HICA

Alderlea - Care Home

Inspection report

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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

Alderlea – Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection, which was unannounced and took place on 6 and 9 April 2018.

At the last inspection in February and March 2017 the service did not meet all of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. At that inspection the service was rated 'Requires Improvement'. This was because the provider had not ensured people's safety with regard to management of medicines and assessment and treatment following accidents. It was also because they had not always reported incidents and events of importance and did not always use the quality auditing system effectively. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the rating of the key questions 'Is the service safe?', 'Is the service effective?' and 'Is the service well-led?' to at least good.

At this inspection the provider had improved practice so that the management of medicines was safely carried out. All aspect of the management of medicines was found to be safe. Accidents and incidents were appropriately managed, risk assessed and mitigated. They had improved practice and people received assessment of their needs following accidents and incidents. They had also ensured that all significant events had been reported to the Care Quality Commission and that audits were more effective.

Alderlea – Care Home provides personal care and accommodation for up to 40 people, who may be living with dementia. The service has single bedrooms and bathrooms situated at ground floor and first floor levels. All the bedrooms have a sink and some have en-suite toilet facilities. There are communal sitting and dining areas on the ground floor. The service is situated in a residential area and has a small car park or on-street parking. On the day of the inspection, there were 27 people living there.

The provider was required to have a registered manager in post. On the day of the inspection there was a manager that had been in post for eleven months and registered for the last two. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

People were protected from the risk of harm because systems were in place to detect, monitor and report potential or actual safeguarding concerns. Staff were appropriately trained in safeguarding adults from abuse and understood their responsibilities in respect of managing potential and actual safeguarding concerns. The premises were safely maintained and there was evidence in the form of maintenance certificates, contracts and records to show this. Equipment was safely used in the service.

Recruitment policies, procedures and practices were carefully followed to ensure staff were assessed as suitable to care for and support vulnerable people. Staffing numbers were sufficient to meet people's needs. People were protected from the risks of infection and disease because good infection control management systems and practices were in place. The provider had systems in place to acknowledge and record when things went wrong and from which lessons could be learnt by the registered manager and staff. These were documented and discussed to ensure problems or mistakes were not repeated.

Staff encouraged people to make choices and decisions wherever possible in order to exercise control over their lives. People were cared for and supported by qualified and competent staff who were themselves regularly supervised and received annual appraisals of their personal performance. Staff respected the diversity that people presented and met their individual needs. People's nutrition and hydration needs were met to support their health and wellbeing. The provider worked collaboratively with other health and social care professionals and supported people with their health care needs.

The premises were suitable for providing care to older people and measures had been taken when developing the service to include features which ensured the environment was appropriate for those people living with dementia. People's mental capacity was appropriately assessed and their rights were protected. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Everyone that worked in the service had knowledge and understanding of their roles and responsibilities in respect of the Mental Capacity Act (MCA) 2005 and they understood the importance of people being supported to make decisions for themselves.

People received compassionate care from kind staff that knew about people's needs and preferences. People were involved in all aspects of their care and their right to express their views was respected. The management team set good examples to the staff team with regard to attitude and approach, which meant staff had good role models to follow. People's wellbeing, privacy, dignity and independence were monitored and respected.

We saw that people were supported according to their person-centred care plans, which reflected their needs well and which were regularly reviewed. There were opportunities to engage in pastimes and activities if people wished. People maintained family connections and support networks and their communication needs were assessed and met. We found that there was an effective complaint procedure in place and people's complaints were investigated without bias. The service sensitively managed people's needs with regard to end of life preferences, wishes and care.

The provider was now meeting regulation in respect of quality assurance systems and these were effective. Audits, satisfaction surveys, meetings, handovers and the provider's own internal quality monitoring tools ensured there was effective monitoring of service delivery. The culture of the service was person-centred, open, inclusive, empowering and ensured good outcomes for people. The registered manager understood their responsibilities with regard to good governance and practiced a management style that was open, inclusive and approachable. Engagement and involvement of people, public and staff was fostered. The registered manager strove for continuous learning around best practice, updated their learning and practice at every opportunity and searched for innovative ways to deliver the service. The service fostered good partnerships with other agencies and organisations. Data protection underpinned the management of records.

Further information is in the detailed findings below.

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 protected from the risk of harm. Staff were trained in safeguarding vulnerable adults and understood their responsibilities. Risks were managed and reduced.

