Avante Care and Support Limited

Bridge Haven

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 7 June 2018 and was unannounced.

Bridge Haven is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Bridge Haven accommodates up to 53 people in one purpose built building. There were 36 people using the service during our inspection.

There was no registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager had been appointed in December 2017, they had applied to CQC to become registered as the manager at the time of this inspection, but no decision had yet been made about their application. In the week following this inspection a decision was made to agree their application.

Bridge Haven was last inspected in April 2017. One breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was identified. We issued a requirement notice relating to safe care and treatment. We asked the provider to take action and they sent us an action plan. The provider wrote to us to say what they would do to meet legal requirements in relation to the breach. We undertook this inspection to check that they had followed their plan and to confirm that they now met legal requirements. We found improvements had been made, and the previous breach had been met.

At our previous inspection medicines were not consistently managed safely. At this inspection we found that improvements had been made and medicines were now managed safely. At our last inspection we recommended that the provider ensured sufficient staff were on duty to meet people's needs. At this inspection we found that staffing levels were safe and met people's needs. People told us they felt there were enough staff and they didn't have to wait long when they needed help. The manager had focused on ensuring there were enough staff by focusing on recruitment, looking at different ways of recruiting staff, such as open days.

People were protected from the risk of abuse. Staff had received safeguarding training. They were aware of how to recognise and report safeguarding concerns. Staff knew about the whistle blowing policy and were confident they could raise any concerns with the provider or outside agencies if needed.

Equipment and the premises received regular checks and servicing to ensure it was safe. The manager monitored incidents and accidents to make sure the care provided was safe. Emergency plans were in place so if an emergency happened, like a fire, the staff knew what to do. The premises were designed, adapted and decorated to meet people's needs and wishes. The manager told us about plans to further improve the environment for people; these included improving some outside areas and some of the communal areas.

Staff had completed induction training when they first started to work at the service. Staff were supported during their induction, monitored and assessed to check that they had attained the right skills and knowledge to be able to care for, support and meet people's needs. There were staff meetings, so staff could discuss any issues and share new ideas with their colleagues, to improve people's care and lives.

Staff worked well together and ensured that clear communication between themselves and external health professionals took place; for example, with care managers, commissioners, GP's and district nurses.

The care and support needs of each person were different, and each person's care plan was personal to them. People had detailed care plans, risk assessments and guidance in place to help staff to support them in an individual way. Some plans did not contain clear and specific guidance for staff, however, after we highlighted this to the manager they took steps to ensure this was immediately put right.

Staff encouraged people to be involved and feel included in their environment. People were offered varied activities and participated in social activities. Staff knew people and their support needs well. Staff were caring, kind and respected people's privacy and dignity. There were positive and caring interactions between the staff and people and people were comfortable and at ease with the staff.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff had an understanding of The Mental Capacity Act (2005) and when people lacked the capacity to consent to staying at the service, the registered manager had applied for Deprivation of Liberty Safeguards (DoLS.) People were involved in making decisions about their care and staff knew how to communicate with them.

People were encouraged to eat and drink enough and were offered choices around their meals and hydration needs. Staff understood people's likes and dislikes and dietary requirements and promoted people to eat a healthy diet. The service was not currently supporting anyone at the end of their life.

Quality assurance audits were carried out to identify any shortfalls within the service and how the service could improve. Action was taken to implement improvements. Staff told us that the service was well led and that they felt supported by the manager to make sure they could support and care for people safely and effectively. Staff said they could go to the manager at any time and they would be listened to.

The registered manager was fully aware of their regulatory responsibilities and had notified us of any important events that had happened in the service. The rating was displayed clearly on a notice board in the hallway and on the providers website. The manager had fostered links with the local community and encouraged staff involvement in developing the service. A system to respond to concerns was in place. People and their relatives knew how to raise concerns and were confident they would be listened to.

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 received their medicines when they needed them and in a way that was safe. They were stored safely.

There were enough staff to keep people safe. Staff were recruited safely.

Accidents and incidents were documented and were analysed to look at ways of reducing the chance of them happening again.

Risks to people were assessed and managed to ensure their health and safety.

People were protected from the risks of avoidable harm and abuse. Staff knew how to recognise and respond to abuse and understood the processes and procedures in place to keep people safe.

Is the service effective?

Good

The service was effective.

Staff understood the importance of gaining consent and giving people choice.

Staff received training and support to enable them to carry out their roles effectively.

People's health was monitored and staff ensured people had access to external healthcare professionals when they needed it.

