Care UK Community Partnerships Ltd

Mildenhall Lodge

Inspection report

St Johns Close
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Tel: 01638445036

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 3 February 2016 and was unannounced.

The service is registered for up to 60 older people who may require residential, nursing or dementia care. There were 40 people at the home on the day of our inspection and one of the units has not opened since the home first opened. There was a newly 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.'

The home had an unannounced, comprehensive inspection on the 17 and 22 December 2014. The home was given a rating of requires improvement in every key line of enquiry we inspect against. We also identified a number of breaches of legislation for: medication, records and staffing. During our inspection on the 3 February 2016 we saw considerable improvements but still consider the service has not done enough in terms of ensuring the home is adequately staffed at all times, staff are suitably deployed and staff have the necessary skills and experience. For all other areas inspected we considered them good.

Feedback about staffing levels and our observations on the day confirmed that people did not always get their needs met in a timely way as some staff were not yet fully familiar with people's needs, there was ineffective redeployment of staff at times and not all staff were working cohesively.

However people felt the care they received was good and risks to people's safety were carefully monitored. Staff knew what actions to take if they observed or if people told them they were unsafe.

People received their medicines safely and at the correct time.

Staff recruitment processes were robust and vacant posts had been filled which should help improve the continuity of care.

Gaps in staff training and frequency of supervision were being addressed and staff felt well supported. Staff were accessing the appropriate training and able to demonstrate their knowledge. Some staff's knowledge on the Mental Capacity Act was not sufficiently robust. However the manager and senior staff had a good knowledge. The MCA ensures that, where people have been assessed as lacking capacity to make decisions for themselves, decisions are made in their best interests according to a structured process. The Deprivation of Liberty Safeguards (DoLS) ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

People were supported to eat and drink sufficient to their needs but the timeliness of this support varied

according to the different units. Staff monitored what people ate and drank to make sure it was sufficient to their needs and did not place them at risk of dehydration or malnutrition. Records had improved but did not always accurately reflect what people ate and drank.

People's health care needs were understood by staff and monitored closely so staff could respond to a change in a persons need or risk.

People's care needs were clearly documented and kept under review so they reflected the person's current needs.

There were planned activities to help keep people mentally stimulated and evidence was provided that people were consulted about which activities they would like to do.

There was a robust complaints procedure and opportunity for people to raise concerns/improvements they would like to see.

Staff were caring and helped to promote people's independence and dignity.

The home was well led and improvements had been identified since the last inspection.

The home had adequate quality assurance processes which helped the manager determine what was working well and what required improvement. There was strong leadership and staff felt well supported. People using the service felt things had 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?

Requires Improvement

The service is not always safe.

We were not confident that staffing hours always matched the needs of people using the service.

People received medicines in a safe way by staff trained to administer it.

Staff monitored risks to people's safety and where possible took robust action to reduce risk. Staff knew how to respond to abuse allegations to ensure people were protected as far as they were able.

There were robust recruitment processes in place.

Is the service effective?

Good

The service was effective.

Staff were supported and received training relevant to their role and the needs of people using the service.

Staff supported people lawfully with decisions about their care and welfare.

People were supported to eat and drink enough for their needs.

People's health care needs were met.

Is the service caring?

Good

The service was caring.

Staff were kind and provided support according to people's needs and in a way that promoted people's dignity and independence.

People were consulted about their care needs and the service as a whole.

Is the service responsive?

Good

The service was responsive.

People had sufficient to do and activities were based around their needs as far as possible. This was being developed further to improve activities for people.

People's needs were assessed, planned for and kept under review to ensure the care provided matched people's needs appropriately.

There was a robust complaints procedure in place

Is the service well-led?

Good

The service was well led.

There was a robust quality assurance system which took into account people's views about the service and how it could be improved.

There were audits in place to ensure the service was safe and well managed.

Mildenhall Lodge

Detailed findings

Background to this inspection

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

The inspection took place on the 3 February 2016 and the inspection was unannounced.

The membership of the inspection team consisted of two inspectors and an expert-by-experience. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.' Our expert had experience in dementia care. Prior to our inspection we gathered information already held about the service including feedback from relatives, notifications, which are important events the service are required to tell us about, and previous inspection reports.

