Harbour Healthcare Ltd

Bentley Manor

Inspection report

Sherbourne Road
Crewe
Cheshire
CW1 4LB

Tel: 01270259630

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on the 10 and 13 September 2018 and was unannounced.

At our last inspection on 5 May and 23 June 2017, we found that the service was in breach of regulations relating to safeguarding, the management of risk and good governance. The service was rated overall as 'requires improvement.' We took action by requiring the provider to send us an action plan setting out how they would address these issues. During this inspection we found improvements had been made and the provider was no longer in breach of these regulations. We found that overall the service had improved and is now rated as "good". However, some further improvements were still required related to the safe domain.

Bentley Manor 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. Bentley Manor accommodates up to 80 people across three separate units, each of which have separate adapted facilities. Two of the units specialises in providing care to people living with dementia. At the time of the inspection there were 74 people living at the home.

The majority of people were very positive and complementary about the care and support they received at Bentley Manor. Improvements had been made to demonstrate that risks to people were assessed and action taken to mitigate these risks. We specifically looked at people at risk of falling and found that appropriate action had been taken. In some instances we saw that records had not been updated to reflect the action taken.

Overall, we found that there were sufficient staff to meet the needs of people. However, at certain times levels were affected by unexpected staff absences such as sickness. The registered manager confirmed that action would be taken to ensure all staff understood the systems for managing staff absences, especially at short notice.

Where necessary safeguarding concerns had been identified and reported to the local authority and CQC had also been notified. Staff understood when and how to report safeguarding concerns. Staff were recruited following safer recruitment processes. We found that medicines were managed safely.

Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and understood it's principles. We saw that staff sought consent from people before providing support. Staff were trained to carry out their duties as required. Staff received supervision to support them with their development, however there were occasional gaps and variations in the frequency of these. The management team told us that they would focus on this.

People were supported to meet their nutritional needs. Overall people told us they were happy with the food on offer, however a few comments suggested that the food was sometimes cold and people would

appreciate more fruit and vegetable choices. Any nutritional risks were monitored and action was taken in response.

A range of health professionals were involved in people's care. The registered manager had developed several clinical pathways because of learning from a recent incident at the service.

People told us that they were treated in a kind and caring manner. We saw that staff respected people's dignity and privacy. We saw some good examples of care being provided in a way which met individuals' needs. The service considered people's diverse needs well

People's care plans reflected their physical, mental, emotional and social needs. They included information about people's histories, likes, dislikes and preferences. Activities were available to people, but these had recently reduced due to staff changes. The management team planned to get these back on track. The staff had trained in Namaste care, which provides specific support to people living with dementia.

There was a complaints procedure in place and people told us that they felt able to raise any concerns with staff.

People and staff were positive about the management of the service. The registered manager worked in an open and transparent way. There were arrangements in place to regularly assess and monitor the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Overall there were sufficient staff, but this was affected at times by staff absences.

Medicines were managed safely.

Risk assessments were in place and action was taken to mitigate risks. Some records had not always been updated.

Where necessary safeguarding concerns had been identified and reported to the local authority

Is the service effective?

Good

The service was effective.

Staff spoken with were knowledgeable about the MCA and understood it's principles.

People's nutritional needs were met.

A range of health professionals were involved in people's care. The registered manager had developed several clinical pathways.

Staff were well trained and supported in their roles.

The environment had been well adapted to meet the needs of the people living there.

Is the service caring?

Good

The service was caring.

Staff were kind and caring in their approach.

People were involved in the planning and decisions around their care.

People told us their privacy and dignity was respected by the staff.

Importance was placed on ensuring that the service met people's diverse needs.

Is the service responsive?

Good

The service was responsive.

People's needs were met in a way that took account of their personal preferences.

Care plans were in place and had been reviewed on a regular basis.

Some activities and entertainment took place, however these had recently reduced due to staff changes. This was being addressed.

There was a complaints procedure in place and people felt able to raise any concerns about the service.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post, who was supported by a deputy manager.

People and staff were positive about the management of the service.

People's views on the quality of the service were sought.

