Aden House Limited

Aden House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 19 December 2016 and was announced. At the last inspection in April 2015 we found the service required improvement in all areas. At this inspection we saw the provider had taken positive steps to improve the quality of the service.

Aden House provides a care home service with residential and nursing care for up to 60 older people. There were 50 people living at Aden House at the time of the inspection.

There was a registered manager in place. 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 registered manager was due to leave the service and there was also an acting manager working alongside the registered manager in order to take over the running of the home.

The home was welcoming and friendly. People, staff and visitors reported a homely atmosphere, although the provider acknowledged there was planned refurbishment and we saw equipment was not always stored appropriately. The environment was clean and tidy, although we identified some odours in some of the upstairs areas.

Staffing levels were appropriate to meet people's needs. Secure recruitment procedures ensured staff were suitable to work with vulnerable people, although not all photograph identification was in place to support the verification of agency staff.

Accidents and incidents were recorded well, with clear systems to identify any patterns or trends.

Moving and handling practice was carried out appropriately on the whole, although we observed one incident which put a person at risk of injury.

Medications were managed safely and staff were confident about their responsibilities to make sure people had their medicines on time.

Staff understood the Mental Capacity Act (2005) and the implications for ensuring people's rights were promoted. However, the recording of people's mental capacity was not always clear and there was conflicting information about whether family members had lasting power of attorney.

People enjoyed their meals and the chef and care staff had a good understanding of people's dietary needs.

Staff were caring and attentive to people's needs and there was evidence they had a good rapport with people and their families.

People's dignity and privacy were maintained at all times in their care and the daily routine.

Staff knew people's interests and used time well to engage with people, with plenty of resources to interest people. Some people remained in bed and it was not always clear the reasons for this.

Care plans contained up to date information, although there were some gaps in daily recording and it was not always evident people had been involved in their care planning.

People and their relatives knew how to raise a complaint if they felt this was necessary and we saw complaints were managed appropriately

The registered manager was visible in the service and there was evidence of clear leadership, with any changes being managed in a planned and measured way. People, staff and relatives said the home was well run and managed.

Systems were in place to monitor the quality of the provision and drive improvement and the management team were aware of the strengths and areas to improve.

You can see what action we told the provider to take at the back of the full version of the report.

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.

Staff understood the safeguarding and whistleblowing procedures and how to protect people from abuse.

Accidents and incidents were recorded and trends and patterns identified.

Systems for managing medicines were in place to ensure people received their medicine on time.

Is the service effective?

Requires Improvement

The service was not always effective.

Mental capacity assessments were not always clear and there was little information about whether people's relatives had legal authorisation to support them with decision making where they lacked capacity to do so for themselves.

Staff received effective support through regular training and supervision.

The premises were in need of refurbishment and areas were not always used effectively to meet people's needs.

People enjoyed the meals and there were regular opportunities for eating and drinking.

Is the service caring?

Good

The service was caring.

People experienced kind, caring and compassionate interaction from staff, who emphasised this was people's home first and foremost.

The home was welcoming and friendly.

Staff involved people with good explanations about their care and support.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Many people remained in bed, with no clear reasoning why.

It was not always evident people had been involved in their care plans and there were some gaps in records of daily care tasks.

Staff took time to engage well with people and there was a range of activities and resources accessible to most people.

Is the service well-led?

Good

The service was well led.

The management team were aware of the strengths and areas to improve and were visible in the service. Systems were in place to assess and monitor the quality of the provision and there was continued work in progress to ensure any actions were scheduled for completion.

Changes to the registered manager were communicated and managed in a planned and measured way to ensure continuity of leadership in the home.

Systems were in place to assess and monitor the quality of the provision and there was work in progress to ensure any actions were scheduled for completion.

Aden House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 19 December 2016 and was unannounced.

There were two adult social care 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.

As part of the inspection process we looked at all the information we held about the home. This included notifications sent to us by the home of any accidents and incidents. We also contacted the local authority and contracts team prior to the inspection. We observed practice in the home, spoke with the regional director, registered manager, acting manager, five staff, 16 people and five visitors and looked at records to show how the home was run and how people's needs were met.