Recruitment procedures were safe. Staffing numbers were sufficient to meet people's needs.

The management of medicines was safely carried out and infection control practices were effectively followed.

When events went wrong the provider and staff learnt lessons so that mistakes were not repeated.

Is the service effective?

Good

The service was effective.

People's needs were assessed and staff were skilled and trained to carry out their roles.

Adequate nutrition and hydration ensured people's health and wellbeing. Information sharing and communication was effective.

Premises were safely maintained and facilities were being improved where needed. People's rights were protected and their consent was always obtained.

Is the service caring?

Good

The service was caring.

People received compassionate care from kind staff.

People were provided with the information they needed to stay in control of their lives and maintain their independence.

People's wellbeing, privacy and dignity were monitored and respected.

Is the service responsive?

Good

The service was responsive.

Person-centred support plans were in place and promoted health.

People engaged in pastimes and activities, when they wished to and opportunities for this were very good. People maintained family connections.

An effective complaint procedure ensured complaints were appropriately investigated and responded to.

End of life care was sensitively provided.

Is the service well-led?

Good

The service was well led.

The culture and the management style of the service were positive.

An effective quality assurance system identified and assessed any shortfalls in service delivery.

Experiences of transition between services were well managed, as partnership working was effective.

People made their views known. Recording systems protected people's privacy and confidentiality of information and records were securely held.

Alderlea - 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.

The inspection of Alderlea – Care Home took place on 6 and 9 April 2018 and was unannounced. One Adult Social Care inspector carried out the inspection. Information had been gathered before the inspection from notifications that had been sent to the Care Quality Commission (CQC). Notifications are when providers send us information about certain changes, events or incidents that occur. We also received feedback from local authorities that contracted services with Alderlea – Care Home and reviewed information from people who had contacted CQC to make their views known about the service. We had not requested a 'provider information return' (PIR) from the provider since our last inspection, but we had requested and received an 'action plan' to show when and how the service would improve. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people that used the service, two relatives and the registered manager. We spoke with three staff that worked at Alderlea – Care Home. We looked at care files belonging to four people that used the service and at recruitment files and training records for four staff. We viewed records and documentation relating to the running of the service, including the quality assurance and monitoring, medication management and premises safety systems that were implemented. We also looked at equipment maintenance records and records held in respect of complaints and compliments.

We observed staff providing support to people in communal areas of the premises and we observed the interactions between people that used the service and staff. We looked around the premises and saw communal areas and people's bedrooms.

Good

Is the service safe?

Our findings

People told us they felt safe living at Alderlea – Care Home and that they were protected from risks. People said, "I am certainly safe here with all these staff around", "I feel quite safe living here and just ring for help when I need it", "Staff are always checking on us and making sure we are not at risk of any injury" and "No harm can come to me here." Visitors told us, "My spouse is much safer here than at home. There are plenty of staff around to watch out for them" and "I have no qualms about [Name] being here and I trust the manager and staffing team to keep them safe."

At the last inspection the provider was in breach of regulation 12 regarding poor management of medicines. There were gaps in signatures on the medication administration records (MARs), liquid medicines were inaccurately recorded, some people had missed medicines due to poor stock control or rising late and there were poor instructions on how to give 'as required' medicines.

At this inspection we found that the management of medicines was good and staff were in control of how they ordered, stored, administered and disposed of any unwanted medicines. MARs were being accurately and consistently completed and audits showed there had been no shortfalls with stock controls or ensuring people received their medicines. Instructions for 'as required' medicines were now in place and were detailed regarding the reasons when people should be offered this type of medication.

We found that there were several people receiving controlled drugs (CDs) in the service (those required to be handled in a particularly safe way according to the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001). These were safely handled, stored, recorded and accounted for, in line with current guidance on safe management of medicines. Stock checks tallied with the drug numbers that were held and records were accurate. We observed a senior staff member administering several people's medicines and saw they did so safely and respectfully. The morning medication round was taking a long time to complete and discussions were held with the registered manager to look at ways of reducing this. This regulation was now being complied with.

Systems were used to manage safeguarding incidents and staff were trained in safeguarding people from abuse. Staff demonstrated knowledge of their safeguarding responsibilities and knew how to refer suspected or actual incidents to the local authority safeguarding team. Records showed how safeguarding incidents had been managed. The registered manager sent formal notifications to us regarding safeguarding incidents, which meant they were meeting the requirements of the provider's registration.