There were arrangements in place to regularly assess and monitor the quality of the service.

Bentley Manor

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.

At the time of the inspection CQC was aware of an incident which resulted in a serious injury to a person. We were aware that the incident has been brought to the attention of the Police and a Local Authority who are making further enquiries. During the inspection we therefore explored any current risks and have been assured that the provider has mitigated for these types of risks appropriately.

This inspection took place on 10 and 13 September 2018 and was unannounced. The inspection team consisted of two adult social care inspectors, a specialist nurse advisor and an expert- by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we looked at any notifications received and reviewed any information that had been received from the public. A notification is information about important events, which the provider is required to tell us about by law. We received a Provider Information Return (PIR) from the registered manager before our inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority and they shared their current knowledge about the home. We checked to see whether a Health Watch visit had taken place. Health Watch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of the care. The latest visit was in August 2017 and was positive about the service.

During the inspection we spoke with 12 people who lived at the service and eight relatives/visitors, to seek their views. We also spoke with 21 members of staff including nurses, care staff, the chef, registered manager, the deputy manager, operations director, the activities co-ordinator, the training co-ordinator and the maintenance team.

As some people living at Bentley Manor were not able to tell us about their care experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

We looked at the care records of 10 people who lived at the home and inspected other documentation which related to the day to day management of the service. These records included, staff rotas, quality audits, training and induction records, supervision records and maintenance records. We looked around the building, including bathrooms, store rooms and with permission spoke with some people in their bedrooms. Throughout the inspection we made observations of care and support provided to people.

Requires Improvement

Is the service safe?

Our findings

During our last inspection on 23 May and 5 June 2017 we found that safeguarding procedures had not always been followed. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found that risk assessments relating to people's health, safety and welfare had not always been completed. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made and the provider was no longer in breach of these regulations.

Everyone who we spoke with told us that they felt safe living at Bentley Manor. People commented, "I have peace of mind living here" and "I feel very safe here."

Where necessary safeguarding concerns had been identified and reported to the local authority and the CQC had also been notified. The management team maintained a safeguarding folder which demonstrated that appropriate referrals had been made and any action taken in response. We saw there had been a relatively high number of referrals and we discussed this with the registered manager. They explained that the local authority had made contact with them to discuss the criteria for safeguarding referrals and that it may not have been necessary to report some of the incidents which had been reported.

Policies and procedures were in place which staff followed to help them safeguard people from abuse. Staff had received safeguarding training and they would report any poor practice or abuse to the registered manager or the nurses. One member of staff told us that recent training had been very helpful. There was a safeguarding folder and contact numbers were accessible for staff if they needed to report any safeguarding concerns.

Care files contained individual risk assessments which identified risks to the person and gave instructions for staff to help manage the risks. These risk assessments covered areas such as nutrition, pressure ulcers, falls and choking. Assessment tools had been used to identify if there was any level of risk, such as the Waterlow assessment tool in respect of pressure area care. Staff spoken with could explain action taken to manage any identified risks more safely. We noted in one record that a risk assessment had not been updated to reflect the action that had been taken to reduce the risk further. We also saw in a couple of examples relating to the treatment of wounds, where action had been taken by staff but the records did not reflect this. We raised this with the registered manager.

During the inspection we observed staff moving people around the home in wheelchairs and using hoists to transfer people safely from one area to another. Appropriate equipment for people with decreased mobility such as profiling beds and alternating mattresses were in place to promote skin integrity and to prevent skin breakdown. The Herbert Protocol had been implemented for a number of people. The Herbert Protocol is a national scheme being introduced by the police and other agencies, which encourages care staff to compile useful information, which could be used in the event of a vulnerable person going missing.

Changes had been made to the layout of one of the dementia units which had been separated into three

smaller units. There was now a male unit, female unit and a mixed unit, although people were not restricted to one unit if they wanted to go into the garden or have lunch in another dining room. The registered manager told us that changes had been made in response to the needs of some people living with dementia. This type of environment suited some people's needs and enabled a less restrictive approach, as well as the safer management of risk Staff and visiting relatives told us that the changes had been extremely positive. Staff felt they had more opportunity to support and spend time with people.

