Gracewell Healthcare Limited

Gracewell of Fareham

Inspection report

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14 September 2017

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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

We carried out an unannounced inspection of this home on 13 and 14 September 2017.

Gracewell of Fareham is registered to provide accommodation, nursing and personal care services for up to 89 older people and people who may be living with dementia or a physical disability. At the time of our inspection 68 people lived at the home. They were accommodated in a purpose built building consisting of three floors and six bungalows for people with greater independence. The ground floor accommodation was intended for people with less complex needs, people living with dementia were supported on the first floor and the second floor accommodated people with other, more complex nursing needs. Each floor was divided into two named wings. Each wing had a shared sitting and dining area and each floor had a larger, central shared area. The ground floor had a hair dressing salon and cafeteria.

There was 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.

At the last inspection in October 2016 we identified one breach of the Care Quality Commission (Registration) Regulations 2009 and two continuing breaches and one new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued requirement notices and a warning notice. At this inspection we found there had been improvements and the regulations had been met.

People and visitors felt the service was safe. People looked comfortable, relaxed and happy in their home and with the people they lived with.

People were supported by staff who had a good understanding of how to keep them safe. All staff had undertaken training on safeguarding adults from abuse and displayed good knowledge on how to report any concerns. Staff were able to describe what action they would take to protect people from harm.

Staff had a good understanding of people's needs and spoke in a caring way about the people they supported.

There were sufficient numbers of staff to meet people's needs and to keep them safe. The provider had effective recruitment and selection procedures in place and carried out checks when they employed staff to help ensure people were safe. Staff were well trained and aspects of training were used regularly when planning care and supporting people with their needs and lifestyle choices.

Staff encouraged people to be independent and promoted people's choice and freedom.

The registered manager and staff demonstrated a good understanding of the Mental Capacity Act 2005.

People were supported where possible to make everyday choices such as what they wanted to wear, eat and how to spend their time. The manager was aware of the correct procedures to follow when people did not have the capacity to make decisions for themselves and if safeguards were required, which could restrict them of their freedom and liberty.

Care records contained detailed information about how individuals wished to be supported. People's risks were well managed, monitored and regularly reviewed to help keep people safe.

People were supported to take part in a range of activities inside the home and they reflected people's interests and hobbies.

People were supported to maintain good health through regular access to health and social care professionals, such as GPs and speech and language therapists. People's dietary needs and any risks were understood and met by the staff team.

Staff described the management as supportive and approachable. Staff were well supported through induction and on-going training.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment.

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 were safe from harm because staff were aware of their responsibilities and able to report any concerns.

Risk assessments were in place to keep people safe.

Medicines were well managed.

Systems had been put in place to keep people, visitors and staff safe.

Is the service effective?

Good

The service was effective.

The service was compliant with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported to make choices about their daily lives. People's fluid and nutritional intake was monitored where required.

People's healthcare needs were met and staff worked with health and social care professionals to help people access relevant services.

Is the service caring?

Good

The service was caring.

Staff provided the care and support people needed and treated people with dignity and respect.

People's views were actively sought and they were involved in making decisions about their care and support.

Staff recognised and promoted the role of family and friends in people's lives.

Is the service responsive?

Good

The service was responsive

People received person centred care and support.

People, were encouraged to make their views known and the service responded by making changes.

Is the service well-led?

Good

The service was well led.

The manager and provider demonstrated good management. They had an open, honest and transparent management style with staff and people who used the service.

The provider had systems in place to check on the quality of service people received and any shortfalls identified were acted upon.

Gracewell of Fareham

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. We decided to carry out the inspection following concerns which had been raised with us about the care and welfare of people at the home, and to follow up on a warning notice which was served following the last inspection in February 2017. The Commission served one warning notice for failing to ensure records in the home were clear, accurate and complete to inform the care people needed. The registered provider had failed to ensure systems were in place to effectively assess, monitor and mitigate the risks associated with peoples care.

This inspection checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on 13 and 14 September 2017 and was unannounced. The inspection was carried out on day one by four inspectors, a specialist advisor and an expert by experience. On day two the inspection was carried out by two inspectors, a specialist advisor 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.

Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law. This Information helped us to identify and address potential areas of concern.

During the inspection we spoke with eleven people living at the home and seven visitors. We observed the care people received and the interaction between staff and people using the service.

We spoke with the registered manager and other provider support, five nurses, the clinical lead, three care staff, an activity coordinator and five housekeeping and kitchen staff. We looked at the care records and other associated documents for thirteen people. We also looked at a range of records relating to the management of the service such as accidents/incidents, staff recruitment and training, complaints, quality audits and policies and procedures. We requested some records to be sent to us. We received this

information.

Good

Is the service safe?

Our findings

People told us they felt safe in the home and staff were available to help them. They told us "It's fine living here." "Staff are very kind. They can't do enough for you" and "They help a lot." We asked "Do you feel safe?" One person said "Yes, I like it. It's very nice." Another said; "Yes. Because of all the codes on the doors you know who is coming in." With regards to medicines people said; "They bring them in the morning and stay while I take them." "I have a nebuliser four times a day."

At our inspection in October 2016 we found the registered provider had not deployed sufficient numbers of suitably qualified, competent, skilled and experienced persons. At this inspection we found the registered provider had taken sufficient action to achieve compliance with this Regulation.

There were enough staff to meet people's needs and keep them safe. We looked at the staff duty rota for a four week period around the week of the inspection. Rotas confirmed what staff had told us; that on the first and second floor there were two nurses one for each side, three care staff for each side and one member of staff who was able to assist either side. On the ground floor there was a senior carer each side and a carer; a total of four staff. In addition there were housekeeping and kitchen staff and activity staff. However staff said "Staff don't always have the time to interact with people." Maybe we could do with a couple more staff. It would be good to have an extra person. Mealtimes can be hard".

Staff had been recruited through a recruitment process that ensured they were safe to work with people at risk. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Suitable references were obtained and any gaps in recruitment history were thoroughly explored. Checks were also undertaken with the Nursing and Midwifery Council (NMC) to confirm that nurses were registered with them and were able to practice.

There was a record of staff being interviewed to assess their suitability for the post although the scoring system on these records had usually not been filled in. Each staff member completed a 'probationary' period when they started work, when their abilities and suitability to continue their employment were formally assessed. Newly appointed staff were enrolled on the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the minimum standard that should be covered as part of induction training of new care workers.

Staff said they had received safeguarding training and knew how to report any signs of abuse. Additionally, staff were familiar with the term "whistleblowing" and said they felt confident to raise any concerns about poor care. All of the staff said they believed that any concerns they raised would be taken seriously. One member of staff said "I've had safeguarding training; if I had a concern I would go to the manager or take my concern to head office or CQC if I needed to". Another said; "I would report concerns to the manager or whistle blow if I needed to".

We looked at 13 people's care plans and daily records. Care plans contained risk assessments for areas such

as falls, mobility, skin integrity and malnutrition. Where risks were identified, the plans contained guidance for staff on how to reduce the risk of harm to people. For example, one person had been assessed as having a very high risk of falling. The plan detailed steps staff should take, such as "forgets tripod, encourage to use it, ensure clutter free environment." During our inspection we heard staff reminding this person to use their mobility aid. Where people had been assessed for the risk of dehydration and malnutrition, people's weights were monitored. When people lost weight support and guidance was sought. Some people were having their food and fluid intake monitored. The monitoring charts we looked at had been completed in full. The target intake for each day was written in care plans and was also written on the chart alongside the reason why the person was being monitored. The charts we looked at showed that people had enough to eat and drink. Throughout the inspection we saw that staff regularly offered people drinks and snacks.

Medicines were managed safely. We observed parts of two medicines rounds. The nurses administering the medicines checked people were happy to have their medicines, didn't rush them and waited until they had swallowed their tablets before signing the medicine administration record (MAR). The nurses asked people if they needed any additional pain relief and when people declined, one said "No problem, if you get any pain later on, just let me know".