There had been a considerable number of safeguarding referrals over the last 12 months, one with regard to moving and handling, and all had been appropriately investigated either by the local authority or the provider as instructed to do so by the local authority. The registered manager had followed policy and procedure in all safeguarding cases and had taken appropriate action to cooperate fully with other regulatory bodies.

All staff now used moving and handling and other equipment safely to effectively assist people to move or

transfer around the service. People were assessed for the use of equipment and there were risk assessments in place to ensure it was used correctly.

Other risk assessments were in place to reduce people's risk of harm from, for example, falls, poor positioning, inadequate nutritional intake and the use of bed safety rails. The registered manager ensured that accident and incident records were maintained and staff followed policy and procedure with regard to the action taken to prevent such events. People had personal safety documentation to evacuate them individually from the building in an emergency or in case of fire. Some people also had sensor mats by their beds or chairs to alert staff they were mobilising independently, when they were at high risk of falls.

Maintenance safety certificates were in place for utilities and equipment used in the service, and these were all up-to-date. Contracts of maintenance were in place for ensuring the premises and equipment were regularly maintained. Audits were carried out to ensure fire safety and equipment safety measures were followed.

The organisations' recruitment procedure ensured staff were suitable for the job. Staff files contained documentation for the vetting and screening of candidates. The procedure was supported by consistent recruitment practices around requesting job applications, references and Disclosure and Barring Service (DBS) checks. A DBS check is a legal requirement for anyone applying to work with vulnerable people. It checks if they have a criminal record that would bar them from doing so and helps employers make safer recruitment decisions. We also saw that staff attended interviews, filled out health questionnaires and received correspondence about job offers. All of this meant people were protected from the risk of receiving support from staff that were unsuitable.

Staffing rosters that we reviewed corresponded with the numbers of staff on duty during our inspection. People and their relatives told us they thought there were enough staff to support people with their needs. Staff told us they covered shifts when necessary and found they had sufficient time to carry out their responsibilities to meet people's needs. Shifts consisted of twelve hours throughout the day and night, with some early and twilight shifts being six hours. Rosters showed there were usually three staff working on nights and six or seven during the day time hours. Staff told us they worked flexibly if and when necessary and that there was always a senior staff member on duty.

Systems in place ensured that prevention and control of infection was appropriately managed. The premises were clean and well maintained, staff had completed infection control training, followed guidelines for good practice and had personal protective equipment available to enable them to carry out their roles effectively. Cleaning staff were employed and did a very good job of keeping the premises clean and free from unpleasant odours. People had their own hoist slings to avoid cross infection and these were stored separately wherever possible and there were sufficient numbers of them to ensure regular laundering. Waste management was appropriate and followed guidelines and contractual arrangements.

The registered manager had set up a lessons learnt file, which had been recorded in a clear format: 'the perceived problem, what was learnt from resolving it, the improvements made, how staff were informed, when the issue would be reviewed by, how successful the changes had been and why.' These examples were used as tools to ensure staff understood what had not gone well and needed improving. One example included a moving and handling incident, which showed that a moving and handling champion now carried out weekly observations on staff to assess their competence. We were informed that lessons learnt were discussed with staff following any incidents or concerns to ensure mistakes were not repeated and people received a safer service. One change made to staff deployment was that the registered manager now required one staff member in the lounge at all times.

Good

Is the service effective?

Our findings

People told us they felt the staff at Alderlea – Care Home understood them well and had the knowledge to care for them. They felt that everything they required was provided. They said, "Staff know what they are doing and seem to be skilled in caring", "I think some meals are better than others, but generally food is good" and "I have no worries about the food we are given or the support we receive." Visitors said, "Staff seem to be very skilled and I have no reason to doubt any of them", "[Name] always enjoys the food" and "The home is suitably equipped and provides a nice environment."

At the last inspection the provider was in breach of regulation for failing to assess people following falls and after sustaining injuries during the night. Therefore they did not receive the care and treatment they required. Some people's airflow mattresses were not correctly set and monitoring food and fluid intake for one person who was prone to urine infections, was ineffective. This also meant that some support to people was poor.

At this inspection we found that these concerns had been addressed so that people received effective assessments of their needs following accidents and were appropriately treated by healthcare professionals. Procedures were clearly defined to ensure anyone having an accident was fully assessed. Airflow mattresses had been set according to people's needs and were regularly checked. Monitoring charts were being used more effectively to show people's nutritional input and output.