People were provided with a range of nutritious foods and drinks.

The premises were designed, adapted and decorated to meet people's needs and wishes. The manager told us about plans to further improve the environment for people.

Is the service caring?

Good

The service was caring.

Staff took the time needed to communicate with people and included people in conversations.

Staff spoke with people in a caring, dignified and compassionate way.

Staff supported people to maintain contact with their family.

People were treated with kindness, respect and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care and support was mostly planned in line with their individual care and support needs. Some records required more detail to ensure they were person centred and specific.

Staff had a good understanding of people's needs and preferences.

People were supported to take part in activities that they chose.

There was a complaints system and people knew how to complain.

The service was not supporting anyone at the end of their life.

Is the service well-led?

Good

The service was well-led.

There was a manager in post, during the inspection they were not registered with the CQC. Since the inspection, they have become registered.

The manager understood their regulatory responsibility and had submitted statutory notifications as needed.

People, their relatives and staff were positive about the leadership at the service. Staff felt supported by the management.

Regular audits and checks were undertaken at the service to make sure it was safe and running effectively.

Bridge Haven

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 7 June 2018 and was unannounced. The inspection team consisted of three adult social care inspectors and an expert-by-experience. The expert-by-experience had a personal understanding of having a loved one living in a care home.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met and spoke with 18 people who lived at Bridge Haven and observed their care, including the lunchtime meal, medicine administration and some activities. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people's relatives throughout the day. We inspected the environment, including communal areas, bathrooms and some people's bedrooms. We spoke with four care staff, kitchen staff, the manager, and the provider's director of care.

During the inspection we reviewed six people's care plans and associated records. We also looked at other records, these included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

We displayed posters in the communal areas of the service inviting feedback from people and relatives. Following this inspection visit, we did not receive any additional feedback.

Good

Is the service safe?

Our findings

At our last inspection medicines were not always managed safely. They were not routinely dated upon opening, there were gaps in recording administration of some medicines and a medicine error had occurred because the checks made on prescriptions returned from the GP had not been effective in identifying a duplicate prescription. This was a breach of Regulation 12 of the Health & Social care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. At this inspection we found that medicines were now managed safely and in the way people preferred.

Medicines were stored in a dedicated room which was organised and clean. Records relating to the management of medicines were completed fully and accurately. Medicines were dated on opening. Some people had 'as and when required' (PRN) medicines; there was a protocol in place to guide staff when the medicine should be offered, the minimum time between doses and how often a person could have the medicine in 24 hours. Medicines were administered by staff who had received training and had their competency checked by the manager. One person told us, "I always get my medicines on time, they are very precise about that which is a relief as I would always forget."

At our last inspection we recommended that the provider ensured sufficient staff were on duty at all times to meet people's needs. At this inspection we found that staffing levels were safe and met people's needs. Since the manager had joined the service, they had focused on ensuring they recruited enough suitable staff. They told us they had held recruitment open days and had been involved in many rounds of recruitment. They felt that this had been worthwhile as they had been able to build a strong and competent staff team. There were still some vacancies remaining but staffing levels were much improved since our last inspection and the manager was confident they would be able to recruit to the vacancies.

We reviewed staffing rotas for the four weeks prior to our inspection and found that levels matched those that we had been told about. During the inspection the staffing levels matched the number of staff on the duty rota and there were enough staff available to meet people's individual needs and keep them safe. Staffing was flexible and adapted to people's activities and appointments, for example, on the day of the inspection staffing levels had been amended to include a planned outing for some people. During the inspection staff were not rushed and told us they felt staffing levels were appropriate. People also felt staffing levels were good, comments included, "There are usually quite a number of staff on duty, so we don't have to wait for a cuppa or anything" and "I can always call a member of staff when I need someone, and they are quick as anything at getting to me without fail." One relative told us, "I visit as much as I can and there is always a good amount of help and staff here."

Safeguarding and whistleblowing policies and procedures remained in place for staff to follow and staff had received training. They were able to tell us how they would recognise and respond to abuse, one member of staff told us "I would look for a person's reaction to their carers and/or would note how staff spoke to people." Staff were confident that any concerns they raised would be taken seriously and investigated by the management team, to ensure people were protected. Staff were aware of the whistle blowing policy and knew they could take concerns to agencies outside of the service if they felt they were not being dealt with

properly. People told us they felt safe living at Bridge Haven, comments included, "I feel safe because of all the staff here to help me, there is always someone around when I need them, not like when I was living on my own" and "I feel safe in my room at night when I have a bell next to me and I know someone will come to me if I need them." The manager told us they had a good working relationship with the local safeguarding team and could discuss with them any concerns they may have.