We looked at five care plans, staff duty rosters, two recruitment files and records relating to the safety of the premises and equipment.

Good

Is the service safe?

Our findings

People mostly told us they felt safe. One person said: "I get up in the morning, I feel safe, nurses around, they talk to me". Another person said: "I am very safe and happy here indeed". Another said: "As soon as I walked through the door, they made me feel so welcome, they make me feel brilliant. I feel safe and comfortable here". One person said: "I do get frightened when someone [staff] walks onto my room during the night. It would not be bad if they tell me who is coming, but to just walk in, this frightened me. I also locked my door, another resident took my key. We could not find the key, they gave me a replacement. That is why I do not feel 100 per cent safe".

Relatives we spoke with all stated they did not have any issues with regards to safety of their family members. One relative told us: "Our [family member] has always stated to us they would never come to a home. After a spell in hospital we brought our [family member] here. We cannot believe how happy they have been here; they have told us they do not want to return home, this is home. This has removed a great burden from the family". Another relative said: "Yes, my [family member] is safe from harm or any abuse".

Safeguarding training was undertaken by the registered manager and refreshed every six months. The registered manager told us safeguarding issues were discussed at managers' meetings. Care staff we spoke with were aware of how to spot signs of abuse and understood how to make referrals to the local authority safeguarding team and the Care Quality Commission (CQC). They were aware of the whistleblowing policy and felt any concerns they raised would be taken seriously. The registered manager told us staff were given information about whistleblowing and told us: "They're aware it's a duty of care". Safeguarding incidents were recorded and referred according to the correct procedures, with lessons learned identified for future reference. The registered manager told us they would rather over-report any potential concerns to the safeguarding authority.

Recruitment procedures were sound with a flowchart to index at each stage of the vetting process before staff were deemed suitable to work in the home. Where agency staff were used, their profile was obtained from the agency first, with information about their identity and training. We noted not all agency staff had a photograph on their profile page to help verify their identity.

Our observations of staffing levels, along with staff rotas showed these were sufficient to ensure people's needs were met and staff were attentive when people required assistance. We heard mixed views from people about staffing levels; the majority of people said there were always enough staff on duty, and clearly told us they had no concerns about staffing levels at all, but some people did not think so. For example, one person said: "I do not feel there's enough staff, especially on a night. They need to recruit more staff". Another person said: "Certain times, short staff, no staff. They do their best in these circumstances". One relative said: "It seems sometimes they are short staffed. We do not expect one to one care but do see sometimes they are short staffed. This we do not feel has an effect on our [family member].

Accidents and incidents were recorded and analysed to identify if any trends or patterns existed. Where accidents occurred there was clear evidence of the location, time of the accident and any follow up action

taken to ensure people's well being. Where falls were recorded, monitoring was carried out and referrals to the falls team were made as appropriate. The registered manager had an oversight of the risks within the home.

People's care plans included any necessary risk assessments and staff understood people's moving and handling assessments to be able to support them appropriately. We saw practice on all but one occasion with staff giving safe, reassuring and careful assistance to people. For example, one person became upset when using the hoist and staff gave patient explanations and encouragement, engaging with the person throughout. However, we saw one incident where staff used an incorrect method to move a person, which may have put them at risk and we had to ask the acting manager to intervene. This was promptly dealt with by the management team to ensure the person's safety and address staff practice.

The registered manager told us individual risks to people were decided by speaking with each person, their family, their GP and other relevant others to form a holistic picture, with a focus on positive risk taking with people taking ownership of their own risks wherever possible.

For fire safety there was a 'grab bag' to assist staff in dealing with an emergency evacuation if necessary; senior staff took responsibility for this. We saw people had personal emergency evacuation plans (PEEPs) in place which highlighted their individual needs.

Risk assessments in relation to falls were updated monthly or as changes occurred to people's mobility. The risks in people's personal environment was also assessed to ensure their safety when in their rooms. Staff used recognised assessment tools for looking at areas such as nutrition and tissue integrity and these were updated monthly or more frequently if people's health needs changed.