Care planning showed that people were encouraged to exercise choice and control in their relationships with others and in maintaining their position as citizens beyond the health and social care services that they were using. Sometimes people's choice was limited with regard to service development because they were living with dementia and were unable to determine how the service was delivered and changes were made. Staff endeavoured to observe when changes in people's needs required changes in service delivery and these occasions were discussed with management and addressed where necessary.

Staff received training and learned the skills they required to carry out their roles. A staff training record (matrix) was used to review when training was required or needed to be updated and there were certificates held in staff files of the courses they had completed. Records showed training completion rates to be 100% for senior care staff and the support team staff and between 78 and 100% for care staff. The provider had a training team for certain skill areas and also used on-line courses and workbooks to deliver training to its workforce.

Staff completed an induction programme set by the provider, HICA. They received regular one-to-one supervision and took part in a staff appraisal scheme. Induction, supervision and appraisal were all evidenced from documentation in staff files and via discussion with staff. Staff also confirmed to us that they had completed mandatory training to ensure their competence, which is minimum training they are required to do by the provider. They had the opportunity to study for qualifications in health and social care.

Discussion with the management team and staff revealed that people were provided with meals that respected their religion, culture and dietary preferences, as meals were supplied via an outside catering company and delivered to Alderlea – Care Home as part of a regular contract. Therefore when people required vegetarian, gluten free, Kosher or Halal meals, for instance, these could be supplied upon request. People made their choices known regarding nutrition during the assessment of their needs and in 'residents' meetings. Care was taken to seek people's dietary likes and dislikes, allergies and medical conditions. Staff sought the advice of a Speech and Language Therapist (SALT) when needed. Where it was considered appropriate people were asked if they would like the use of adaptive cutlery and crockery aids so that they could maintain their independence.

Nutritional risk assessments were carried out for people with swallowing difficulties or where they needed support to eat and drink. People were asked about their menu choices each day and these were recorded. Food they chose was provided to them. The kitchen staff ensured three nutritional meals a day were available, plus snacks and drinks, including at supper time. People told us they were satisfied with the meals on offer.

Staff worked well with other care and healthcare professionals and this was evidenced in documentation and discussion with staff. We saw that a volunteer assisted people in the dining room to receive meals and drinks and also acted as a companion to them throughout the morning. We saw that many people enjoyed their company.

People and their relatives were consulted about medical conditions and information was recorded in care files. These were reviewed with any changes in conditions and passed to staff in handovers or staff meetings. People saw their doctor on request and the services of the district nurse, chiropodist, dentist and optician were accessed whenever necessary. Health care records held in people's files confirmed when they had seen a professional and the reason why. They contained guidance on how to manage people's health care and recorded the outcome of consultations. Diary notes recorded when people were assisted with the health care that was suggested for them.

For those people that used the service who were living with dementia the signage and environment was conducive to their needs. The communal areas were open-plan and enabled staff to observe people easily. Toilets, bathrooms and bedrooms were signed and colour coded for quick identification, though some signs were small. Some people had their names and a small picture of something of interest to them on bedroom doors to assist with finding their personal space, but the registered manager was planning to put up memory boxes to improve this. People's bedrooms were personalised with their possessions, family photos and trinkets. Carpets, furniture fabrics and wallpapers were mostly plain and ensured people could navigate their environment easily. Environment incorporates design and building layout, colour schemes, textures, experience, light, sound and smell.

We discussed dementia environments with the registered manager and they agreed they would look at further developing the environment so that it was the best it could be to aid people's orientation and reduce anxiety. They were signposted to the information that can be found in research undertaken by various universities, leaders in dementia care and other reputable sources in dementia care.

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 interest and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called 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 assessed as lacking capacity to make specific decisions any made on their behalf were done so using best interest processes. Staff were aware of these processes and requirements under the MCA. We saw examples of best interest decisions made for people in relation to receiving personal care, using safety bed rails and having medicines administered. DoLS applications were made and reviews carried out to renew them. All of this was managed within the requirements of the MCA legislation. One staff said, "I judge people's moods each day to determine whether or not they will be receptive to offers of help. And it all depends on if they are feeling well or not." Some people signed documents that gave permission for their care plan to be implemented, photographs to be taken or medication to be handled.

Good

Is the service caring?