During our inspection each inspector based themselves on one of the three units to cover the whole home. We observed care being provided, looked at four care plans, staff records and other records relating to the management of the business. We carried out a medication audit and looked at medicine records We spoke with 15 people using the service, ten relatives, eleven staff including care staff, senior staff, ancillary staff catering and domestic staff and we spoke with one health professional.

Requires Improvement

Is the service safe?

Our findings

At the last inspection to this service on the 17and 22 December 2014 we found there were not enough staff employed to effectively meet people's needs. We made this a breach under our regulatory powers. At this inspection there had been some improvements but staff were still not suitably redeployed on some units at the busiest times of the day. This meant we were not ensured people's needs were met in a timely way. One person said, "I don't think they have enough staff. You don't see many about" Another said, "Staffing is hit and miss. It's been better recently." Another said "There has been more stability recently. It's really improved in the last year."

We spoke with a number of relatives and received some written concerns following our inspection about the timeliness of the care provided. One relative told us, "Mornings they need more staff, lots of the residents are late getting up and have late breakfasts." They told us, "We had concerns and at a relatives meeting before Christmas we spoke about the staffing levels and there not being enough staff at mealtimes and they sorted that out straight away."

On the day of our inspection the home had the number of staff it said it needed and in some areas of the home staff were working effectively to ensure people's needs were met in a timely way. However in the nursing unit staff told us they still felt under pressure to get everyone one up in reasonable time and in accordance with their wishes and needs. One staff told us, "Not enough staff in the mornings – it is now 11.25 and we are still doing breakfast and personal care still got one more to do. We need four staff to do personal care and one to do the breakfast. They bring people in from the agency but they don't know the residents."

During our inspection we noted that staff were still assisting people with their personal care just prior to lunch and some people were just finishing breakfast as lunch was about to be served. At 12.05 we observed people in the dining room in the Miller suite. One person had breakfast in front of them which was cold and there were no staff in the vicinity to assist them. We spoke with the regional manager who said several people were late to bed. They said additional staff were redeployed to help care staff at lunch time. However we observed that not all staff worked effectively and did not always pull together as a team. Times of meals being served were said to be flexible but we observed inadequate spacing between breakfast and lunch which might result in people not feeling hungry.

Staff told us staffing levels had increased recently. However they also said they did not always have the full complement of staff, when asked how often they were short they said, 'about 50 % of the time.' This was not supported by the staffing rotas we saw. On the nursing unit staff told us at least nine people needed two staff to assist so even with four staff it was difficult to assist people in a timely way. They said this was exacerbated but only one hoist. A relative also told us, "It is wonderful and the only thing we complain about is they only have one small hoist and that might be elsewhere and they might have to wait half an hour to go to the toilet, the staff apologise to us about the wait for the toilet" "It is not so much staff needed as more machines to help people to the toilet."

Staff recruitment was ongoing and there had been some success with new staff appointed and a significant reduction of the number of agency staff being used. The manager told us 400 hundred agency hours had been used a week but this had recently reduced to 200 hours a week. Both the manager and deputy manager were fairly new to post and were confident they had recruited to the vacant posts and were in the process of waiting for recruitment checks to come through before giving new staff a start date. This would mean agency hours would no longer be needed to fill vacant posts.

Staff records showed that the provider followed a robust recruitment process and appropriate checks were undertaken before staff started work. We spoke with one new member of staff and they were able to describe the recruitment process and confirmed that they were asked to provide at least two references and were asked for identification and a DBS check. The staff files we looked at provided evidence of: references, application forms, a criminal records check and personal identification. The interview process helped ensure only suitable staff were employed.

Risks to people's safety were reduced as far as possible and people were monitored for their safety. One relative told us their family member was quite safe. They had a special bed for their needs which could be lowered to help them get out of bed safely. They had a sensor alarm so staff would be alerted as to when they were mobile and at increased risk of falls. Other people had special adapted equipment and beds suitable for their needs. Some people had crash mats where bedrails were not the most suitable means of keeping people safe. Risk assessments were included as part of people's overall care plan and detailed how staff should monitor and minimise risks to people in relation to skin integrity, aspiration, falls, night care and their manual handling needs, mental health needs, hydration and diet. Risk assessments had been reviewed in the last month.