Medicine profiles were in place. These included photographs of people, their preferences in relation to how they liked to take their medicines and a record of any allergies. This meant that any staff who were unfamiliar with people would know how to support people with their medicines.
There were MAR gap monitoring forms in place. Staff said they checked the MAR's for any missing signatures and the forms showed that when this happened, the incident was reported to the registered manager. We saw there was one gap in one of the charts we looked at, and this had been reported.

Topical medicine administration charts however, had not been consistently signed by staff. For example, one person had been prescribed a barrier cream. The instructions on the topical chart were "apply on sacrum", but the chart had not been signed since 09/09/2017. Another person had been prescribed a cream for dry skin, but this chart had not been signed on two occasions during August. Staff had not written on the charts if the creams were not needed on these days and therefore this meant there was a risk that people did not always have creams and lotions applied as prescribed. Following the inspection the registered manager sent us information confirming the action they had taken to ensure that staff signed for creams and lotions they had applied.
Transcribed entries on the MAR's had generally been signed and countersigned to check the accuracy of the entry. However, we did see one entry that had been handwritten that wasn't signed or countersigned. The dose that had been written was incorrect which meant there was a risk that the person might have the wrong dose administered. We showed this to the nurse on duty at the time of our inspection who said they would rectify this. Following the inspection the registered manager sent us information confirming that this had been rectified.

Some people were having their medicines administered covertly. This is when medicines are "disguised" in food or drink. Additionally, some of these people were having their medicines crushed. Crushing medicines can alter their mode of action and so pharmacist advice is recommended in order to confirm it is safe to do so. All of the records we looked at showed that mental capacity assessments had been completed and that best interest decisions had been made with input from the GP and the pharmacist. Most of the charts showed that the decision to administer the medicines this way had been regularly reviewed; however the frequency of reviews was variable. The form stated this should be done monthly, but not all forms had been reviewed this frequently. Following the inspection the registered manager sent us information on the changes they had made to ensure that reviews would take place in a timely manner.

Some people had been prescribed medicines on an "as required" (PRN) basis. In these instances there were PRN protocols in place which provided information to staff on how often these could be given. Staff had documented when they had been administered and the reasons why, which meant that any trends could be easily identified. However, the protocols did not inform staff how to identify when people who were unable to ask for pain relief might be in pain. We looked at the protocol for one person and a member of staff had ticked the box to indicate that the person was unable to request PRN medication. The form guided staff, "if appropriate detail indicators that PRN medication may be required", but there was nothing documented. Other forms we looked at also did not contain any details of signs that people were in pain. Despite this, there were pain assessment charts in the MAR file with body maps that showed where people had previously experienced pain. Having this detail in place would mean that staff that were unfamiliar with people, such as agency staff or staff who were new in post, would be more easily able to recognise when a person was in pain. Following the inspection the registered manager sent us details of the changes they had made to pain relief protocols.

Some people were self-administering their medicines. In these instances, we saw that self-medicating assessments had been completed and these had been reviewed monthly. The assessments had been signed by staff and by the people who had been assessed. We spoke with one person who was self-administering. They confirmed that staff checked they had taken their medicines each day.

Medicines were stored safely, including controlled medicines. Stock levels were checked regularly. When medicines were no longer required, they were disposed of safely. Clinical room temperatures were monitored as were fridge temperatures. This meant that staff ensured medicines were stored within recommended temperature guidelines.

The environment was clean, in a good state of repair and was warm and welcoming. Window restrictors were in place for all the rooms including bedrooms, bathrooms and communal areas. Different coloured bins were in place for washing items and all had lids and were foot operated.
Bath hoists and other hoists were checked and all had a sticker on which highlighted they had been serviced appropriately. Where people required hoists or slide sheets they had their own slings/sheets etc. We saw that these were kept in people's rooms.

The laundry room had a separate entrance for clean and dirty laundry. It was clean and well organised. Staff were able to tell us how the laundry was managed and this was appropriate. Dirty laundry was collected from the communal bathrooms 2 to 4 times daily. Each bathroom had a sheet of paper on the back of the door for staff to sign and enter a time when dirty laundry had been collected.