Risks to people had been identified and assessed and guidelines were in place to reduce risks. There was individual guidance for staff if people were living with epilepsy, regarding their seizures and what may trigger them. Similarly, when people were living with diabetes there was information for staff regarding signs if people's blood sugar levels were too high or too low and what action they should take. Risk assessments were reviewed and updated as changes occurred so that staff were kept up to date. People were protected from the risk of financial abuse. There were clear systems in place and these were regularly audited.

The premises were clean and well maintained. The manager told us about plans to improve the service; these included the redesign of some communal areas and some outside areas. There were records to show that checks took place to help ensure the safety of people, staff and visitors. Procedures were in place for reporting repairs and records were kept of maintenance jobs, which were completed promptly after they had been reported. Portable electrical appliances and firefighting equipment were properly maintained and tested. Health and safety audits were completed and that these were reviewed by management to see if any action was required. These checks enabled people to live in a safe and suitably maintained environment. Staff told us everything was in working order. People had a personal emergency evacuation plan (PEEP). A PEEP sets out specific physical and communication requirements that each person has, to ensure that they can be safely evacuated from the service in the event of a fire. The business continuity plan detailed the steps staff should take in order to keep people safe in the event of emergencies.

Accidents and incidents involving people were recorded and management reviewed these reports to ensure that appropriate action had been taken following any accident or incident to reduce the risk of further occurrences.

Good

Is the service effective?

Our findings

People and relatives told us that staff contacted healthcare professionals when they needed them. One person told us, "Yes, no problems getting to see the GP." Another person commented, "It's a good home, the staff all know what they are doing, I always receive the support I need."

People's needs were assessed using a comprehensive assessment tool before they moved to the service. This supported the manager to consider if the service could meet people's needs and review if any additional staffing or training was required. This assessment was used to formulate the person's care plan. Where possible people and their relatives were involved in planning their care delivery and were aware of risks to be monitored and managed.
Staff completed regular assessments of people's ongoing needs using recognised tools. These included Waterlow assessments (to assess the risk of people developing pressure areas or skin breakdown) and a malnutrition universal screening tool to identify people at risk of losing weight. Specialist mattresses and cushions were used to help support people who were at risk of developing pressure areas. Where concerns were identified around how much people ate or drank, records were made. This enabled staff to track how much people ate and formed a starting point for dieticians to decide if fortified or food supplements were required.

People were weighed regularly and in the event of weight loss, appropriate referrals made and support sought. When fortified meals were recommended or supplementary drinks prescribed, records, staff and people confirmed they were given. Fluid charts were in place, records were up to date and staff were able to tell us of potential signs of dehydration and what to do. Hydration care plans gave staff guidance about how much people should aim to drink in a 24 hour period. People had access to other healthcare professionals such as speech and language therapists, opticians, dentists and a chiropodist when required.

Throughout the inspection we received entirely positive feedback about the quality, nutritional value and choice of food served. Comments from people included, "I think the choice of food is really jolly good. It even smells good", "We can request something to be put on the menu and they are usually able to oblige", "I sometimes ask for an omelette and something light. It is made fresh for me." The head cook was very passionate about their role and the quality of food they served to people. They were aware of individual dietary needs and how to cater for them, along with people's likes, dislikes and favourites. They explained to us that they worked out the nutritional content of meals to enable to them to fortify meals for those who needed it. To support people with diabetes, they offered some dishes in a slightly smaller portion so that they could have the same choice as others. For example; during the inspection creative individual apple pies had been made without sugar, in order that all could enjoy. They told us about one person they had supported to change their diet, with the outcome being that the person was no longer showing symptoms of diabetes despite previously having been diagnosed with type two diabetes. The kitchen was very well organised with appropriate health and safety records along with detailed records about individuals dietary needs to support the kitchen staff to deliver a person centred approach. The cook told us that they spoke to each person every day to see what meals they would like and were always able to offer another choice of they did not want the main menu.

Staff monitored people's health and contacted healthcare professionals when people's needs changed. One person told us, "If I need to see my GP the staff will just call them for me and it is all organised." When one person's behaviour had significantly changed, staff worked with the mental health team and followed the guidance given to develop a support plan to address behaviour that challenged.