Staff were familiar with people's needs and we saw how effective risk management was in place. For example one person's care plan identified that they had lost some weight in the last six months. There was a support plan for eating and drinking that stated a daily fluids they should have (1200 mls) and strategies for staff on how to encourage the person to eat. It was noted that the person must be weighed weekly based on the malnutrition screen tool (MUST assessment.) This is used to calculate a person's body mass index and identify if they are at nutritional risk. It was noted that the person did not like to be weighed and instructions for staff on how to encourage this. Weekly weight records confirmed staff were able to encourage this person and interventions were preventing further weight loss.

We saw further care plans had been completed appropriately and updated monthly. These included: behaviour that challenges, skin care, and medication. Accident and incident form were completed and a body map used which showed how the home monitored any changes to people as a result of a fall or otherwise.

We observed some people who were unable to access their call bells and those who were left unsupervised in communal areas and had no means to summon staff assistance. We noted one person who was lying completely flat unable to use their call bell and calling out. Their tea was on the side and they had no means of reaching it. Staff assisted them but only when we found them and asked them to assist. This was raised with the regional manager who told us they had lots of pendants people could have if they were assessed as suitable.

The Manager told us that the standard was to respond to all call bells within five minutes; anything over this was investigated. We saw that response times were reviewed daily and a brief investigation took place if the response time was over five minutes. There were no major issues with response times.

At our last inspection on the 17 and 22 December 2014 we identified a breach in the safe administration of medication. At this inspection we found medicines were being managed safely. We met with the clinical lead who told us that they carried out observations of staff's practice until they were confident that staff were competent to administer medicines. Medicines were administered by nurses and senior staff only. One nurse confirmed they had been observed for a minimum of three days and the clinical lead had observed on average nine drug rounds. We saw medication competency sheets used to assess staff's ability to give medicines safely and these were sufficiently detailed. Staff competencies were reassessed at least annually or more often if there were concerns about the staff member's practices.

Staff completed an online medication administration course and also had face to face training. We saw the training calendar which showed staff training and competencies were up to date.

There were systems in place to audit the medication to ensure it was being administered as prescribed and was available when people needed it. The home carried out weekly medication audits and there were also external pharmacy audits. Some issues had been identified through these audits but we could see what actions had been taken to address these.

The clinical lead told us they operated a two hour window in terms of people getting their medication so if people were still asleep in the morning they might receive their medicines later but within the agreed time frame. Other medicine times would be varied accordingly as some medicines were time specific and staff were aware of this. We did not see any gaps on the medication recording sheets, (MAR) viewed. There was a named signature sheet to help us identify who had administered the medication. We noted that staff were not always recording on the back of the MAR sheets when they should to explain why medicines had not been administered.

The clinical lead told us there were improved relations with the local GP surgeries and as the named contact the repeated ordering cycle for people medicines had improved. They also told us the GPS were reviewing everyone's medicines particularly people's antipsychotic medication to ensure it was still appropriately prescribed according to need. There was a separate, contemporaneous record for creams. There was a policy around self- administration but the clinical lead said no one currently administered their own medications except for one person who did their own creams and there was a risk assessment in place for this.

Each person had a profile including a photograph and basic personal information including any allergies they had. There were details of how people liked to take their medicines and any special considerations. There were prescribed when necessary, (PRN) protocols so staff would know when it was appropriate to administer medicines not required all the time. The Abbey pain scale is a recognised tool used to help assess people's pain where they might not be able to tell you. This was in place for people with dementia. PRN medicines were reviewed monthly

We looked at the medicine trolleys and these were well organised with everything individually labelled and prescribed. Bottles and creams were dated when opened. We saw medicines were stored according to their instruction and temperatures were in range and taken daily.

People's safety was promoted by well trained staff who knew how to act appropriately when they observed or were told about concerns. People told us they felt safe and were at ease in the presence of staff. Staff we spoke with demonstrated an understanding about safeguarding and the reporting procedures. One member of staff told us. "I have reported a safeguarding concern and was happy with how it was dealt with." Information on how to report concerns was displayed throughout the home. We discussed three recent

safeguarding concerns with the Manager and Regional Director and found these were being dealt with appropriately. Relatives told us that the service was safe and that concerns they had raised had been responded to.

Good

Is the service effective?

Our findings

Staff were sufficiently trained and effectively supported to meet people's needs.

