Dryband One Limited

Bradley House Care Home

Inspection report

Bradley Road
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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

Bradley House Care Home is registered to provide residential care for up to 48 older people, some of whom may be living with dementia. All the accommodation is provided on the ground floor. The home is situated on the outskirts of the town of Grimsby. On the day of the inspection there were 30 people using the service.

The service had a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We undertook this unannounced inspection on the 26 and 27 September 2017. The last full inspection took place on 21 and 22 February 2017 and we found concerns in relation to: person centred care, medicines, consent to care and quality monitoring. The service was rated 'Requires Improvement.'

We received an action plan from the provider about how improvements were to be made. At this current inspection, we looked at the previous breaches of regulations and the action plan to check that improvements had been made and sustained over a period of time. We found significant improvements had been made in all areas, although there was one area that required further improvement.

The overall management and governance of the service had improved, although we found audits of medicines systems needed strengthening in some areas to ensure staff were consistently following best practice guidance. We received information after the inspection that more detailed checks and records were in place. The culture of the service was more open and inclusive.

The service was operating within the principles of the Mental Capacity Act 2005 (MCA). We found improvements in records when people were assessed as not having capacity to make their own decisions. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

Improvements had been made with the standard of recording in the care files. A new recording format had been introduced and care plans had been reviewed and updated to reflect the person's current care needs. We found risk assessments were completed, reviewed and updated when people's needs changed. Supplementary records to monitor areas such as food and fluid intake, repositioning support and personal care were completed in detail and up to date.

Staff knew how to protect people from the risk of harm and abuse and had completed risk assessments in order to minimise concerns. Equipment used in the service was maintained and any repairs were completed in a timely way. The service was clean and tidy.

People's health and nutritional needs were met. Records indicated people had access to health care

professionals and staff arranged for visits from GPs and district nurses when required. They also made referrals to specialist health care professionals such as speech and language therapists and dieticians when required.

Menus provided people with choice and alternatives; drinks and snacks were served in between meals. People had special diets catered for and staff were knowledgeable about these. They completed additional monitoring charts when people had any nutritional concerns.

People who could talk with us told us staff were kind and caring and relatives were pleased with the care delivered to their family member. During the day we observed staff were attentive to people and knocked on doors before entering bedrooms.

Staff were recruited safely and full employment checks carried out before new staff started work. There were sufficient staff on duty to meet people's needs during the day and at night. We saw staff had access to a range of training, supervision and support. Staff spoken with said both training and management support had improved since the last inspection. They felt confident supporting people and said they had the right skills to complete caring tasks. Staff also said that communication had improved and they felt able to express their views in meetings and on a day to day basis with the registered manager.

There was a range of activities for people to participate in; these included one to one sessions, group activities and trips to local facilities.

People told us they felt able to make a complaint in the knowledge that it would be addressed. They said the registered manager was approachable and available when they wanted to speak with them. There was also a trainee manager and team leaders on each shift who could manage day to day areas of concern.

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.

Although medication systems were better managed, further improvements were required to ensure staff consistently followed best practice guidance.

Staff knew how to protect people at risk of abuse and harm. They had completed safeguarding training and knew the actions to take if they witnessed abuse or suspected it had occurred.

There were sufficient staff on duty to meet the needs of people who used the service.

Is the service effective?

Good

The service was effective.

People were supported to make their own decisions as much as possible and when assessed as lacking capacity for this, the provider acted within current legislation and best practice guidelines.

People's nutritional needs were met and menus provided a varied and nutritious diet.

Staff had access to training, supervision and on-going support. This helped them to be confident when meeting people's needs.

Is the service caring?

Good

The service was caring.

People and their relatives were positive about the way in which care and support was provided.

Staff were kind and caring in their approach. Staff had developed positive relationships with the people they supported and were seen to respect their privacy and dignity.

People who used the service were encouraged to be as independent as possible, with support from staff.

Is the service responsive?

Good

The service was responsive.

Staff were very knowledgeable about people's individual needs and improvements had been made in the way people's needs were assessed and care was planned. Relatives told us they had been involved in the assessment and care plan process.

People had the opportunity to participate in activities within the service and in outings to local facilities.

The provider had a complaints policy and procedure which was displayed in the service. People felt able to raise complaints and concerns and staff knew how to manage them.

Is the service well-led?

Good

The service was well-led.

There was a new more comprehensive quality monitoring system in place and in most areas this has worked well and identified areas to improve. Following the inspection, further changes had been made to the medicine audits to support sustained improvements with all aspects of medicines management.

A new registered manager had been appointed since the last inspection. Everyone we spoke with, including people who used the service, relatives, staff and visitors, were complimentary about the registered manager's style and approachability. The culture of openness and support for staff had improved along with staff morale.

