be updated to ensure new or agency staff that were less familiar with the person, understood how to reduce the risks of them falling.

Other risks, such as those linked to the premises, or activities that took place at the service, were assessed and actions agreed to minimise the risks. This helped to ensure people were safe in their environment.

There was a 'colour coding' system in use so staff could quickly identify who would need extra support in the event of a fire or other emergency. However, we were told this system was to be used in conjunction with written guidelines for staff on exactly what support each person needed. We could not find these written guidelines. The registered manager told us these were to be completed as a matter of urgency and would provide all the information staff needed to keep people safe in the event of fire.

During our visit we identified one fire door did not close which would have posed a risk to people in the event of a fire. We also found no information on fire drills having taken place, and a fire risk assessment had not been updated since 2015. We spoke with the registered manager about this. Following our inspection visit they sent us information to show the faulty fire door had already been identified and action was being taken to address this. The information provided also confirmed the provider was investing in a new fire detection system and that other works were planned to ensure people were protected in the event of a fire. The registered manager said this work needed to be done to ensure staff had the information they needed in the event of a fire or other emergency.

At our previous inspection we found medicines were not always given as prescribed.

During this inspection we reviewed a number of medication records for people and found improvements had been made and people were being given medicines as prescribed, and that these had been stored safely. We observed staff speaking with people clearly about what medicines they were taking, and staff

ensured people gave their consent. We observed one person who was supported to have an inhaler say, "This is to help me get my breath."

There was a Medicines Administration Record (MAR) folder with people's medicines records, which included clear and comprehensive information on allergies and, what action should be taken in the event of a medicines error. There was also a 'variable dose' policy which guided staff on how to identify what dose to administer to people where their prescription allowed for a variable dose.

Photographs of all tablets people were taking were attached to MAR sheets so staff could see what they looked like. This helped to reduce the risk of administration errors. Errors in the administration of medicines were identified and dealt with quickly. For example, a number of MAR sheets had gaps where medication had not been signed for on a particular day. The lead nurse had noticed these immediately and had reported this to the registered manager. The registered manager planned to address these in upcoming supervision sessions with the member of staff concerned.

Arrangements had been made for staff to record 'patch' medicines and to document the removal of an old patch and replacement with a new one. Patch medicines are those that are applied directly to people's skin. However, we found there was not always a map used for staff to refer to. We raised this with the lead nurse and the registered manager, who assured us staff put the patch on the side opposite to where they had taken the last one off. They told us in future they would add 'left' and 'right' to people's MAR sheet so this was clearer.

We spent time observing the interactions between the people living in the home and the staff supporting them. We saw people were relaxed and comfortable around staff and responded positively when staff approached them. Relatives told us they thought people were safe and well cared for.

The provider protected people from the risk of harm and abuse. Staff had received training in how to protect people from abuse and understood their responsibilities to report any concerns. Staff were able to give us examples of what might be cause for concern, what signs they would look out for and what action they would take. One staff member told us, "I have never witnessed anything [of concern] but if I did I would tell the manager. If they did not listen, I would tell CQC."

There were policies and procedures for staff to follow should they be concerned that abuse had happened. The registered manager had made safeguarding referrals to the Local Authority, and notified the CQC when referrals had been made. The registered manager kept written records of safeguarding referrals they had made so they could keep track of them and identify the outcomes of any investigations.

The provider's recruitment process ensured risks to people's safety were minimised, and that staff with the right skills, knowledge and values were brought in to work at the home. Staff told us they had to wait for checks and references to come through before they started working in the home. Records showed the registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about potential new staff. The DBS is a national agency that keeps records of criminal convictions.

Relatives we spoke with told us they thought there were enough staff. Staff agreed, with one staff member telling us, "Staff numbers are really good. We have four or five normally, working two per floor." During our inspection we saw staff were on hand to respond to people where required, and we did not see people waiting to have their needs met.

The registered manager told us they used a dependency tool to establish how many staff were needed to meet people's care needs. The registered manager told us staffing was flexible, and "depends on what is happening on the day. We can bring extra in if we need to." The registered manager used agency staff to ensure there was adequate nursing cover.

Good

Is the service effective?

Our findings

Most people we spoke with were unable to give an opinion on whether or not staff were well trained and knew how to support them. However, one person told us, "Oh yes, they are very good." When asked if they thought the staff were well trained, one relative told us, "I think they [staff] try their best." Talking about the support their relative received, one relative said, "The staff are marvellous with him."