Staff felt well supported but did refer to the number of different managers they had seen and how this had affected consistency. All the staff we spoke with felt the current management team were responsive and were bringing positive changes to the service. One staff said, "I feel supported. The Manager and Deputy are approachable." Staff felt having a clinical lead had made a big difference and said they were visible on the floor encouraging and supporting staff with best practice. Staff told us they had not always received regular supervision. The Manager was aware that there were gaps in supervision and we saw that a system was in place to address this. About 75 % of staff had received a supervision or appraisal meeting in the last 2 months. The Manager confirmed that those staff outstanding would receive an appraisal in February 2016 and that the schedule for the year would be completed. Nurses spoken with did not have key areas of practice based on their clinical skills but saw that nurses were being supported with revalidation and keeping their clinical skills up to date.

There was a training matrix in place which showed about 80% compliance. The Manager explained that this was because of the recent increase in new staff and that work was in progress to address the shortfalls. We spoke with staff who told us they had received training appropriate to their roles and gave a range of examples including: basic life support, fire safety, dementia care, supervision, care planning, MUST, NVQ, safeguarding, and Mental Capacity Act (MCA) and Deprivation of Liberties Safeguards. (DoLS.) Staff said some training was face to face and others were e-learning. Staff said they had received training specific to their role and training specific to people's needs although felt this could be extended to cover a wider range of medical conditions affecting people using the service.

Staff had been identified as champions for certain areas such as nutrition. Information about this was clearly displayed on the walls. The Manager told us this was fairly new and staff had been elected for roles based on their expertise and interest. Opportunities for additional relevant training would be made available.

Staff were not able to consistently demonstrate an understanding of MCA and DoLS or describe what this meant for their day to day practice. However, we did observe that staff offered people choices during the day and treated people with care and respect. We also saw that staff had completed some basic training but this in itself was insufficient. We saw that two applications for DoLS had been approved by the local authority and further applications were in progress. They were supported a mental capacity assessment and best interest decision statement. Senior staff were aware of their responsibilities under the Mental Capacity Act.

People were generally complimentary about the food and there was evidence that people were supported to eat and drink enough for their needs. Records demonstrated how risks in relation to nutrition and hydration were managed.

One person told us, "Overall it is good but the food could be improved. They tend to do a menu but what comes is not always the dish that it says." Another person told us," The food is not always hot." Another said, "They are very accommodating if I ask for something else, plain like a jacket potato or salad."

We observed staff serving up the main meal at lunch time and saw care staff encouraging people to eat and promoting choice and upholding people's dignity where they required assistance. Food was served efficiently and looked attractive. There were enough staff to support people effectively.

Relatives were made welcome and we saw one person had a visitor and staff set up a table in their room so they could have some privacy.

We spoke with one relative who told us their family member had definitely improved since being here. They said they had gained weight and had needed to. They said this was because staff supported them to eat. Another relative said "We like it here, they look after us, my relative has put weight on since coming here and we never have any problems and come and go as we please and their husband comes and has an evening meal with them."

Drinks and snacks were offered to people throughout the day. Both care staff and kitchen staff demonstrated an understanding of how to meet people's nutritional needs.

People's fluid intake was being monitored. Records of fluids were totalled up by night staff then handed over to day staff to take action where people had drunk below the targets set. The same target was set for everyone at 1200 mls. For most records viewed people were getting over this but where the fluid in-take was lower than 1200 mls staff were told to encourage and promote more fluid. People's weights were being monitored according to risk. For example where people had lost weight recently and they were considered at risk of malnutrition they were being weighed weekly. The home had introduced a weight tracker so they could monitor at a glance who was at risk and where people's weight was decreasing over a period of time. This tracker did not include people currently being weighed weekly. We had to look at the computerised record for this information. We looked at a number of people's weights and they were fairly static, where weight loss had been identified actions had been taken to prevent further weight loss. For examples food was being fortified, and people were offered home-made milk shakes and snack plates. When a person was newly admitted their food and fluids were monitored for up to seven days to identify any potential concerns. Most people had food and fluid charts unless there was no clinical reason to do so. Information was highlighted visually with a safety cross, highlighted in red when the person was at risk and green when they were drinking enough.

Staff had the skills they needed to monitor and report on any changes to people's health care needs. There was appropriate information in people's care plans and risk assessments were in place for any area of concern. Daily eleven o'clock meetings and handovers between each shift were used to pass on any concerns about people to ensure increased monitoring or if necessary a visit from a health care professional. This was recorded on the professional visit sheet. Weekly clinical meetings were held to discuss people's health care needs and any risk or change to their health care needs so this could be followed up when necessary.