Environmental risks were assessed and maintenance records showed regular safety checks of premises and equipment. The registered manager showed us evidence of regular walk rounds to ensure safety in the home. We noted on our tour of the building, in some bedrooms there were containers with drink thickener agent; this is prescribed to thicken people's drinks if they are at risk of aspiration by drinking normal fluids, but is potentially a choking hazard if accidentally swallowed in its dry form. The acting manager said they would ensure this was stored securely with immediate effect and confirmed this had been done.

We looked at how medication administration records (MAR) and information in care notes for people living in the home supported the safe handling of their medicines. We also reviewed records for the receipt, storage and disposal of medicines.

We found people's medicines were available at the home to administer when they needed them and people told us they had their medicines on time. We asked a registered nurse about the safe handling of medicines to ensure people received the correct medication at the correct time. We found they had a good understanding of their responsibilities. Where people may refuse to take their medicine, there was clear information for staff in people's care plans about what to do, both to protect people's rights and to ensure their good health. For example, one person had declined to take their antibiotic tablets; staff contacted the person's GP for advice and to discuss whether liquid form would be more appropriate.

Arrangements for the administration of PRN (when needed) medicines protected people from the unnecessary use of medicines. We saw records which demonstrated under what circumstances PRN medicines should be given and at what frequency. The registered nurse demonstrated a good understanding of the protocol. In people's care records we saw staff had information about how to identify if a person was in pain, particularly if had difficulty communicating this, such as those living with dementia.

Where people at high risk of choking were prescribed thickener for their drinks, there were very clear instructions and guidance for staff from the speech and language therapist (SALT) to ensure safe care.

We noted the date of opening was recorded on all liquids, creams and eye drops that were being used and found the dates were within permitted timescales. Creams and ointments were prescribed and dispensed on an individual basis. We saw there was appropriate storage for the amount and type of items in use. The treatment room was locked when not in use. The medicines refrigerator and treatment room temperatures were checked and recorded daily to ensure medicines were being stored at the required temperatures.

We observed part of the lunchtime medicines round. Staff asked people how they were feeling, whether they had any pain or if they needed their inhaler. Staff patiently waited with each person until they had taken their medicines and then they updated the records accordingly. Staff told us they knew how people preferred to take their medicines and there was a medication profile listing each person's preferences, although the details were not completed on one of the forms we looked at.

We saw a number of practical steps were in place to address the potential risks of cross infection. We observed all staff washed their hands appropriately between tasks and had disposable gloves and aprons to support people with their personal care. However, we detected an offensive odour in one area; the housekeeper informed us one of the four sluices was not working and this had been reported.

Requires Improvement

Is the service effective?

Our findings

People told us staff were able to carry out their work effectively. One person said: "Yes they are good. If they're not sure they will find out what to do". Another person said: "I was previously a nurse. I know what standards are. The standards from these nurses are pretty good". Another person said: "Yes they are trained, they make me feel secure and safe". Another person told us: "Most of the staff know what they are doing, I can speak to them. They help me" and another person said: "I do what they ask me to do; they are good with me" and "Anything we get we need; staff are excellent".

One relative told us: "Individual staff are good. They seem to be trained. They can cope with our [family member] who can get aggressive" and another relative said: "Some staff know how to speak to [our relative] who can become angry, aggressive. Some staff I think are not trained and find it hard. If you are trained you can cope with this behaviour; generally staff are good".

Staff we spoke with told us they felt supported to undertake the training they needed for their role. Records showed staff received regular up to date relevant training in topics such as moving and handling, food safety, dementia care, health and safety, end of life care and the Mental Capacity Act (2005). Records showed new staff had a thorough induction which covered a period of 12 weeks. The registered manager told us induction included shadowing more experienced staff until staff felt confident.

Staff told us, and supervision records showed they engaged in regular supervision meetings with their line manager to discuss issues relating to their work and professional development. These were done in groups and individually. Staff told us the registered manager regularly checked their practice through observations and discussion, formally and informally and we saw records of competency checks that had been completed. The registered manager told us they felt supported by senior managers to run the home and they were available for guidance and support when necessary.

Communication between staff was effective to ensure people's needs were met. We sat in on a shift handover and heard clear and detailed information shared between the outgoing and incoming staff, which included clinical risks and general care needs and observations of people's mood and well-being. This helped to ensure continuity of care for people.