Daily cleaning schedules were in place and the head house keeper said they carried out a daily walk around in the am/pm and before they left to make sure all tasks were completed. Personal protective equipment (PPE) was not left in people's rooms but was accessed by staff when required from the sluice. Staff were seen to be wearing PPE's appropriately.

Good

Is the service effective?

Our findings

People received care and support from staff who knew them well and who had the skills and training to meet their needs. We asked people if they used their buzzers how quickly did staff respond? One person said; "They come quickly." "If I press the emergency buzzer they come running."

At our inspection in October 2016 we found the registered provider had not ensured the staff employed had received appropriate supervision and appraisal to enable them to carry out the duties they were employed to perform. At this inspection we found the registered provider had taken sufficient action to achieve compliance with this Regulation.

Staff had the skills and knowledge to support people effectively because they knew them well. Staff said they had regular supervisions sessions "every three months or so". All said if they had an issue between supervisions they could speak to the clinical lead.

The provider monitored staff training on a spread sheet matrix which gave details of when individual members of staff had completed training considered essential to their role. Subjects included for example were; infection control, food hygiene, fire safety, safeguarding, dementia awareness, mental capacity awareness and moving and handling. The matrix also included dates of when the training needed to be completed. This was updated daily and on the day of the inspection 84% of staff members had completed all mandatory training. There was an action plan in place to increase this number.

The registered manager had identified a need for extra support for staff to gain their Care Certificate and this has been organised. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. It aims to ensure that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Nursing staff said they had access to training and development in order to meet their professional registration requirements. Comments included "We had venepuncture training recently and end of life training" and "We can access training no problem." One nurse was knew in post and said their induction was "very thorough". They showed us their induction programme and explained they had to complete competency assessments before being able to work unsupervised. They said they had a mentor and felt well supported. Another member of staff said, "They have been very thorough in teaching me the ropes. I have felt really supported by the manager and all the staff."

Staff members confirmed they had access to a range of training courses to enable them to have the ability to carry out their job to the required standard.

Staff received regular one-to-one sessions of supervision with their line manager. This was a formal process which provided opportunities to check performance and ensure staff were being supported appropriately. Staff told us that they found the supervisions to be effective and had helped to resolve any issues that they had previously had. Annual appraisals were not always taking place. This meant that staff did not have the

opportunity to formally discuss training and development needs. Objectives were not set or assessed to enable staff to progress to their full potential. This was discussed with the registered manager and she told us that they had been focussing on the supervisions and that annual appraisals would be implemented very soon.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). There were 33 people who lived at the home where an application had been made to the local authority with regard to them remaining at the home to receive all care. Some of these applications had been authorised and were identified in people's care records as having Deprivation of Liberty Safeguards in place. Other Deprivation of Liberty Safeguards applications were awaiting authorisation. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards.

We asked staff about issues of consent and about their understanding of the Mental Capacity Act 2005. Staff we spoke with could tell us the implications of the Act and of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. The purpose of DoLS, which is part of the Act, is to ensure that someone, in this case living in a residential setting, is only deprived of their liberty in a safe and appropriate way. This is done when it is in the best interests of the person, has been agreed by families and professionals and there is no other way to safely care for them.

Care plans contained capacity assessments for all other aspects of people's care, and when people lacked capacity best interest decisions had been made. The documentation in place for these was clear and showed that people's advocates and health professionals had been involved in the decision making process. However, consent to care was not always sought in line with legislation and guidance. This was because although people had given their consent to their care when able, those that lacked capacity had not always had their capacity assessed for all aspects of their care. Some people had sensor mats in place which alerted staff when they stood up. In these instances, people had not always consented to their use. There were no capacity assessments in place to show that people's ability to consent had been assessed and no best interest process documentation in place. We discussed this with one of the nurses on duty and they said they would ensure this was put in place immediately. The registered manager contacted us after the inspection to tell us that the capacity assessments for the use of the sensor mats had been completed.