Staff told us they had an induction when they started working in the home. This included training to help them ensure they were supporting people safely including health and safety; moving and handling and safeguarding. They told us they also shadowed experienced staff. The provider encouraged new staff to obtain further qualifications associated with their role. Some new staff had accepted the opportunity to undertake a Level 3 Diploma in health and social care. Staff told us they felt well supported when they started working at the home.

The Care Certificate assesses staff against a specific set of nationally agreed standards. Staff have to demonstrate they have the skills, knowledge and behaviours to ensure they provide compassionate and high quality care and support. The registered manager told us they were looking at how they could begin to use the Care Certificate to induct new staff to the home.

Staff told us they were well trained and knew how to support people effectively. They were satisfied with the range of training available to them. We saw staff helping people to transfer from one chair to another. They used a hoist where people had been assessed as needing this to support them. They did this safely and effectively, and were seen to be putting their training into practice. We spoke with one member of staff who had taken on responsibility for engaging with and stimulating people living with dementia. They told us they had been supported to undertake some training to better understand how to engage people and to support other staff members to do so. They said, "I have just completed distance learning in person-centred care planning. I learnt about how to consider people's cultural and religious needs for example." They explained, "A Church of England reader comes in for communion once a month. I have also contacted the local Roman Catholic church to see if they can come in. Where people have other religions, I have spoken with families to ask if people used to attend churches or places of worship, and if they did or if they think people would benefit I can arrange something."

A training record was held by the registered manager, which outlined training each member of staff had undertaken and when. The provider had guidance in place which outlined what training staff should complete depending on their role. The registered manager told us they ensured this guidance was followed, and also monitored what other training staff needed. They told us this was in response to the changing needs of people, as well as discussions with staff and day to day observations of their practice by the registered manager and senior carers.

Staff told us they felt supported in their role and had regular opportunities to talk with senior staff if they needed to. They told us the senior carers observed their practice on a regular basis and would frequently talk to them about how they might do things differently. Staff also had opportunities for formal supervision

meetings. The provider had a "supervision" policy, which stated staff should have a supervision meeting every six months. One staff member said, "I can see [senior carer] whenever I want. We get loads of opportunities." In addition to this, staff also attended group supervision meetings. For example, staff had attended a group supervision meeting recently to talk about the correct use of slings for people who needed to be hoisted when transferring from, for example, a bed to their chair.

Staff told us there were handover meetings twice daily, once in the morning, and again in the evening. They told us this helped them to understand what had happened prior to them being on shift which enabled them to know how to respond to people so they could provide effective care on any given day.

The provider ensured nursing staff working in the home maintained their knowledge, skills and values. Records showed the registered manager conducted annual checks of nursing staff to ensure they complied with the requirements of the Nursing and Midwifery Council (NMC) to retain their professional registration. Records also showed that nursing staff had their competence to administer medicines checked on an annual basis.

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 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.

Staff asked for people's consent before supporting them. We observed how staff approached people and explained what they were about to do. There was clear communication, and people were asked their opinions about how they wanted to be supported.

The registered manager had an understanding of the legislation in relation to the Deprivation of Liberty safeguards (DoLS). Where restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant authorities so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation.

Staff had a basic understanding of MCA and DoLS. They knew people who lacked capacity needed to be supported where decisions needed to be made in their 'best interests', for example. One staff member said that they might need to, "Ask family, friends, or a doctor." The staff member went on to tell us about people who had 'fluctuating' capacity and about the need to seek consent.

Capacity assessments had been completed where required and documented the level of understanding people had of decisions to be made in relation to their care. However, where decisions had been made in people's 'best interests', these were not always clearly recorded in people's care records. For example, some care records read, "GP has given consent." We discussed this with the registered manager and the lead nurse, who both agreed it was not possible for a GP to give consent, but that a process of making a best interests decision where someone lacked capacity in a particular area, would need to have been undertaken and documented. The registered manager assured us best interest decision making and recording would be improved.

Risks to people's nutrition and hydration were minimised. People with specific needs and risks in relation to their diet had a nutritional assessment and care plans were in place detailing actions required. We spoke

with a visiting health professional with responsibility for assessing people's needs for eating and drinking. They told us, "In general I have found the staff okay. They follow the instructions that I leave, there is nothing that really gives me concern". Records showed where people were at risk of losing weight, plans were in place to monitor this and records were completed to ensure this happened.