Our findings

People and visitors told us that people got on well with each other and the staff. People said, "The girls are very caring and we all get on so well" and "The staff here are very pleasant, respectful and I have no doubt that they care very much." Visitors said, "I've found staff to be friendly and helpful. [Name] likes most of them and does have favourites, but I think they are all very good" and "Staff are happy and cheerful and encourage variety in people's day."

Staff were observed to be professional but thoughtful in their approach to people. Staff knew about people's needs and preferences and were kind when they offered support. They were instructed in and expected to follow the 6C's of caring: care, compassion, competence, communication, courage and commitment. These were mentioned in daily staff 'huddles' where they would convene for sharing information about people. Information was shared to ensure staff were fully aware of people's care and support needs particularly as they changed with illness, accident or further debilitation due to age.

The management team led by example. They were polite, attentive and informative in their daily approach to people that used the service and visitors. Staff told us that the management team members were happy to stand in when required to help support people and that they could always be relied upon for this and other assistance when necessary.

At the time of our inspection we were told that people with diverse needs were adequately provided for. Those with religious, cultural, physical and sexual orientation requirements had these respected. Care plans, for example, recorded people's faith, country of origin and race, any disabilities, sexual orientation and the gender they had chosen if different to what they were assigned at birth.

People's individual daily routines, preferences for outings or meeting up with family members, activity and nutritional choices were all assessed and recorded. Records showed, for example, how people wanted to be addressed, any festivals they followed and who was significant in their lives. Staff knew these details and responded to them accordingly.

People's general well-being was considered and monitored by the staff who knew what might upset their mental or physical health. The staff operated a 'resident of the month' system whereby the person appointed had an extra review of their support plan, their bedroom was deep cleaned by the domestic staff and checked by the handyman for any repairs needed. The cook also spoke with them to determine any specific nutritional changes or needs and preferences.

While almost everyone living at Alderlea – Care Home had relatives or friends to represent them, we were told that advocacy services were available if required. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in representing them. Information was provided to people about who to contact and support was offered to ensure anyone needing an advocate was put in touch with one.

People had been consulted about their wishes following illness and were assured their right to life was protected and respected by the health and social care services they used. Every effort was made to ensure people received prompt medical treatment at these times. However, some had 'do not attempt cardiopulmonary resuscitation' documents in place to protect them from any unnecessary and unpleasant treatment at times of serious heart failure. All of this was subject to best interest decisions being made where people did not have capacity to make their wishes known.

People experienced privacy, dignity and independence wherever possible and staff understood how they should respect these so that people remained in control of their lives. Staff told us they provided personal care in people's bedrooms and bathrooms, knocked on doors before entering where people might be in a state of undress and ensured all doors and curtains were kept closed when assisting people with personal care so they were never seen in an undignified situation.

The 'dignity in care' campaign was championed in the service and was discussed across the staff team as well as with relatives in coffee mornings. We saw evidence in people's files of the ways in which personal care was provided and instructions included how to support people in the most appropriate way to ensure their privacy and dignity was respected. We heard people being addressed appropriately when asked to make choices or accompany staff so they could provide care and support.

Good

Is the service responsive?

Our findings

People told us they felt their needs were being appropriately met and their requests and wishes responded to in the best possible way. They said, "Staff help me with anything I want", "I have all the support I need and staff are very helpful and always available" and "I could not want for better."

People were assessed regarding their individual needs, using the organisation's own assessment process, which covered all relevant areas of care. People's care files reflected the needs that people appeared to present. Care files contained, for example, assessment details on particular health conditions and needs, palliative care handover forms, instructions on medical attention following heart attack, patient passports, decisions made for those without capacity, one page profiles, involvement of family members and discussions with them, detailed support plans, 'getting to know you' forms, risk assessment forms and reviews of support plan and risk assessment documents.

Care plans were person-centred and contained information under all assessed areas of need. They provided information for staff on how best to meet people's needs. They contained personal risk assessment forms to show how risk to people was reduced. We saw that care plans and risk assessments were reviewed monthly or as people's needs changed. 'Champions' for topics such as dignity, infection control, dementia and nutrition and hydration were set up amongst the staff team and included one of the cooks. One staff was soon to be set up as an equality and diversity 'champion'. These staff were tasked with promoting excellence in these areas and were expected to challenge anyone that did not uphold good practice.