The environment was appropriately decorated for the residents and throughout the corridors there were age appropriate things of interest for people living with a cognitive impairment. Within the communal lounge area there were a lot of different memory activities, including a desk with an old style type writer and telephone, a dressing chest with costume jewellery, a hat and bag stand and a dolls area where people had access to dolls etc. A daily newsletter was also available to people. The activities coordinator told us that this was produced daily and for people that remained in their rooms a copy was taken to them and discussed. People had personalised memory boxes outside their bedrooms. This helped them to identify their rooms. The corridors also had hand rails of contrasting colours to ensure that these were easily seen by people with sight or cognitive impairments.

We observed lunch on all units over the two days. The atmosphere was pleasant and relaxed. Some people ate at the dining tables and others in the lounge area. Staff assisted those that needed it and this was done sensitively with staff telling the person what the food was, asking if they enjoyed it and were they ready for more.

People had access to ongoing health care. Records confirmed people had regular input from a range of

health professionals when required. This included GPs, the mental health team and the community psychiatric nurse.

Good

Is the service caring?

Our findings

We spent time in communal areas observing interactions between staff and people who lived at the service. Staff knew people well and called them by name. One person said "I enjoy living here, I wouldn't stay if I didn't. I had a stay in hospital and so went to stay on the top floor, but am now back here in the same room. They're very attentive."

People using the service responded well to staff, they appeared relaxed and there was lots of chatting and laughing. We overheard staff speak to people kindly. For example, we heard one member of staff say "Your hair looks really lovely today" to one person. On another occasion we saw one person struggling to walk along the corridor. We asked them if they were ok and they said they were lost. A member of staff came along, brought a wheelchair and helped the person to sit in it. They said "Let me wheel you back to your room" and "Would you like me to get you a cup of tea?"

Staff said "We have some brilliant care staff here" and "Most of the care staff are very good," Other comments from staff included, "The residents and their families keep me working here. We get lots of positive feedback and that really makes my day" and "I get a lot of job satisfaction working here. I would recommend it."

Staff were seen to support people in a caring manner. For example, we saw one person being transferred with the use of a hoist. Two members of staff supported with this. Continual reassurance was offered to the person and this was done in a calm and relaxed manner. During another hoist transfer two members of staff were present. Staff knew what they were doing and clear instruction was given to the person with ongoing reassurance.

A number of people were supported with their lunch in their rooms and there did not appear to be enough staff to do this. For example, one person did not receive their meal until 1.25 pm. The activities coordinator was asked to help support people with lunch. We discussed this with the registered manager as there appeared to be an issue during the inspection of support needed and numbers of staff. They informed us after the inspection they were considering ways to manage this with the possibility of protected meal times where all staff could be trained to support people with their meals.

Staff asked people what they wanted for lunch and read out the menu and choices to people individually. Where people required support with their food, care staff did this respectfully, they sat with them, did not hurry them and explained what they had been given. A member of staff noted that the meal they were about to support a person with was very hot. They transferred this to a cold plate to help cool it down.

Food looked appetising and pureed meals were well presented. A member of staff was present in the dining areas. This member of staff encouraged people to eat their meals and offered alternatives when they saw that food was not being eaten. People were encouraged to be independent, for example where food was required to be cut up, appropriate cutlery was provided. For lunch people were asked if they wanted to sit at the dining table. One person said, "No I don't think so." The member of staff said, "Do you what to stay there

then?" (lounge chair). The person was supported to have their meal in the lounge chair. Another member of staff asked a person, "Where do you fancy having your lunch?"

We observed the activities coordinator in the communal lounge doing a quiz with people. The questions asked were age appropriate and all people appeared happy, engaged and enjoyed the activity. On the first day of the inspection we observed a visiting entertainer who knew everyone's name and spoke to them each individually complimenting each one on something personal to them. It was a lively hour with people joining in with the entertainer.

The activities coordinator knew all the residents names and throughout the activity there was good humour and respectful interactions. We heard people being asked if they would like to join in the activities. People were given a choice of activities. In the afternoon we saw people doing glass painting. One person said "I don't have to do anything but I get a bit bored. We have music and the TV on. We had the animal zoo the other day, it was lovely." Another said "There is some pretty good stuff. Personally I'm not keen on the musical stuff but I sometimes go. I've made some good friends here with the residents."