We spoke with the chef about how food was chosen for people. They told us menus were determined by the provider every four weeks, and ingredients needed to prepare the food were delivered to the home regularly. There was a board on display in the kitchen which included information on who had a special diet, for example, a softened or pureed diet. The chef told us if someone's dietary needs changed, the registered manager let them know and they would ensure the information board was updated. They also told us how they fortified foods to enhance people's calorie and fat intake to reduce the risk of people losing weight. They explained they added cream to food such as mashed potato, and used full fat milk and butter wherever possible. They were aware of people's individual dietary requirements. For example, they told us about one person who had a low sugar diet due to diabetes. They explained, "I go on the internet and get recipes off there for people with diabetes."

At lunch time, people were supported to choose where they wanted to eat. For example, we observed staff asking one person if they preferred to eat in the dining room or the 'tea room'. Staff communicated clearly and effectively, giving the person time to respond. Assistance and support was offered to people at lunch time if they needed it. For example, one staff member asked a person, "Do you want me to cut it up for you?"

Staff ensured people had a choice of drinks available, and that they had enough to drink. For example, one staff member noticed a person had finished their drink. They asked the person, "Do you want another drink [person's name]?"

There was a 'picture board' in the dining area, which we had been told earlier in the day would be updated with photographs of food on offer to help people choose what they wanted to eat. However, at lunch time, the board had not been updated. There were photographs of breakfast, toast, banana and ice cream, none of which were on offer on the lunch time menu that day. People were asked verbally what they wanted to eat, but we did not see people being given a visual choice of plated meals. This can be helpful for people living with dementia, who may not understand or be able to respond to a verbal choice, but may be able to indicate what they want to eat, by pointing to a plated meal for example.

One person had their food pureed due to difficulties with swallowing. A specialised plate was used so the different food items were separated. However, we saw all the food was of the same colour. The staff member assisting the person did not speak with them about what food they were eating, which could have enhanced the experience of the person and encouraged them to enjoy their food.

People and their relatives told us people were supported to access health professionals when required. One person told us, "I get to see someone for my toes and hearing." They added they also saw the doctor, "When I ask for him." One relative told us, "They [staff] are very good at getting the doctor in."

Good

Is the service caring?

Our findings

People told us staff were mostly kind and caring and treated them with respect. One person told us, "Staff are caring. I would not say all, but the biggest part of them." We saw people interacting on a one to one basis with staff. One staff member was particularly good at interacting with people, and people responded positively to them. They were patient and kind and repeated information each time someone asked them as if it was the first time they had asked the question. One person reached out their hand to a member of staff. We observed the staff member take the person's hand and sit and chat with them. They seemed happy and reassured by this.

Relatives felt there was a caring, family-type atmosphere which helped people to feel cared for and valued. One relative told us staff were "lovely", and that they were "very caring." Another relative told us, "There is a very homely atmosphere here."
The registered manager had tried to ensure people's environment was comfortable and personal to them. The registered manager told us the home previously had shared rooms, but a decision was taken not to have any shared in order to support people's dignity and privacy.

During our inspection visit we saw lots of evidence of respect for people as equals. Staff supported people in ways that helped to maintain people's dignity and privacy. Staff were observed and heard to be discreet when people needed assistance and always spoke to people with respect. We saw staff knock on bedroom doors and identify themselves rather than just entering, all of which were positive indicators of an environment which respects individual needs and wishes and promotes dignity.

Staff encouraged people to be as independent as possible. Staff supported people in ways that made it possible for them to do things for themselves. While eating for example, staff encouraged people to hold their own cutlery. Relatives agreed. One relative spoke with us about how the staff had worked with their family member when they had been discharged from hospital. They felt the person had improved since they had been living in the home, and this was due in part to the good work of the staff. They told us, "The staff are marvellous with [person's name]."

People were supported to maintain relationships with family and friends. Relatives told us there were no restrictions on when they could visit or how long they could stay for. On the day of our inspection visit, a number of relatives were visiting people, and we saw they were comfortable with staff and were made to feel welcome. Over lunch time, families were encouraged to come in and sit with people. This resulted in a lively, happy atmosphere, with lots of chatter and conversation taking place. One relative spoke with us about how the home had helped people and their families celebrate Christmas together if they wanted to. They told us, "Christmas was fantastic. We had a beautiful dinner, all the family came down and had dinner with [name]. Nothing was too much trouble."