Activities were held in-house with an activities coordinator, whom people talked a lot about and liked very much. This staff member had worked for many years at Alderlea – Care Home and had established some very good relationships with people that used the service. They had also developed a comprehensive activities programme that took into consideration everyone's preferences, abilities and temperaments.

Pastimes for people ranged from one-to-one hand massages, reading of poetry and discussions to group fun such as festive parties, gardening, entertainers and dog shows. The activities coordinator arranged for outings to places such as The Deep, Cleethorpes and to visit local scout troops. They had arranged for an exchange of events whereby the local scout leader was to come and give a gardening talk to people in the service and they were to give a talk on dementia to the scouts.

People's activities and pastimes were all logged using photographs; several activities albums had been set up, and records maintained of when, how and what resulted from events that took place for individuals and groups. The coordinator was extremely committed to having a big impact on people's lives and said, "It is my job to make people smile. I have set things up for people that greatly impacted on them and made their lives worthwhile." A monthly newsletter was published with articles of interest and past and forthcoming events including pictures of people engaging in these.

Past adventures included coffee mornings where, for example, discussion topics with people and their

relatives were words associated with 'dignity', quizzes were held to 'name that sound' and armchair exercises were carried out. Future plans included 'GI Girls' singers, a hundredth birthday party to be recorded by a local newspaper and a street party for the Royal Wedding due in May 2018. Also planned was a joining of forces with local school children who had buried a time capsule 50 years ago and were going to dig it up, open it to see and read about what was popular in the late 1970's and then refill it with today's artefacts and information. People at Alderlea – Care Home were to be included in the opening of the capsule and witnessing and recording the event.

The registered manager was aware of the Accessible Information Standard (AIS), but had yet to formalise the standard's assessment process so that all assessments included discussion with people and relatives about communication needs. The AIS aims to ensure that those with a disability receive accessible health and social care information in the format that best meets those needs. Communication needs were asked about with regard to hearing and sight loss but these checks did not include language differences or any learning difficulties. People living with dementia made up a large proportion of those using the service and their needs were made known by their behaviour, which staff learned to understand and respond to. Information was mainly given to people in verbal format, although staff had learned to understand how some people responded to gestures and facial expressions best. We were told that in the past people had received information in large print, via loop systems and other languages where necessary, but only as the need presented itself.

The provider's complaint policy and procedure were visible in the service. Records held on complaints showed that they were handled within timescales. A complaint log showed how issues had been analysed to avoid repetition and there were strategies put in place to ensure problems were resolved. People and visitors told us they knew how to complain and had discussed issues in the past, but not for some time. One visitor said, "I would make my complaint known verbally to the manager if I had a need to. I sometimes query my relative's health care needs and staff just access the relevant services." Records showed that no complaints had been received in the last eight months. We were told by staff that relatives usually mentioned any niggles as they arose and discussed these with the registered manager as necessary because they were very approachable. Compliments were also recorded in the form of letters and cards.

We assessed how people were cared for at the end of their life and found that staff sought appropriate healthcare support to enable people to have a comfortable, pain-free and dignified death. Staff told us how they supported people and were sensitive to people's needs and those of their relatives at that time of people's lives. The service had a relative's room where they could stay over if they wished.

People and their relatives were treated respectfully, with compassion and dignity. Information was provided when necessary and communication was good. All care needs and end of life arrangements were recorded within people's care plans so that staff had instructions on how to look after people and what people or their family wanted. Some people had a 'palliative care patient' handover sheet completed by a community nurse, which stated they wished to remain in the home and not be admitted to hospital unless, for example, sepsis or severe dehydration was evident. Staff told us that people received regular monitoring and support checks. These were recorded on monitoring charts for nutritional intake and output, pressure relief and application of topical creams and lotions.

Good

Is the service well-led?

Our findings

People we spoke with felt the service was a good place to live as the staff were helpful and cheerful. Staff said that the culture of the service was, friendly, caring and empowering. Visitors said, "The manager is very good. The activities lady is excellent. The administrator is extremely helpful" and "I have no reason to believe that the service is poorly managed. I think the manager has done a very good job since she arrived."

At the last inspection the provider was in breach of regulation 18 (Registration) Regulations 2009 regarding some statutory notifications not being sent to the Commission. We wrote to the provider reminding them of their responsibility and they responded by taking appropriate action. Some minor improvements were also needed regarding the quality assurance audits.