Throughout our inspection we saw people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. When people were not able to verbally communicate effectively we saw staff were observant of body language to ensure people's best interests were being met. Our discussions with staff and people using the service, along with documentation we saw showed consent was sought before the delivery of care.

We spoke with the registered manager who demonstrated an appropriate understanding of current legislation regarding the Mental Capacity Act 2005 and how it had to be applied in practice. 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.

Records showed staff carried out the two stage test to determine whether people lacked capacity in relation to decision making; however the nature of each specific decision to be taken was not always completed.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people were subject to DoLS, the relevant person's representatives were seen to have been involved in decision making and involved in the regular reviews of care needs.

Our observations of the environment and reviews of people's care plans suggested the provider used methods which may be a deprivation of liberty, such as coded access to doors. Where this was required to ensure people's safety and security, there was evidence of discussions having taken place in each person's best interest.

Care plans had details of where families had been appropriately involved and consulted in best interest decision making or where reviews of care plans had been undertaken. However, it was not evident from care records whether some people had appointed attorneys by way of a lasting power of attorney (LPA) or where people lacked mental capacity, had deputies appointed by the Court of Protection.

We observed the dining experience for people and found this to be positive and sociable. People we spoke with were happy with the choice of food being served at Aden House. Comments about the meals included: "Breakfast was nice; big breakfast", "Food is marvellous, no issues whatsoever", "I like the meals; if I do not like something I can have an alternative meal", "Food is excellent, really enjoy it", "The meals are good, no problems" and "Alright most of the time, sometimes do not like it. It's better than what I would have made at home, it varies". Another person said: "Tea, that's my favourite, tea time".

One member of staff told us: "I go to see each and every service user every day to check what they would like to eat. This is recorded; the menu is set but if a service user wants an alternative we try to get this".

Relatives' comments included: "My [family member] loves the food. We often come to the dining table with [them] to help them eat" and "We have no issues with the food given to our [family member]". One relative told us their family member had lost weight since being in the home and told us: "The staff try to get them to have supplements but my [family member] does not like them".

We saw there was a varied menu printed and placed on the dining tables and although this did not reflect different cultural or vegetarian options, staff said these would be provided if required and added to the menu. In the butterfly unit (for people living with dementia) we saw people were supported to choose their meals with visual choices of food on different plates. We noticed the choices offered varied in content and this may have meant people were choosing a particular meal because of it's size, rather than the content.

At lunchtime we observed staff encouraged people's independence or supported them to eat where necessary. We noted however, there were not always enough staff deployed to support people and the pace at which they assisted appeared hurried on occasion. Where some people were served their meals they were not always given chance to decide how much or the component parts, such as gravy and drinks choices

were limited to tea and coffee.

Opportunities for people to have drinks and snacks were ongoing throughout the day, in the communal areas and in people's own rooms. Staff reminded people to eat and drink and we saw juice, fresh fruit and mince pies were accessible in communal areas.

Nutritional risk assessments were completed and people's weight was monitored on a monthly basis. Where there were concerns about a person's weight, they were weighed weekly. People had a dietary profile sheet which detailed their dietary needs, likes, dislikes and allergies. A malnutrition universal screening tool (MUST) was used to assess people's nutritional risks and where there were concerns identified, referrals to other professionals were made. On one person's care plan we noted they were living with dementia and chose to eat with their fingers, so staff were mindful to offer suitable food that could be picked up by the person to ensure they were maintaining their food intake.

Where people had involvement with the dietician or the speech and language therapist for swallowing difficulties, clear information was available to staff as to how each person should be supported. For example, one person's record showed how their food was to be prepared and which foods to avoid and the staff we spoke with were aware of this.

Staff recorded people's food and fluid intake, although the quality of the recording was variable. Some people's records we looked at were detailed with percentages and quantities of food eaten, whereas there were gaps in other people's records, or entries which were vague and stated a person had eaten 'all' of their meal, but no indication of how much this meant. We noted one person's food intake was recorded, but not dated. We discussed this with the management team who said they were confident this was a recording issue rather than a practice issue. Our observations of practice showed people were regularly encouraged and supported with nutrition and hydration. We heard a member of staff encouraging a person to drink by taking their own drink and saying: "Come on, let's have a drink together".