We saw people's personal details and records were held securely at the home. Records were filed in locked cabinets and locked storage facilities, so only authorised staff were able to access personal and sensitive information.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection in March 2016, we found care planning and review was not robust and in some cases there was no evidence that this had happened. This meant people were not always supported in ways that were focussed on them.

At this inspection, we found some improvements had been made, but that care plans remained task focussed and were not sufficiently personalised. We also found that whilst there was evidence that care plans had been regularly reviewed, evidence of reviews did not always include the views of the person themselves and how these had been ascertained. Neither did they include relative's views.

One relative told us they were not aware of care reviews having taken place, but that staff talked to them about what people needed and how and when their needs had changed. People and relatives confirmed that they were involved in discussions about their individual care and support, however in some of the care plans we reviewed this was not clearly documented. Consultation and consent should be in place for everyone living in the home. We discussed this with the lead nurse who told us, "I agree with you, the care plans are not what I think a care plan should be and I was surprised when I saw them but they will get sorted now." We also raised our concerns with the registered manager who explained, "We know that the care plans are not right and we are in the process of sorting this. It's not going to be easy but we will do it. There have been staffing issues with nurses but hopefully we can now move forward." They also explained they were in the process of moving all care plans to the provider's new format. They said this would make care plans more personalised and detailed.

At our last inspection, we found people did not have the opportunity to engage in activities which took note of their personal interests, likes or dislikes. We also found interactions were predominantly 'task focussed'.

At this inspection, we found improvements had been made. There was now a range of activities on offer for people to take part in if they wanted to. We spoke with a member of staff who was responsible for arranging and facilitating activities in the home. They told us, "Things are moving forwards. We now have the therapy dog for example, along with a variety of entertainment." They added, "To start with I have concentrated on group activities. Now that is up and running I want to focus on more one to one activities."

Relatives told us they thought the home responded well to people's needs, and supported the choices they made. For example, one relative commented, "At night, [name] is able to stay up and watch films. [Name] always liked doing that." They also told us they regularly saw staff interacting with people. They added, "I can go home without worrying." Another relative told us, "Whatever I have suggested, they are straight at it."

We observed how some care staff used their skills and knowledge of people to enhance people's day to day experiences. For example, we observed one member of care staff with a book about trains sitting with a person and talking to them about what was in the book. While they were chatting, the staff member asked the person if the music was too loud. The person nodded so the staff member turned the music down. The person responded well to this interaction.

However, care staff did not always take opportunities to interact with people, and the interaction remained focussed on 'tasks' to be completed rather than people's lived experiences. For example, we observed care staff enter communal areas of the home on three occasions, without greeting the people in the room or conversing with them. We also observed two members of staff supporting a person to transfer from their wheelchair to an easy chair. Whilst this was done safely, there was no interaction with the person. We raised this with the registered manager and the lead nurse. They agreed this meant opportunities to respond better to the needs of people living with dementia through engagement and interaction were being missed. They told us they planned to raise this at staff meetings and in training.

Most of the people living in the home were diagnosed with varying stages of dementia, but there was little evidence of implemented nationally recognised areas of good practice, which would have helped the home respond to those people's needs. There was very little dementia friendly signage for example. The home had numerous dead end corridors which did not help people experiencing advanced dementia, and the lack of signage compounded this problem further. Some thought had been given to specific décor and the use of tone and colour to help orientate people. For example, people had bedroom doors which were a different colour to help orientate them. We also saw personal photographs of individuals on doors to assist them to find their own rooms. The registered manager told us they planned to visit local services which were designed to support people living with dementia so they could implement good ideas in the home.

Everyone we spoke with told us they were satisfied with the service and had no reason to make a formal complaint. Relatives told us they had not had cause to complain, but were confident about raising any concerns with the registered manager. The provider's complaints policy was accessible to people which informed them how to make a complaint and how to pursue it if they were not satisfied with their response. Records showed that complaints received within the last 12 months had been resolved to people's satisfaction.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in March 2016, we found systems designed to check the quality and safety of the service provided were not being used and were not effective.