Accidents and incidents were monitored and appropriate steps taken to protect people from the risk of harm. Staff completed accident and incident forms when any incidents occurred. The management team also completed a monthly log which reviewed any accidents and incidents as well as other risks to ensure that appropriate action had been taken to prevent a recurrence of the event. A new audit was being introduced which analysed these in more detail. We reviewed the care records of two people who we identified had experienced recent falls. We saw that appropriate assessments were in place and action had been taken to mitigate the risks as safely as possible.

Overall, we found there were sufficient staff to meet the needs of people, however this was affected at times by staff absences such as leave or sickness. We found in the dementia units staff were visible and had time to sit and chat with people. However, whilst some people were satisfied, some people living in the nursing unit indicated there were times they were kept waiting for support. During the inspection we saw that staff were busy and on occasion call bells would ring for several minutes. Comments included, "They usually come in less than 10 minutes"; "At nights they come quickly but days no" and "He says it can be up to twenty minutes."

Staff told us that usually there were sufficient staff, but there were occasional issues when staff were absent, due to sickness at short notice. The registered manager showed us that a staffing tool was in place to determine the number of staff required to the dependency levels of people using the service. We reviewed the rotas and saw that staffing levels could sometimes vary. The registered manager explained there were often more staff on duty than the dependency levels indicated were required. Rotas showed that the numbers of staff had been maintained using agency workers. There had been a recent occasion where there had not been the expected number of staff on a weekend shift due to sickness and staff told us this had impacted on the provision of drinks in the afternoon on one of the units. The registered manager was concerned about this and advised us that the on-call service had not been made aware of this issue, otherwise alternative arrangements would have been made. He also advised that the expectation is for the whole staff team to support each other throughout the home. The registered manager confirmed that he would ensure that all staff understood the systems for managing staff absences, especially at short notice.

We reviewed three staff files which showed that all necessary checks had been carried out before each member of staff began to work within the home, including a full employment history check and Disclosure and Barring Service (DBS) check. The DBS is a national agency that checks if a person has any criminal convictions. Through this recruitment process, the registered manager was able to check that staff were suitable and qualified for the role they were being appointed to and not putting people they care for at risk. We saw that where agency staff were used information about their training and necessary checks were provided by the agency. However, there was no record of any initial orientation or induction to the home. The registered manger told us he had devised a checklist, which was under review by the regional manager.

We found that medicines were managed safely. During the inspection we observed part of the medication round. Medicines were given by staff who were trained and their competency checked. The home used an electronic recording system and staff told us this helped reduce the potential for errors. We saw that following a previous incident where medication had not been given as prescribed due to an administration

error, this had been addressed with the staff and systems were in place to prevent this in future. Medicines were stored safely in line with requirements. Room and fridge temperatures were recorded daily. Medicines were labelled with directions for use, however we found that the date of opening had not always been recorded. This meant that staff may not always realise when the medicines were no longer effective. We raised this with the registered manager.

One person was supported to administer their own treatment and appropriate risk assessments were in place. We asked about 'as required' medicines and the procedures to ensure that people got these medicines at the time they needed them. We saw that there were protocols in place for some of these medicines. We asked about covert medication (Medication which is hidden in people's food and drink). Some people had their medication administered by this approach and we saw that appropriate procedures had been followed, taking account of the Mental Capacity Act (2005).

We saw from records that the provider had arrangements in place for the on-going maintenance of the building. We spoke with the maintenance team who demonstrated that routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. People had personal evacuation plans (PEEPs) in place in case of any emergencies and we saw that regular fire drills had been undertaken. There was a business continuity plan in place, with contingency plans for any unforeseen emergencies.

All areas of the service were clean and tidy and infection control procedures were followed to keep people safe. We noted in the communal areas of the dementia units that fridges and cooking equipment such as kettles and toasters were accessible to people. The registered manager told us the equipment was kept securely after breakfast when staff were not present. He agreed to ensure that a risk assessment was undertaken in case items kept in the fridge could pose any risk to people and arranged for locks to be installed straight away. Staff were provided with personal protective equipment (PPE) gloves and aprons. The home was equipped throughout with hand washing facilities.