Staff received training in a range of topics to support them to carry out their roles effectively. Staff who were new to the organisation received an induction. This included a five-day classroom based course, the Care Certificate (The Care Certificate is an identified set of standards that social care workers adhere to in their daily working life.), shadowing experienced staff and undergoing competency checks before they could work on their own. The manager told us they were in the process of introducing a home specific induction, whereby leads from each department would give new staff an induction to their roles. They were also introducing a 'buddy' system so that new staff could partner with more experienced staff for ongoing support.

Staff received ongoing support through regular updates, supervisions and annual appraisals. The manager had been supervising all the team but had recently allocated some of this responsibility to senior staff within the service. Staff continued to receive updates in mandatory training and were offered other additional training that was relevant to people they supported. For example, 'care of the dying', care planning and the principles of the Eden alternative (a philosophy aiming to combat loneliness, helplessness, and boredom experienced by older people in residential settings). Staff training was recorded and monitored by the organisations head office and they flagged it to the manager when a training course was due. The staff we spoke with were positive about the range of training courses that were available to them. One member of staff told us, "All the training provided is of good quality, especially dementia training. There's an ongoing program in place and all training needs are discussed at supervision." Staff were encouraged to study and gain qualifications. Many had completed qualifications in health and social care and a number were completing distance learning courses in relevant topics.

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 so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had applied for DoLS when required. A DoLS application had not been made for one person who had recently moved to the service. We raised this with the manager and, by the end of the inspection, they confirmed an application had now been made. Otherwise DoLS applications were made as required and any specific conditions attached to authorisations met.

Staff understood the principles of the MCA and people were offered choices throughout the inspection, like where they would like to spend their time and what they would like to drink. When important decisions needed to be made on people's behalf, best interest meetings had taken place with people who knew the person well.

Bridge Haven was purpose built and met people's needs. The corridors and doorways were wide and the manager had due regard to guidance of best practice for a dementia care setting. For example, there were handrails in corridors to aid mobility. Signage to toilets and lounge areas were easily visible and in written

and pictorial forms. Peoples bedroom doors were painted in different colours to help people to more easily distinguish them. This helped to aid people's awareness of their surroundings. There was a cinema and another room, complete with a bar, tables and seating set out as a pub. Bedrooms were personalised with people's own possessions, photographs and pictures. There was a garden that people were able to access and spend time in. Toilets and bathrooms were clean and had hand towels and liquid soap for people and staff to use.

Good

Is the service caring?

Our findings

People told us and indicated that they felt staff were thoughtful and acted in a caring manner. Comments included, "The girls are ever so gentle they really are and so kind. They don't rush they have a chat too which I look forward to" and "The girls are most caring and very kind. They are quiet, caring and I really feel that they care."

There was a person-centred culture at the service, with care planned around the individual. Staff knew about people's background, their preferences, likes and dislikes and their hopes and goals. Staff spent time with people to get to know them. There were descriptions of what was important to people and how to care for them in their care plan. Staff talked about people's needs in a knowledgeable way and explained how people were given the information they needed in a way they understood so that they could make choices.

Staff supported people in a way that they preferred. People responded well to staff and looked comfortable in their company. Staff interacted with people in a way that demonstrated they understood their individual needs and had a good rapport with them. Staff talked about and treated people in a respectful manner. Staff treated people with kindness and compassion. One person told us that when they were feeling low staff, "always stay to cheer me up and make sure we have a laugh."

When people required support, staff provided it in a gentle and caring manner. At one point during the morning one person became agitated with another person who was banging their spoon on a bowl, the staff quickly spotted this and quietly and effectively diffused the situation. They quietly spoke to the person and engaged them in a conversation before removing the empty bowl.

People told us, and we observed that staff were respectful and knocked on bathroom and people's doors before entering. One person told us, "The staff always knock on my door and always ask if it is alright to enter before coming in or starting to help me." Staff spent time with people and gave them the support they needed. People could choose whether they wanted to spend time in communal areas or time in the privacy of their bedrooms. One person told us, "It can be tiring at times to be in a room full of people but somehow they always know when I am ready to go to my room for a bit of peace and quiet."

People could have visitors when they wanted and were supported to have as much contact with family and friends as they wanted to, one person told us, "My family and friends don't ever need to make a time to come they can just come as if it was my own home." A relative commented, "I just do not need to worry now I know they are being cared for and I can visit at all times." Another told us they had wanted to drop a nightshirt off that they had forgotten to pack and came back late in the evening to bring it. They sat with their loved one for a while without any problem.