At this inspection we found improvements had been made. The registered manager told us they had not fully understood the importance or the process of auditing effectively when we last inspected the service. However, since that time they explained the provider had given them training, support and guidance in how to audit effectively, and that systems were now in place to do this, so the service could improve.

There were a range of audits completed by the provider to help the service improve. These had identified some of the issues we identified in our inspection. For example, a provider visit two weeks prior to our inspection visit had identified updates needed to care plans, including better recording of best interests decisions and how these impacted on people's care. An action plan had been developed by the registered manager and the provider, in order to address the issues identified.

A recent audit had been completed of all accidents and incidents that had taken place over the preceding months. This identified a need to review the timings of staff breaks to ensure staff could keep an eye on people at times where it had been identified that people were more likely to fall.

The provider had systems in place to gather the views of people, relatives and others with a view to learning more about the service they provided and how it could be improved. Questionnaires had been sent out to people living in the home and their relatives in December 2016. The registered manager had made some brief hand written notes summarising key feedback, and told us they had not yet had an opportunity to formulate an action plan so feedback could be used to help the service improve. The registered manager told us there had been a 'relatives and residents' meeting recently, which had been very interactive. They told us they hoped to be able to use these meetings as further opportunities to get people's views and improve the service as a result. One relative told us they had attended a recent meeting and found it "quite positive."

At our last inspection, we found the registered manager did not have time to fulfil their role as registered manager while they were also on duty as one of the nursing staff.

At this inspection we found progress had been made on this, but this had not been sustained, due to unforeseen circumstances. This meant that whilst improved auditing systems had identified issues needing to be addressed, such as the need for more personalised care plans, improvements had not been made as a result. The registered manager explained the provider had recognised they needed to be relieved of their nursing duties in order to focus on managing the home. An extra member of nursing staff had been recruited to enable this to happen, but due to an extended absence from the service, this had not been as effective as they had hoped. A new clinical lead had been recruited shortly prior to our inspection visit. They told us, "I think [registered manager] needs to be taken off her role as a nurse on the floor so they can focus on being a manager."

People were positive about the registered manager. One person said, "I like her I do. It is her attitude." Relatives also told us they felt the registered manager was very visible around the home, and had a good rapport with people and staff. One relative commented, "[Registered manager] is always about. [Person's name] looks forward to being with them." When talking about why they helped their family member choose the home, one relative told us, "I love it!" They added, "I think they [staff] are brilliant."

External professionals were also positive about the registered manager. We spoke with a visiting health professional who told us, "[Registered manager] is very good, very effective."

Staff felt well supported by the registered manager, and told us the home was a good place to work. One staff member told us, "I feel it is like a family. I like coming to work. It's quite a stable staff team. We laugh every day." Another staff member told us, "I do feel valued for what I do, [registered manager] is very approachable and I feel she listens to me when I raise things with them." Another staff member said, "Yes they have supported me to do NVQ level 2 and 3 and I feel the directors are approachable and supportive. They go out of their way when here to speak to you. They have just ordered a load of new furniture so I do think they invest in the home if needed. They are very good."

We observed the registered manager role-modelling for staff on how to engage and interact with people living in the home. For example, they communicated with people on their level, maintained eye contact and ensured they spoke clearly to help people understand and converse. However, whilst the registered manager showed good practice in this area, and was visibly demonstrating this around the home, not all staff had been able to understand the importance of working in a less task focussed way, and of using opportunities to interact with people living with dementia.

In discussion with staff, it was clear there was a lack of knowledge around person centred planning and person centred support processes. This was another area where there was a need for action to ensure that people' s needs were central to the functions of the service. This included helping people achieve aspirations and dreams as well as having their personal care needs met. We raised this with the registered manager, who agreed we had identified similar issues at our previous inspection. They told us they would work with the lead nurse and the provider to develop ways of helping staff understand the importance of this.

Staff told us they had the opportunity to share their views at staff meetings. Records showed staff had the opportunity to discuss the developing needs of people living in the home and share any concerns they might have. Staff told us they were listened to and that made them more likely to share their views. They told us issues were discussed, actions were agreed and progress on actions was fed back by the registered manager.

The registered manager understood their legal responsibility for submitting statutory notifications to us. This included incidents that affected the service or people who used the service. These had been reported to us as required throughout the previous 12 months.