Good

Is the service effective?

Our findings

People living in the home and their relatives offered positive comments about the care and support provided. They told us, "They're great; they're never bad tempered, even if patients are having a go at them they're calm and they calm them down". "I love all the staff; I've not met anyone, top or bottom, who I don't like. I don't think I could have got anywhere better; the care is second to none" and "They do a good job running about these girls, especially at mealtimes."

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. People can only be deprived of their liberty to 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

DoLS applications had been submitted appropriately to the supervisory body (local authority). There was a DoLS log in place to alert the management team to when renewal applications were due to ensure authorisations were kept up to date.

Staff spoken with were knowledgeable about the MCA and understood it's principles. We saw that staff sought consent from people before providing support. One staff member told us, "Some people have dementia, but are still able to choose." People signed their care plans to consent to their care, however where they lacked capacity, staff carried out capacity assessments and these were decision specific. For example, one person's capacity to decide about the use of bed rails had been assessed. Where people lacked capacity to make decisions, best interest decisions were then being made and recorded in consultation with appropriate people.

Staff were trained to carry out their duties as required. There was a training co-ordinator based at Bentley Manor, who we spoke with. Training was provided both face to face and electronically. This was monitored and a matrix was in place which identified when training was due. We saw that staff were 89% complaint with training which the provider considered mandatory, this included dementia awareness, safeguarding, fire safety, manual handling, first aid, Mental Capacity Act (MCA) 2005 and medicines management. The training co-ordinator offered a weekly support group for staff.

Staff told us they were supported with their development and were offered extra training as necessary. For example, dementia friends, wound management and catheter care. The management team had recently identified some training needs and the clinical lead planned to undertake specific sessions. New staff to the service undertook an induction and were also required to complete the Care certificate. The care certificate is a national set of standards that care staff are expected to meet. This helped ensure that staff had the knowledge and skills necessary to carry out their role effectively.

Records showed that most staff had received a supervision with a senior member of staff. Staff told us they received this support but the frequency was variable. We saw there were some gaps on the supervision matrix which suggested that some staff had not received supervision. However, the registered manager explained how these staff were undergoing an induction and had separate meetings, not recorded on the matrix. The management team confirmed there would be more of a focus to ensure all staff received six supervision sessions per year, as required by the provider's policy.

People's care records demonstrated that their physical and mental needs were assessed on admission to the home and reviewed on a regular basis. Care records contained information which considered the advice and guidance of other health professionals when planning outcomes. For example, guidance from speech and language therapists (SALT) was used in developing eating and drinking care plans for people who had difficulty swallowing

People were supported to meet their nutritional needs. Overall people told us they were happy with the food on offer, however a few comments suggested that the food was sometimes cold and people would appreciate more fruit and vegetable choices. Comments included, "The food is generally pretty good"; "Mostly hot, but not always" and "The only vegetables we get really are peas and carrots. A lot of people don't like veg but I do, I like proper green vegetables"

People's nutrition and hydration was monitored to ensure their nutritional needs were being met. We saw records of people's weights being regularly updated. People were weighed on a regular basis and any significant changes were referred to the GP for advice and support. A relative told us, "It's been wonderful, they pick up when he's not eaten, he has a cooked meal every day, they were bothered that he was losing weight." Where a person wished to lose weight, we saw that the chef was aware and prepared a suitable meal. The registered manager kept a monthly overview of people's weights to provide oversight and ensure that appropriate action had been taken if there were any concerns.

We observed the lunchtime meals in two of the units. The food was well presented and looked appetising. People spoken with told us they were enjoying the food. We saw that people were given a choice, staff were aware of people's likes and dislikes and supported people where necessary. A member of staff was seated with people eating lunch and we were advised how the social interaction encouraged people to eat. We observed drinks and snacks being offered to people between meals.