Good

Is the service caring?

Our findings

The care we observed was good and we saw staff regularly interacting with people and the atmosphere was calm and relaxed. One family member told us, 'that staff were inclusive and enabled them as a family to be as involved as much as they wanted to be and included them in all decisions relating to their family members care.' Another said, "Staff are great and they come and talk to you, nice girls." Another said, "Staff are very kind, they all seem caring."

We spoke with lots of people who were mostly complimentary. One said, "It is alright and the staff are ok. It is a nice clean place and I would recommend it." Another said "I think people get fantastic care." Another person said, "It is out of this world here and I cannot thank these people enough, just cannot thank these ladies enough"

Interactions we observed between staff and people who used the service were caring and appropriate to the situation. We saw some excellent examples of care provided with great kindness and empathy. One member of staff told us, "It would be the first choice care home for a family member. I feel very confident about it." Others, unprompted, told us they would be happy for a relative to be there.

The environment promoted people's independence and there were sensory objects on the wall for people to touch particularly to promote sensory experiences for people living with dementia.
People had memory boxes to help them identify their rooms and their bedrooms were personalised.

We saw one person was being supported to eat and their breakfast. The staff member supported the person to put a bib on and commented, "This is more because I am likely to spill it." "You are doing brilliant." The staff member talked to the person about what was on the radio, the music and activities they enjoyed and asked what they would like to do during the day. The interactions were extremely positive.

Relatives raised very few concerns but did say about things going missing including clothes and teeth for which they would be reimbursed.

Relatives confirmed that meetings were held and they had the opportunity to have their say and things changed as a result of their feedback. People confirmed that resident meetings were held and they were consulted about day to day decisions about the home and their plan of care.

Good

Is the service responsive?

Our findings

People's assessed needs were being met but not always in a timely way. We observed staff taking up until lunch time to assist people with their personal care and staff were prioritising people to assist first where families had requested this rather than according to people's individual preferences and wishes. We found staff knowledgeable and new staff were supported by more experienced staff which meant people were supported by staff that knew them. People were well dressed and staff were attentive to their needs. On the nursing floor people were sometimes left unattended and without emotional stimulation as staff were attending to other people. However the interactions we observed were kind and caring.

We spoke with people who were able to tell us about their experiences. One person was tucking into a full English breakfast and then was expecting a visit from their relatives. They said they went downstairs in the afternoon to the 'café.' Another person was being supported by staff to have their breakfast and there was good conversation between them.

There was a range of activities provided to keep people stimulated and these were decided according to people's wishes. People were encouraged to offer their views about what they would like to do. For example, votes were being taken for preferred Easter activities.

A Manager from another home was providing support and advice on activities and resources that would be appropriate for people at the home. We saw that the resources offered were of interest to people.

One person said, "I have been to flower arranging today, we used to have bingo but not now, we could do with more activities. We had a meeting after Christmas and they asked us what we wanted to do. We went to Elveden last summer and to a Restaurant and to tea at the Riverside" The flower arranging was attended by about ten people and during the morning vegetable peeling was another planned activity which took place in the 'café area. .

Other people told us about some of the activities provided which included: cooking, a Christmas pantomime, and regular visits from the hairdressers. People had access to a 'café' downstairs and we saw many families met there with their relatives. People were encouraged to bird watch from the café and record anything seen on a flipchart. Music was on and off throughout the day and two people played their harmonicas which other people using the service seemed to enjoy.

A range of current and up and coming activities were advertised. These included: Pet Care day, Holy Communion annual schedule; food tasting for Chinese New Year; and a Valentines meal. Minutes of the Activities Forum Meeting dated 16th January 2016 was on display which indicated which activities people enjoyed and ideas for additional activities.

The home had a resident of the day, which meant each day of the month they reviewed one person's needs in relation to their care, housekeeping and catering needs. The idea of these reviews was so that a number of staff would be involved and spend time with the person to ensure their needs were being met. This

included the care staff, the chef, the housekeeper, and activity staff. We felt this was a good idea but not all reviews included comments from other key members of staff so we could not be assured resident of day was being used as intended. Staff had regular handovers between each shift and we saw the written handover sheets and communication book. If there were concerns about a person's needs this was passed on. Senior staff held an eleven o'clock meeting each day which included the manager, head of departments and clinical lead. The purpose of this meeting was to identify any concerns or actions which needed to be taken quickly to help the smooth running of the home.