Staff told us that people who needed support were supported by their families or their care manager, and no one required any advocacy services. Information about advocates, self-advocacy groups and how to contact an advocate was held within the service, should people need it. An advocate is someone who supports a person to make sure their views are heard and their rights upheld to ensure that people had the

support they needed.

Staff described how they supported people with their personal care, whilst respecting their privacy and dignity. This included explaining to people what they were doing before they carried out each personal care task. People, who needed it, were given support with washing and dressing. When people had to attend health care appointments, they were supported by staff that knew them well, and would be able to help health care professionals understand their communication needs.

Some people required additional support to communicate. Staff used some signs and symbols to assist people's understanding where possible. There were pictures displayed of the staff at the service, activities on offer and of the menu to reinforce people's understanding. We were told that the service had a recently produced statement of purpose (a document describing what the service offers) in an easy to read format. We were sent this after the inspection and the manager told us they would be sharing this with people.

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially.

Requires Improvement

Is the service responsive?

Our findings

Visitors told us staff were responsive when their relative's care needs changed. One visitor told us, "The staff know [my loved one] really well and are very quick to notice any change in them. I feel she is looked after very well, I can't fault anything, I really can't." Another commented, "My [loved one] is so happy since moving in here and so well cared for at all times. They would definitely let me know if they were not happy about anything." People told us they felt they received the support they needed and were happy. One person told us, "I feel very lucky because I am so well looked after and respected by all around me. What I find so nice is that I am asked what I like and what I don't like. I don't feel that anyone is 'told' what and when to do things, but we are allowed to do things in our own time and on our terms."

Each person had a care plan, which included details about their choices and preferences. There were details about what people liked to eat and drink, when they wanted to get up and go to bed and how they liked to receive their care. Health conditions were identified and most care plans provided guidance for staff about how to support people and what to do to reduce identified risks. However, while people received the help and support they needed, some care plans were not updated to reflect events, show all the measures aimed at reducing risk, or provide appropriate guidance for staff. For example, one person had fallen and although appropriate action was taken to reduce the risk of future falls, the person's falls diary had not been completed nor their risk assessment revisited to show the actions taken to reduce the likelihood of repeated falls. Another person had a skin condition requiring treatment by the District Nursing Team, however, there was no care plan to provide care staff with guidance or caution when washing the person or drying their skin. In another care plan, although records were kept about instances of behaviour that could challenge others and staff, there was not detailed guidance available for staff to help support the person to manage these behaviours. While the frequency of the person's behaviours that challenged had decreased, the lack of guidance presented a risk of inconsistent support. During the inspection the manager and providers representative told us about new care plans that they were in the process of introducing and immediately following our inspection the manager sent us reviewed and updated documents. This is an area for improvement.

Within people's care plans were life histories, guidance on communication and personal risk assessments. In addition, there was guidance describing how the staff should support the person with various needs, including what they could and could not do for themselves, what they needed help with and how to support them. Care plans contained information about people's wishes and preferences and guidance on people's likes and dislikes around food, drinks and activities.

Health plans detailed people's health care needs and involvement of any health care professionals. Each person had a healthcare passport, which would give healthcare professionals details on how to best support the person in healthcare settings if needed, such as if the person needed a stay in hospital. Care plans were regularly reviewed and mostly reflected the care and support given to people during the inspection.

People had review meetings to discuss their care and support. They invited care managers, family and staff. When able, people were encouraged to be involved in the content of their care plan and where possible

family or friends were asked to assist. Where people had been involved, and were able to, they had signed their care plan.

There was a comprehensive policy about dealing with complaints that staff and the manager followed. Complaints since the last inspection had been investigated and responded to. People and their relatives told us they felt management and staff were approachable and that they were listened to and changes were made in response to their concerns raised. We were shown a guide about the service in an accessible format, this contained guidance for people about how to raise concerns.

Staff had developed positive relationships with people and their friends and families. Staff kept relatives up to date with any changes in people's health. People and relatives felt the care and support delivered to people received at the service was responsive and suited to their individual needs.

People's end of life wishes had been discussed and were recorded in their care plans together with any Do Not Attempt Resuscitation (DNAR) decisions. This promoted good practice to ensure people were supported in accordance with their wishes. When people received end of life care, the service had adopted a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medicines. People often experience new or worsening symptoms outside of normal GP practice hours. The provision of 'Just in Case' boxes seeks to avoid distress caused by poor access to medications in out of hours periods, by anticipating symptom and pain control needs and enabling immediate availability of key medicines within the service. At the time of our inspection, no one was receiving end of life care.