Care plans contained information relating to people's health needs. We found detailed Information about people's health needs such as catheter care or specialist feeding devices. Charts we in place to record the care that people had received, including fluid intake and positional turns, which had in the main been completed as required. We noted that checks we not in place to ensure that air mattress settings were always set correctly, in case they were accidently altered. We discussed this with the registered manager, who agreed to put a system in place.

Records showed a range of health professionals had been involved in people's care. This included hospital staff, consultants, GPs, speech and language therapists and dieticians. People were also supported to attend hospital appointments. The registered manager had developed several clinical pathways because of learning from a recent incident at the service. These provided a guide and detailed essential steps to be taken in the care of people with specific clinical problems, such as weight loss or falls. Relatives told us that they were kept informed about any changes to people's health, they said. "They always ring me at home if (name) needs to see a doctor" and "If there are any updates on their health they contact me instantly".

People's bedrooms were comfortable and well decorated. They contained individualised items, such as

photographs, ornaments and some people had their own telephones. Two of the units supported people living with dementia and we found the environment had been adapted to meet their needs. For example, we saw tactile items on display, memorabilia, memory boxes, hand rails painted in a contrasting colour and toilet doors were painted in specific colours so they could be identified more easily. Most bedrooms displayed people's names and photographs to help people identify their rooms. There was an outside garden and a few lounges which people could use if they wanted to spend any private time with visitors.

Good

Is the service caring?

Our findings

People who lived at Bentley told us that overall, they felt well cared for. Comments included, "They know more about me than I know about myself";" "They're very kind and caring, they've always been very respectful"; "We have really kind and caring staff here" Relatives told us, "They know what he likes" and "It was a nice thing that the first day he was here I got a call from (name) in the evening to say, 'Your husband is settled in and is now fast asleep'."

We observed staff interactions with people and saw staff were kind and caring in their approach. Staff chatted with people in a friendly way, were patient and gave people time to respond. People appeared very comfortable in their surroundings and with the staff. We overheard staff transferring a person using a hoist. They were kind and patient with the person and explained exactly what they were doing.

Where possible people were involved in the planning and decisions around their care. Staff told us they supported each person with as much choice as possible, such as what time they wanted to go to bed and when they got up. One person told us they preferred to stay in bed and that staff respected this. Their wish to have an occasional drink of whisky was also respected.

Staff spoken with, including the registered and deputy managers were very knowledgeable about people's likes and preferences. The culture at the home was caring and supportive of people's individual needs. We saw that staff had built up positive relationships with people. One person came into the lounge and lay on the settee for a nap. They looked at ease doing this and staff told us this was what the person used to like to do when they lived at home and were aware of the importance of them still being able to do this. Another person had visitors and they were all seated outside enjoying a game of cards. A staff member said" You definitely get chance to know people, you know them more than your own family!".

Overall people told us that staff had time to respond to their needs and listen to any concerns. However, we received some comments especially on the nursing unit, that staff were very busy at times, which sometimes made it difficult to respond to people's needs in a timely way. This tended to be when there were unexpected staff absences. However, we saw staff spending time with people in the dementia units. One carer was playing dominoes with a person and another sat with a person looking through a book.

People spoken with told us they believed their privacy and dignity was respected by the staff. One person said, "He's (carer) one of the nicest guys you could ever meet. I've named him Mr Dignity". Dignity was promoted by the management team and we saw that 95% of staff had undertaken training in the subject. Certain staff members were dignity champions and there was a dignity tree in the reception area, with numerous comments that people had added to say what dignity meant to them.

Equality and Diversity was part of the provider's mandatory training requirements to ensure people were cared for without discrimination and in a way, that respected their differences. We saw that the service considered people's diverse needs. The registered manager told us further work was being undertaken to ensure that the service was as inclusive as possible. For example, a lesbian, gay, bisexual and

transgender(LGBT) carer support event had been held and the service had started to make links with Silver Rainbows, which is a social network for older LGBT people in Cheshire. The documentation used by the provider was being reviewed to ensure that the terminology used within it was inclusive of diverse needs. In a further example the registered manager explained how staff had noticed that one person whose first language was not English had at times found it difficult to engage with people. Therefore, they had used Google translator to translate some common phrases into the person's first language which improved communication.