Staff respected people's privacy and dignity. Staff were seen to knock on peoples doors before entering their bedrooms. They also asked or waited for people's permission before entering. We heard a staff member knock, gently open the door and say to a person, "Hello (name of person) its only me, can I come in." We saw another person walking into the communal lounge with their buttons undone on their top. A member of staff immediately noticed this and discreetly supported the person to do their buttons up. One person asked a member of staff if they could get a box of chocolates. The member of staff replied with, "Of course, I will sort that out." Another member of staff was heard asking a person, "What would you like to wear today".

Good

Is the service responsive?

Our findings

People told us the staff knew the support they needed and provided this at the time they required it. For example one person said, "They know I like to be showered early so I have a shower about 6.30 and that's fine." Another person said "I was going to have a bath but I'm too puffy, so the girls are going to give me a shower." As we left the room a member of staff said, "[Name] when you are ready for a shower just let me know."

Care plans were person centred. They contained "Who am I" documents which gave details about people's lives prior to moving to the service. Preferences in relation to personal hygiene, daily routines and male or female care staff had also been documented.

Some people displayed behaviour that others might find upsetting. In these instances, the care plans were comprehensive and detailed why the person might behave in a certain way. Triggers were listed and actions staff should take to relieve any anxiety or agitation. Communication between staff and other health professionals was documented and when advice had been sought this was included within the care plan. For example, advice about one person's distressed behaviour had been sought from the community psychiatric nurse. We saw a person banging on a door with their walking frame. A member of staff immediately came to assist and they went together for a walk in the corridor.

Care plans in relation to people's clinical needs were also detailed. For example where a person had a pressure sore, there was clear guidance to staff in relation to when the dressing should be changed and what dressing to be used. This information was supported by a body map, and we saw that these were regularly updated along with the wound dressing care plan. Where we saw that there were concerns about reduced food/fluid intake action had been taken in a timely manner which included contacting the GP and dietician. Food and fluid charts and fortified drinks were arranged and in place. Another example, was where a person was prone to urinary tract infections. The plan explained why the person tended to get infections and the actions staff should take to minimise this, such as "needs to drink at least 1.5 litres per day." Additionally the signs of an infection were listed for staff to be aware of. However staff said, "It can be a bit of a struggle to make sure that people get enough fluids." They went on to explain that on the middle floor seven people required assistance with eating and drinking. Staff said "There are not always enough staff, seven (in total) is fine if they are regular staff and no one needs extra support."

Advanced care plans had been completed. These plans detailed people's preferences in relation to their end of life care and one we looked at had been completed in conjunction with the person's family members.

One member of staff said "When I came here I worried that because it was so big it might be institutionalised, but it's not, far from it. The staff don't seem constricted by time here." We saw that some people stayed in bed and didn't get up until late morning, whist others were up and about. One member of staff said "It's entirely people's choice. Some are early risers, some not. Some like to have a rest on the bed later in the day."

People were offered a choice of nutritious and appetising meals. Alternative meals were prepared if people didn't want the options on offer. Drinks and snacks were also available throughout the day. Lunch was served in different areas of the home and some people had lunch in their rooms. Lunch was served at different times so all people could be assisted if they needed it. Staff knew people well and engaged in conversation that made people smile. Staff gave appropriate encouragement which promoted choice and independence while people were eating. One person did not eat their meal and was offered a range of other food, they chose a jam sandwich which was quickly made for them and they appeared to enjoy eating this.

The chef was aware of people's special dietary needs and described how they would meet these. They told us that they met with the nutrition and hydration champion in the home on a weekly basis to ensure they were kept up to date with peoples changing needs. Information about peoples dietary needs were displayed on colour coded cards in the kitchen.