The service had a full-time activities coordinator in post. People told us they were supported to take part in a variety of activities including music therapy, physiotherapy, quizzes, bingo, singers and entertainers. Planned social events took place celebrating national events such as the recent royal wedding and on the day of our inspection two people attended a ceremony in London, where they would meet the Queen. During the inspection a group of people took part in a singing activity, which they appeared to enjoy. Most people were positive about the variety and frequency of activities, although we received mixed feedback from relatives. Comments included, "One thing I must say is that there is not enough to occupy them" and "I can't say that I am aware of many organised activities but there is often something going on when I arrive."

Good

Is the service well-led?

Our findings

People felt the service was well run. One person told us, "It seems well run; the staff know what they're doing." We also received complimentary comments from relatives; "I do feel it is well run, yes. There is respect but not in an authoritarian way"; "I am often asked how I feel things are being done and if there is anything I feel could be changed" and "I do feel that things are managed very well and very efficiently. All the staff know what is what and it is ship shape."

At the time of our inspection there was not a registered manager in post. A new manager had been recruited in December 2017 and was going through the process of applying to become registered. Since our inspection their application has been agreed. Staff told us they felt confident that the new manager was leading the service well, "The service is well managed, [the manager] is very good, switched on and visible around the home"; "[The manager] is very approachable, no concerns about poor care" and "I feel valued and supported, had a career in care and this is by far the best managed home."

There were systems and processes to help care staff to be clear about their responsibilities. This included there being two senior care leads who led each shift. Arrangements had also been made for a senior member of staff to be on call during out of office hours to give advice and assistance to care staff should it be needed. One member of staff told us, "I'm very clear about role, job description in place, regular supervision and staff meetings."

Regular team meetings were held, giving staff the opportunity to share information and discuss concerns. The manager attended regional manager meetings, where best practice and updates were shared in order for the manager to bring information back to their team. Accidents and incidents were also discussed at team meetings to help identify any emerging trends.

Resident and relative's meetings were held and discussed topics such as menus, activities and upcoming events. Relatives told us, "I am often asked how I feel things are being done and if there is anything I feel could be changed"; "Yes we have meetings and I am asked what my views are and I have filled out a questionnaire" and "I do feel listened to and I do feel a part of the home in so far as they really do value out input and views and we often see our little ideas such as new signs and different choice of soft drinks being implemented."

The manager and senior staff completed a range of checks and audits on the service. Regular health and safety and infection control audits were completed and any actions that were identified were completed and signed off. Regular checks on medicines were completed and the manager sampled and checked people's care plans to ensure they contained the necessary level of detail. Audits by the provider's quality team and head office staff gave additional scrutiny and led to action plans for improvement. Names of people responsible for actions and timescales were added to any action plans for improvement. Accidents, incidents and complaints were reviewed by the manager and by staff at the provider's head office to check if any patterns were emerging. These were used for learning and improving the service.

The manager and staff worked in partnership and liaised with a range of professionals and other organisations when people's needs changed. There continued to be a range of policies and procedures for staff to refer to for advice and support. Policies were up to date and staff knew how to access them. We were told that the organisation was in the process of introducing a new Human Rights Act Policy to guide staff. The manager told us they had recently completed the Skills for Care Well led programme (a programme designed to development managers and improve leadership in services) and that they had joined the local registered managers network; this gave them opportunity to discuss current best practice with other social care managers. Links with the local community had been forged, with visits from the local primary school and playschool taking place. There were many photographs in the service of visits that had taken place.

The provider had a mission; 'to enable the journey through care by providing personalised home support and residential services, where everyone has a vibrant and fulfilling life. This was underpinned by a set of values, which were displayed within the service. The provider had also developed a philosophy of care with the Eden Alternative (a national person-centred planning tool, with a set of 10 principles) based upon putting the person at the centre of decision making about the way they want to continue to live their life.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of certain changes and important events that happen in the service. These are referred to as Statutory Notifications. This enables us to check that appropriate action had been taken. The manager was aware that they had to inform CQC of significant events and any allegations of abuse in a timely way and had done so. This is important so that we can check that people are being kept safe.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. We found the rating had been displayed at the service and on the providers website. This is important so that members of public know how well the service is meeting people's needs and people can be informed of our judgements.

People who lived in the service and their relatives had been invited to complete questionnaires about the quality of the service and to make suggestions about how the service could be improved. Action had been taken to act upon any feedback that had been received.