Staff were aware of the need to maintain people's privacy and ensure that records were kept confidential. For example, we saw a white board used by staff providing an over view of people's needs, was kept covered so that visitors could not read it. The service had also implemented a new signing in book which made visitor's signatures more private.

Good

Is the service responsive?

Our findings

We asked people and their relative's if the care they received at Bentley Manor was responsive, they told us, "We please ourselves what we wear";"(Name) complained about the mattress being too hard and they have changed it four times." and" They discussed his care plan with me when he moved in."

Overall people received personalised care that was responsive to their needs. Staff were knowledgeable about people's individual preferences and told us they respected these. One member of staff commented, "One person likes to get up later, one person doesn't like a wash before breakfast, but we give people options every day." Staff were skilled at using distraction techniques for people living with dementia when they were a little distressed. We saw that people looked clean and well cared for, one person liked to wear jewellery and staff had supported them with this. Whilst we saw that some people had their nails polished we also observed that some people's nails looked in need of cleaning and we raised this with the registered manager.

People's care plans reflected their physical, mental, emotional and social needs. They included information about people's histories, likes, dislikes and preferences. Staff told us they had access to these care records and were also informed about changes to people's needs in daily handover meetings. The records reviewed indicated that people and relatives had been involved in their care planning and reviews where appropriate.

The service identified and met the communication needs of people with sensory loss. For example, one person was partially sighted and liked to walk around the home independently. Staff told us the person had been finding it difficult to identify their bedroom. Staff used information about the person's history and displayed a picture of a large clock next to their bedroom door. This meant they could identify their room without assistance from staff and promoted their independence

People told us that some activities and entertainment were available at the home. However, people's experience varied and comments included, "The activities co-ordinator does some craft down here and (name) goes upstairs sometimes for bingo."; "I've not seen any activities going on since I've been here," and "There is a brilliant lady that comes in to do it, but it's very random."

There were two full-time activities co-ordinators. One of the activities coordinators had been recently appointed and was undertaking an induction. People said that lately activities had reduced and not everyone was aware when activities were taking place. The activity schedule on display was three weeks out of date. People also told us that the church services had stopped and some people missed these. During the inspection we saw an exercise session taking place with an outside sports coach, which people were enjoying. People were also enjoying a game of dominoes and cards. There was bingo, quizzes and the occasional singer. The activities coordinator carried out some one- to -one activities with people in their bedrooms, such as card making. The provider had also introduced "The Daily Sparkle" which was a daily sheet providing articles to read and some quizzes.

The registered manager confirmed that due to staff changes and focus being on activities such as the summer fair and bake-off day, more recently there had been less planned activities. However, this was work in progress and they aimed to get back to the previous levels of activities, outings and entertainment as soon as possible.

Some meaningful activities were provided for people who were unable to communicate. Staff had been trained to provide Namaste Care. Namaste Care is a programme developed to meet the needs of people with advanced dementia for human contact, sensory stimulation and meaningful activity. One of the lounges had been developed into a Namaste room, where staff for example provided hand massages in a calm and soothing environment. The registered manager gave us examples where people had really benefitted from this approach.

People were supported to maintain relationships that mattered to them. Relatives were able to visit without restriction and told us how they were encouraged to be involved, for example visiting for Father's Day lunch. The staff explained how they had supported one person with arrangements to enable them to visit family members abroad, which had been a great success.

We saw that information was available to relatives and visitors in the reception area. The provider had installed a television screen which displayed notices and was updated regularly. Feedback from relatives indicated this made information more accessible. We saw guidance about people's sight and hearing documented in their care plans and information could be made available for people in larger formats if required. This meant the provider looked at ways to make sure people had access to the information they needed in a way they could understand it. This complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for providers of NHS and publicly funded care to ensure people with a disability or sensory loss can access and understand information they are given.

People's care records showed that they had been offered the opportunity to discuss their end of life wishes. Where people did not want to be resuscitated in the event of a decline in their health, a signed form completed by a health professional was displayed at the front of their care record. This helped ensure staff had access to important information. We saw that staff had undertaken specialist training such as bereavement support.