Relatives told us that staff informed them if there were any changes to their family members needs and said the communication between them and the home was good

Care staff spoken with demonstrated a good understanding of the care planning process but some staff said they did not always refer to the main care plan but relied more on the room folders which had information about people's main care needs.

The provider had a complaints policy and procedure and had there was evidence that this was followed. We discussed with the manager the most recent complaint (January 2016) and saw that this had been responded to in line with the provider's policy. A number of people and their relatives told us that where they had raised concerns and or suggestions these had been appropriately dealt with.

Good

Is the service well-led?

Our findings

The service was well managed and run in the interest of people using it. Most people we spoke with were happy with the way the home was gradually improving and had confidence with the new manager to continue with these positive changes. One person told us, "I can't believe how much the home has changed in the last year." A staff member told us about all of the managers there had been but said the current one is 'particularly strong.' They said, "The home is in such a good place. People are given the opportunity to join in activities." Another said, "I think overall there are enough staff. Whenever it is hectic staff handle it." One relative told us, "There is a monthly relative meeting and staffing has improved." Another said, "The Manager always makes herself available."

There was strong governance and leadership at this service. The culture of the home was improving and all staff we spoke with felt well supported and felt things were moving in the right direction. The manager, deputy manager and clinical lead were experienced and working hard to support staff and develop the team so they had the right skills and competencies to deliver high standards of care. We perceived the main threat to the continuity of the service was the high number of vacant hours and use of agency staff. However the Regional manager told us this would soon be a thing of the past as they had actively and successfully recruited to all vacant hours. They also told us staffing levels had increased in line with people's needs and they were carrying out a mapping exercise. This was to help determine how staff were spending their times and how best to redeploy staff to ensure their hours were used effectively.

There were systems in place to assess the quality of the service, such as the health and safety audits we viewed. The frequency of audits had varied but the Regional Manager said now they had a static management team in place audits would take place monthly.

At the last inspection on the 17 and 22 December we identified a breach in records but saw improvements on this occasion. We looked at people's care records which were both in paper form and on an electronic system. Staff told us they received training on the electronic system and had their own individual log in details. Records in people's rooms told us their needs at a glance and how often people received care around their specific needs and safety. Records showed us how risks were being managed particularly around nutrition. However there were gaps in people's nutritional records which was difficult for us to then assess how much people were actually eating and drinking. For example where a person who was at nutritional risks refused a meal there was no evidence they were offered an alternative or if snacks had been given throughout the day with was at odds from what we observed where snacks were available throughout our inspection. There was nothing recorded in the evening which meant records showed people were going for long intervals without drinking or eating. This was inconsistent with what staff told us.

Care plans contained up to date risk assessments and the associated support plans were relevant to their care. Care plans also demonstrated that that people were supported to access health care professionals when required. There was scope to improve the room records which had some gaps on cream charts, repositioning charts and mattress checks. Good life history information about people had been put together and was held in a record in their rooms.

A system was in place for managing complaints and we saw that this was followed. Relatives told us that concerns they had raised had been addressed. There were opportunities for staff, relatives and people using the service to be involved and have their say both on a daily, monthly and as part of an annual quality assurance review.

The attitude of both the Manager and Regional Director to suggestions for improvement was very positive and indicated a proactive approach and open culture. They demonstrated pride in the improvements they had made since the last inspection and much positive intent.

A manager from another home was present on the day of our inspection. We were told how they were sharing best practice around activities and resources; and also helping to review how staff are deployed. Currently they were at the home two days a week. We saw that people responded well to the resources that she had brought.

The manager had come up with an idea called scores on the doors which was basically a voting system in which people put forward ideas of what they would like and the most popular ideas went forward. So for example people had voted for a pub, other people had asked for more roast dinner, (twice a week instead of once.). Other people had suggested a pet but not everyone liked animals. In response the home has got a number of budgerigars and the receptionist brought in her pet dogs. A number of relatives were also observed bringing in their pet dogs.

We only spoke with one health care professional as part of this visit and they told us the home were responsive to their ideas and tried hard to meet individual needs. Community engagement had increased with the opening up of the community centre and increased participation/event in the community.