At this inspection we found that notifications had been sent to us for all events and incidents as required by regulation, in the last year. These included safeguarding concerns, accidents, events that stopped the service from running, authorised restrictions and deaths. The new manager fully understood their responsibilities to ensure events were notified to us and so the service fulfilled its registration responsibilities.

We found that quality assurance audits had improved so they were more effective at highlighting shortfalls and planning to address issues. Audits were completed on, for example, health and safety, infection control, medication, moving and handling and care plans. The registered manager understood their governance responsibilities and ensured quality performance, risk and regulatory requirements were monitored and mitigated. Quality audits were completed internally and the organisation carried out its own internal quality auditing using a specific tool to identify any non-compliance with regulations. This assessment tool showed that improvements had been made since the last inspection in 2017. There was also a shift handover system, which ensured people's needs were discussed and monitored.

Aspects of the quality assurance system included sending out satisfaction surveys to people that used the service, relatives and health care professionals. One relative we spoke with recalled completing a survey but another could not. The last satisfaction survey was issued to people that used the service in October 2017 and those returned contained positive comments about the staff and service delivery.

Surveys issued to relatives in January 2018 contained a mixture of positive and not so positive comments and these had been honestly written to reflect, on the whole, satisfaction with the service. Two comments identified a need for improvement in communication and continence care. These had been considered as beneficial to the service because it meant that action could be taken to address them positively and make the improvements. An action plan had been set up to address this feedback and we saw that communication was now via a variety of methods: telephone calls to relatives, face-to-face conversations when visiting, chats with people's key workers, communication books in all communal areas and the staff 'huddles' to ensure all staff knew about the events in people's lives and could relate these to family members. We saw that continence care had been looked at individually for those people that required it

and care plans were updated and aids were identified and accessed.

Staff surveys were also issued in January 2018 and these contained positive comments along with some requests for more pay, redecoration of the premises, greater spend on the building and more cleaning staff to be employed. Some of these issues raised were being addressed by the registered manager. Health care professionals surveys, similarly issued in January, contained the comments; 'Clients expressed different behaviour, which staff have dealt with well', 'A well-run service with great staff', 'Staff always position my client well so that she can feed herself and maintain her independence' and 'Carers work well with clients because they know them well.'

Meetings were held for people that used the service and relatives, where all areas of service delivery were discussed: staff approach and knowledge, dignity, privacy, decoration, food, activities, complaints and outings. Relatives confirmed they had attended relatives' meetings and found these to be useful. Staff meetings were also held to obtain their views of how people were benefiting from the service and to discuss any areas where people's health or independence was deteriorating so that changes in their care could be made. The registered manager and deputy manager also completed out of hours visits to the service to establish if policy and procedure was being followed and practice and record keeping was as expected when they were absent from the building.

The provider was required to have a registered manager in post and on the day of the inspection the manager had been registered for two months but had been managing the service for almost a year. The registered manager was aware of the need to maintain their 'duty of candour'. This is the responsibility under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 to be honest and to apologise for any mistake made.

The management style of the registered manager and deputy manager was open, inclusive and enabling. Staff told us that "The manager is very supportive and a good motivator. They empower us", "They are much respected and get my full support" and "The manager is easy to get on with and understands our frustrations. She always mucks in when needed." Many positive comments expressed also referred to the deputy manager. The staff knew about the visions and values of the organisation, stating they understood and implemented them whenever possible.

The registered manager and activities coordinator already had good community links set up for people that used the service, but were building these further. Connections were in place with local schools (visits from children and the capsule opening as mentioned earlier), scouts, religious organisations, health services and social organisations. People were given discounts at a small café in the local library.

The registered manager strove for continuous learning around best practice and met with other care home managers in the organisation. They updated their learning and practice at any opportunity and worked towards improving the service by searching for innovative ways of delivering the service and the means of sustaining them.

The service fostered partnerships with other agencies and organisations by keeping in contact with them, sharing information and listening to and acting on advice when it was offered. This was confirmed by the staff we spoke with and evidence in care plans of the care, support and treatment provided to people. People were seen as individuals with differing needs and preferences.

Data protection was appropriately managed and the service was registered with the Information Commissioner's Office. The registered manager was aware of the imminent new data protection legislation

being introduced by the European Communion. They were also extremely astute at knowing about and using the recording systems in operation and remembering information about people's needs, the running of the service and where it was all kept.