The chef had recently introduced more pureed food including sandwiches and birthday cakes which were visually appealing to ensure people with swallowing difficulties were given the same choices on the menu. People were encouraged to give feedback about the food in the form of regular meetings and comments books were going to be introduced. We were told that there was a 'show plate' with samples of the food available at each mealtime. We saw some people in two areas were asked what they would like to eat and shown an example dish on day two for the lamb moussaka, we did not see the alternative - a pasta bake. Not every dining area on either of the two days had a show plate for people to see and people were not offered a choice. We fed this back to the registered manager and chef, who expressed their disappointment that this had not been done and assured us that they would resolve this.

On the second say we observed an activity session. Staff welcomed everyone to the activity; people were sat in a circle. There was quiet background music. People were asked to do some stretches, and then they used balls to help them stretch and preform some strength exercises. The activities coordinator was aware of people's physical abilities and modified the exercises for each person. The activities coordinator explained to each person how to modify the exercise before the exercise started, so there was no embarrassment for those doing a modified version of the exercise.

In the hallway there was a notice board 'You said, we did' highlighting some issues raised and what had been done. For example, there was a request for more male orientated activities. A monthly gents club had been arranged. Another comment said the communication with the chef was not good and as a result staff had arranged feedback forms in the dining rooms. Some people had commented they didn't know who the manager was; a photo of the registered manager was put on display in reception showing which also informed people of the days the manager was working. This shows that the registered manager responds to suggestions and ideas.

The home had a complaints procedure. Complaints were logged and we saw these were responded to within the provider's 28 day timescales and were investigated by the management team. We saw that there had been several issues raised since the last inspection and all had been resolved in line with the process. One visitor said; "I am not his main carer, his sons are. I visit more often than they can and they have asked me to raise any issues. There has been nothing to complain about." Another said; "Feedback from complaints always feels like I am being fobbed off." The registered manager was aware of the concerns from the second visitor and was working with them to resolve matters.

Good

Is the service well-led?

Our findings

Staff were positive about the management team. The registered manager was described as approachable and had an open door policy. One staff member said, "She listens to suggestions from staff to improve the home." Staff told us that senior staff had "Very high standards which means we all do." One senior manager was described as very supportive and cultivated a good team approach. Members of staff said they hoped the current registered manager would stay in post. Comments included, "I just wish for a permanent manager, it's been hard with so many changes" and "Morale is on the up I think. It does feel like we're all pulling together. It's all down to the manager's influence. I take my hat off to her."

Staff told us there was a daily huddle where senior staff met to discuss any issues that were happening in the area they worked. We attended one on the first day of the inspection and staff exchanged information about staffing and any concerns they had about people's health and wellbeing. Nurses said they had regular nurse meetings as well as other staff meetings. One said "We didn't use to have nurse meetings, but we do now. We had one just last week." We asked staff if they felt supported. Comments included, "Yes, now I am. [Name] is one of the best managers. She does support me." We asked about supervision, "Yes, every 3 - 4 months." "I also go to the daily 'Huddle' meeting with the heads of departments." "I never had supervision until [Name] started."

At our inspection in October 2016 we found the registered provider had not notified the Commission without delay of incidents involving any abuse or allegation of abuse in relation to a service user and any incident which is reported to, or investigated by the police. At this inspection we found the registered provider had taken sufficient action to achieve compliance with this Regulation.

The registered manager was aware of the legal requirements of their registration in notifying the CQC about events they are required to do so by law, such as protecting people from harm. We had reviewed information when planning the inspection and the registered manager had been timely in informing us of any concerns and issues. Audit systems were in place to ensure people received a quality service. The manager was aware that these needed to be completed.

At our inspection in October 2016 we found the registered provider had not operated an effective systems and processes to maintain accurate, complete and contemporaneous records in respect of each service user. At this inspection we found the registered provider had taken sufficient action to achieve compliance with this Regulation.

There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. The registered manager and provider carried out regular audits which included medicine management, infection control, the environment and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures and fire safety. Where issues or concerns were identified action was taken.

The care plans and records we looked at were clear and informed staff of the care and support people

needed, this included information about risks. We saw they had been updated when there had been any changes in people's well-being. Staff logged accidents and incidents. These logs would be analysed to identify any trends for behaviour incidents, and if needed the registered manager would have discussions with individual staff members and other professionals.