At mealtimes in the butterfly unit we saw all people used blue melamine plates and cups. Although different coloured crockery can help some people living with dementia to more easily identify the food on their plates, melamine plates and cups may compromise people's dignity and there was no evidence of person centred discussion around this.

The chef had a good understanding of people's dietary needs and preferences and recognised the importance of good nutrition to support people's health. The chef told us staff updated them with people's dietary needs they could offer people a varied and balanced diet in keeping with their preferences. Although there was a four week menu in place prepared at the registered provider's head office, the chef said some adjustments were made if people did not enjoy what was on offer. Where people needed extra calories, the chef said milkshakes were prepared and meals were fortified where possible.

Records showed arrangements were in place that made sure people's health needs were met. We saw examples where staff had worked with other professionals when people's needs had changed. This had included GPs, hospital staff, speech and language therapists, dieticians, social workers, opticians and podiatrists. One person was particularly unwell during the inspection and staff were prompt in seeking medical attention.

Our tour of the building showed many aspects of a friendly and responsive environment, with respect for people's privacy and dignity. Some areas were showing signs of wear and tear, such as carpets, fixtures and fittings and the management team said they were aware of this as part of their planned improvement

programme. Some areas were cramped, such as part of the butterfly unit and there were only a few chairs readily available for visitors to use. One bright and airy lounge was not utilised well and used mostly as storage for equipment.

Good

Is the service caring?

Our findings

People made positive comments about feeling cared for. One person said: "The staff are marvellous, brilliant, so caring". Another person said: "Very nice indeed, caring, compassionate with me". Another person said: "They are brilliant. I get up in the morning, they come to see how I am, they talk to me, they listen. No nurse makes me unhappy". One person told us: "They are very caring, they treat me like a mother, they come to sit with me, talk to me" and another said: "They treat me with respect; they always knock at the door and wait until I call them". Other comments included: "As it stands I cannot fault them. I love them, they respect me, I respect them" and "I was very apprehensive when I came. As soon as I walked through the doors I was welcomed. This is home."

Relatives we spoke with said: "My [family member] is so happy here" and "My [family member] has never been so happy, this is their fourth care home. This is the best, best care".

The management team and all staff had a warm and engaging rapport with people. Staff spoke respectfully with people and frequently acknowledged them by name, asking how they were feeling and taking time to listen. There was a homely and friendly atmosphere which was commented upon by people, staff and visitors. Staff placed emphasis on the home as being people's home, rather than staff's workplace.

Staff spoke with compassion about the people they cared for and were clearly dedicated to providing a caring environment. One member of staff told us they treated people in the same way as they would their own relatives. All staff we spoke with said they would be happy for their own relatives to live at Aden House.

People's care plans acknowledged their spiritual and cultural needs. Some people said they enjoyed in house church services and one person's care plan said they should be offered the choice to attend, where they may not be able to directly express their wishes themselves. We saw these were listed on the activities schedule.

People looked well cared for and they wore suitable clothing. We saw staff took care to ensure people had important items such as their glasses and they noticed when people's dignity may be compromised. For example, one person's clothing began to ride up and staff helped them adjust this. Another person had their legs exposed and staff brought them a blanket. We had no concerns about people's dignity at this inspection. The registered manager told us they had oversight of staff practice and made sure people's dignity and rights were promoted, for example by having access to their call bell. Many people at the home had the support of families and friends and our discussion with the staff showed they had a good insight into the requirements to provide people with advocacy where this was deemed appropriate to protect their rights.

We looked around the home and in doing so inspected some bedrooms. We noted staff always knocked on doors prior to entering, respecting people's need for privacy. We saw rooms contained personal effects, such as treasured items, family photographs, radio and television.

Staff we spoke with told us they tried to establish people's wishes for the end of their life and we saw sometimes these were recorded on people's care plans. The registered manager told us end of life care was discussed upon admission to the home and staff were sensitive and compassionate about people's end of life needs. Improved documentation was being introduced in the home to ensure all aspects of people's end of life care was planned for where necessary.