The provider had a complaints procedure which was on display in the reception area. Almost everyone spoken with said they were comfortable giving feedback and felt it would be listened to and acted on. However, the registered manager told us that a recent relative satisfaction survey had highlighted that some people were unclear how to raise a formal complaint. He advised that the complaints procedure was already on display but introduced a regular manager's drop-in surgery. The complaints procedure is given to people moving into the home and the registered manager had discussed the process at a relatives' meetings.

We saw that the registered manager kept a complaints folder which contained details of any complaints, along with action taken to investigate, respond and where appropriate apologies were provided. A monthly audit was also undertaken and we saw the registered manager had used these as opportunities to drive improvements. For example, following a small number of complaints in one of the units a staff meeting had been held to discuss these and consider further action.

Good

Is the service well-led?

Our findings

At our inspection on 23 May and 5 June 2017. we found that the provider had failed to have robust systems in place to recognise and address the breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took action by requiring the provider to send us an action plan setting out how they would address this issue. During this inspection we found improvements had been made and the provider was no longer in breach of this regulation.

We received positive feedback from people, relatives and staff about the management team. Comments included, "(Registered manager) he's very nice, I've raised quite a lot of issues with him which he has said he'll put right"; "The staff and everybody love (registered manager), I'm very fond of him, I felt happy with him from right when we first met him at home" and "(Registered manager) seems friendly and approachable and the assistant manager is very nice; they're both very amiable."

We saw that suitable management systems were in place. There continued to be a manager who was registered with The Care Quality Commission (CQC). The registered manager was available throughout the inspection and engaged positively with the inspection process. He was well supported by a deputy manager, regional manager and quality team. The management team continued to demonstrate good knowledge about all aspects of the service, including the needs of people living there and the staff team. During all contact with The Commission the management team have demonstrated an open and transparent approach and any areas for improvement or development. They were keen to learn from any incidents or issues and make the necessary improvements. They liaised closely with health and social care professionals to improve practice.

The registered manager had regular contact with people and their relatives, his office was based in the reception area and we saw that he had built effective relationships with people and visitors. Relatives told us they knew who the manager was, could raise any concerns and felt they would get a positive response. He had introduced a "manager's surgery" to give people the opportunity to raise any concerns on a regular basis.

Overall, we found that staff were motivated and positive about the management team. There were some concerns about difficulties which arose from staff absences. Those spoken with were clear about their own roles and responsibilities. They all told us there was a friendly atmosphere within the service and they felt part of a team. Staff felt well supported and knew who to go to with any concerns. They told us, "Morale is good"; "I love it, we work together as a team" and "The atmosphere is better, it's more organised and we all work together." The provider had invested in a counselling support service which was available to staff, to promote their wellbeing.

People's views on the quality of the service were sought. The registered manager involved people and their relatives in discussions about the running of the home and regular relatives' meetings were held, although we were advised that these were not well attended. A newsletter was also issued which included the dates of

any meetings.

The provider also worked in partnership with health colleagues to achieve a smooth transition when people needed to go into hospital. They were part of the red bag scheme, which meant that a dedicated red bag would be packed with standardised paperwork for the person, as well as medication and clothes for discharge. This aims to make the handover more smooth and effective between the care home, ambulance and hospital staff.

There were arrangements in place to regularly assess and monitor the quality of the service. The registered manager continued to complete Key Performance Indicators (KPIs). KPI's are objectives that the service measures to check how effective they are. A number of areas were reviewed on a monthly basis, including safeguarding, weight loss, pressure ulcers amongst others. They were reviewed by the regional manager to ensure that appropriate action had been taken where necessary.

Regular audits were also undertaken in a number of other areas including, the dining experience, falls prevention, medication, safeguarding, catering and the premises. The regional manager undertook a quality visit and we saw that any issues identified and follow up actions completed. The provider had implemented a service improvement plan which identified key areas for further focus.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. This is called a notification. We checked our records and found that the registered manager had made the appropriate notifications to CQC as required. The current CQC rating was displayed as legally required on the registered provider's web site and within the home.