Requires Improvement

Is the service responsive?

Our findings

People told us they thought the care at the home was responsive to their needs. One person said: "I cannot grumble, nothing to complain about, everything is good for me". Another person said: "Staff know who we are, they know what we like and dislike" and another person said: "I have nothing to complain about, they look after me well". People told us they were not rushed, they could get up and go to bed when they wanted to and spend the day how they chose.

We heard mixed views from relatives. One person's relatives said: "I brought my [other family member] here in the past. I have now brought my [family member]. Great care; they have settled my [family member] beyond all expectations. We were told [they] would never get out of bed – now my [family member] comes to the dining table, lounge, communal area". Another relative told us staff should not always rely on what their [family member] told them. For example, when supporting them with continence care, the relative felt staff should make their own checks, rather than accept what their family member said, as this was sometimes not accurate. They also said basic provision was not always there, such as towels in their family member's room, or a jug of water but no cup. Another relative was confident their family member's care was responsive. They said: "Anything major, the home will let us know"

The care plans we looked at showed people's needs were assessed prior to admission. The registered manager told us pre-assessments were done by senior staff and families were involved where relevant to help to personalise people's rooms. Care planning used established tools to track people's improvements or declines in health status. Examples included Waterlow scores for pressure ulcer assessments and the use of pressure-relieving mattresses and cushions. Care plans recorded what the person could do for themselves and identified areas where the person required support. For example, with moving and handling, the person's mobility was assessed and equipment listed along with how many staff should support the person. Care plans listed strategies staff could use to support people living with dementia with their personal care.

We saw reviews of people's care were completed and the registered manager told us they were hoping to improve this by nominating a 'resident of the day' so all staff were involved in ensuring care planning was up to date for individuals. We were also shown new documentation which was being rolled out and this included more person-centred planning for all aspects of people's care, including end of life care.

People's individual personal care files detailed all aspects of personal care being delivered including repositioning, food and fluid intake/output monitoring. We noted some records around people's daily care were not updated in a timely manner which suggested care was not always delivered according to people's needs. For example, one person's care plan stated they should be repositioned two to three-hourly, yet the record showed much longer gaps between times and some records had no dates or did not follow consecutively. The registered manager said they felt this was a recording weakness than a practice concern as they had no concerns around people's care and there were no incidents of pressure ulcers currently in the home.

We spoke with staff about certain elements of people's care. Their answers demonstrated they had a good

understand of people's needs and were aware of when changes had recently taken place. We saw care was delivered in keeping with people's care plans, For example, where care plans stated people liked to be clean shaven we saw this was facilitated; where plans showed people needed pressure relieving equipment, this was in place. One person's plan stated staff were to ensure a person was wearing their glasses and we saw staff took care to do so.

Staff knew what people liked and disliked, but not always their personal histories. For example, staff knew one person loved to dance, but did not know what their previous job was. However, very detailed information was available on people's care records to show their family history and life history, how they liked to spend time

We observed various activities which people engaged in, such as playing games, bowls, arts and crafts. The activities schedule for each month was varied and people's care records showed which activities they had been involved in individually. For example, one person's care record showed they had enjoyed engaging with a film, musical instruments, newspapers and magazines. The local school children had also visited to sing with people in the home.

People made comments about the activities, such as "I look forward to doing the crosswords", "We like going for walks in the garden" and "I do get fed up but look forward to playing the games". People were invited to join in with what was taking place. One person was asked if they wanted to do a jigsaw but they were unable to because of poor eyesight.

In the butterfly unit we saw there were many resources to interest people, although there was conflicting stimuli at times, such as music playing from the television and from another source and flashing lights. This might overstimulate some people living with dementia.

During the inspection we noted 16 of the 50 people living in the home remained in bed. There was no clear rationale as to why this was or evidence about whether alternatives had been considered or discussed with them. This meant some people may be at risk of social isolation, although we saw evidence the activity coordinators visited people in their rooms. Some people stated this was their preference, but there was a lack of care planning around this.

Three activity coordinators covered both units in the home and they made sure all people were informed about activities taking place. We saw there were many activities in preparation for the Christmas festivities and the activities staff had chosen personalised presents for each resident, based upon what might appeal to their interests.

The registered manager told us they had an open door for families to be able to approach them any time. Relatives' involvement was encouraged through quality surveys, meetings and newsletters. We saw these were displayed on noticeboards for relatives to see along with future meeting dates.

People and their relatives told us they knew how to complain and some said they were confident action would be taken. One person said: "I'd tell the boss". Another person said they would speak with any of the staff if they had anything to complain about, but added: "But I've nothing to say that needs sorting, I'm quite happy with everything". One relative said: "We have no issues whatsoever, we have total peace of mind". However, another relative we spoke with said: "The staff listen but they do little action. I have complained about things going missing from my relative's room. My family member's hygiene, such as nails getting cut have not been done", This relative also told us their family member's personal care needs and independence were not being managed well.

We saw the complaints procedure was displayed, although this would not be easily read by everyone due to its high position and small print. Where complaints were recorded these showed they had been responded to appropriately, with meetings to resolve issues as necessary. Compliments were also received in the form of letters and thank you cards.

Good

Is the service well-led?

Our findings

People we spoke with said they thought the home was well run. Everyone knew who the registered manager was and they were aware of forthcoming changes to the registered manager. One person said: "The new manager has not been here for long, seems pleasant, very efficient as far as I can judge". Another person said: "Managers are good" and another person said: "Just great, no complaints, different girls but all good" and another person said: "I could recommend this place to my friends".

Relatives we spoke with said: "[Manager's name] is brilliant, always welcoming, always takes time to speak to us". Another relative said: "This place does not smell, it's clean, they are very welcoming. We are happy with management" and another relative said: "The new manager is going to do a root and branch survey, this gives us reassurance". Other relatives' comments included 'very welcoming, always approachable' and 'best [manager] we have seen, instantly puts us as relatives at ease'.

The registered manager had good knowledge and experience of running the home. We were told the registered manager was leaving to work at another of the provider's homes and so the acting manager was working alongside them to become the temporary manager following a thorough handover period. The longer term plans were then for a more permanent registered manager to be appointed with full support from the management team overall. We found the management changes were communicated in a transparent way via staff and relatives' meetings as well as the new manager's presence in the home.

Staff reported an open culture and told us morale was good amongst members of the staff team. We saw this was evident in staff interactions with one another and with managers; there was friendly professional communication and staff appeared to be motivated and happy in their roles. The registered manager and acting manager said they felt supported in their role by senior managers.

The regional director, registered manager and acting manager told us they were committed to continuous improvement of the service and there was programme of improvements planned. The management team knew the strengths of the service and the areas that needed to improve and there was a quality performance indicator tool to help to identify key areas. Whilst we observed some weakness in the quality of care records, these were not widespread throughout the home. Where we found areas to improve in the 'responsive' domain, the acting manager told us they had also identified many of these matters to address.

We saw evidence of home manager walk abouts and flash meetings, held regularly. We observed a flash meeting during the inspection, held with all senior and key staff. Flash meetings discussed staffing levels, resident concerns, catering, maintenance, housekeeping, management, health and safety, nursing care, medicines, food and fluid intake and activities.

We saw examples of audits carried out which had either confirmed good practice or identified where improvements had yet to be made. We saw regular audits carried out for aspects such as medication, activity provision, equipment, mealtimes, call bell response, philosophy of care, resident care and nutrition. The provider employed a compliance lead to carry out quality visits and they were present on the day of the

inspection. We saw where issues were identified, action plans frequently followed for managers and staff to address.

Communication with staff teams was regular through meetings and handovers. Staff understood the vision and values of the service and their individual roles and they were proud of the care they provided. Where audits and inspections highlighted areas to improve this had resulted in action plans to ensure improvement was implemented, although some issues were still work in progress.

Documentation to support the running of the home was in place, such as maintenance records, safety checks, policies and procedures. There was evidence of partnership working with other professionals to meet people's needs. Ratings from the last inspection were displayed and the provider submitted statutory notifications to CQC as required.