Feedback systems were in place to obtain people's views such as surveys and meetings.

Bradley House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered provider was 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 unannounced inspection took place on 26 and 27 September 2017 and was completed by an adult social care inspector who was accompanied on the first day by an expert by experience, who had experience of supporting older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day a pharmacy inspector also attended the inspection accompanied by a newly appointed adult social care inspector, who was shadowing them, observing the inspection of the medicines systems.

Before the inspection, the provider completed a Provider Information Return (PIR). This 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. The PIR was received in a timely way and was completed fully. We looked at notifications sent in to us by the provider, which gave us information about how incidents and accidents were managed. We also spoke with the local authority safeguarding team, and the contracts and commissioning team about their views of the service.

During the inspection we used the Short Observational Framework Tool for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who used the service. We observed staff interacting with people and the level of support provided to people throughout the day, including meal times.

We spoke with twelve people who used the service, five of their relatives, and two visiting health and social care professionals. We also spoke with the operations director, trainee manager and a selection of staff; these included three team leaders, the administrator, two care workers, the cook, laundry assistant, domestic and the maintenance person.

The care files for six people who used the service were looked at. We also looked at other important

documentation relating to people who used the service such as incident and accident records and medication administration records. We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the current legislation.

A selection of documentation relating to the management and running of the service was looked at. This included three staff recruitment files, training records, staff rotas, minutes of meetings with staff and people who used the service, complaints and quality assurance audits. We completed a tour of the building and checked the environment for cleanliness and safety.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of the service in February 2017, we had concerns regarding how medicines were managed. At this inspection, we found overall that satisfactory improvements had been made in the majority of the medicines systems. Some further improvements in relation to aspects of recording and temperature monitoring of storage areas was required.

At our previous inspection we identified issues with the management of controlled drugs [medicines that require extra checks and special storage arrangements]. We found that appropriate arrangements were now in place: they were stored and recorded appropriately, access to them was restricted and the keys held securely. However, staff did not regularly carry out balance checks of controlled drugs.

Medication administration records (MARs) contained photographs of service users and all records we checked clearly stated if the person had any allergies. On our previous inspection we identified administration records had not been fully completed. These were now completed to show the treatment people had received. We found that handwritten MARs were signed by two members of staff to confirm dosage instructions had been transcribed accurately. Instructions for medicines which should be given at specific times were written on the MAR.

We saw the use of patch charts for people who were prescribed a pain relief patch. This meant it was clear to staff where and when patches had been applied, and reduced the risk of harm from duplicate application. Body maps and topical MARs were now in use, these detailed where creams should be applied and provided clear records of administration. Some people with swallowing problems were prescribed fluid thickeners; staff recorded when they had been used and information was available about how and when to use them for individual people.

We checked the quantities of medicines supplied outside of the monitored dosage system for ten people and found the stock balances to be incorrect for two of them. This meant that we were unable to determine if medicines had been given when they were signed for by staff. Not keeping accurate balances of medicines increases the risk of not having enough medicines in stock to meet the needs of service users.

We also found guidance for 'as required' (PRN) medicines was not available in four records we checked, where the GP had recently changed the prescription. Some medicines were prescribed with a variable dose i.e. one or two tablets to be given. We saw the quantity given was not always recorded, meaning records did not accurately reflect the treatment people had received.

Room temperatures where medicines were stored were recorded daily; however we found temperatures had been recorded above the recommended limit for storing medicines on ten days in September 2017. Staff had not taken any action in response to this. We checked medicines which required cold storage and found records were not always completed in accordance with national guidance because only the current temperature had been recorded. It is recommended that the minimum and maximum temperatures are also monitored to ensure safe storage.

We recommend that the provider further review aspects of their medication systems to ensure they meet best practice guidance.

Staff had received training in how to safeguard people from the risk of abuse or harm. In discussions, they were clear about the different types of abuse, the signs that would alert them and what action to take if they suspected abuse had occurred. Staff understood the provider's whistleblowing procedures.

Accident reports were fully completed and detailed the nature of the incident and the actions taken. We saw that people's care plans had been updated with relevant information following an accident. For example, one person had fallen and measures were put into place to make their room safer. People had risk assessments completed for specific areas which included falls, moving and handling, nutrition, choking, skin integrity and for use of specific equipment such as bedrails. There were documents highlighting a safe system of working for staff when mobilising or transferring people with equipment such as walking frames, wheelchairs, stand aids or hoists. Accidents were recorded and analysed to look for patterns; people were referred to health professionals for advice when they experienced repeated falls.

We found staff were recruited safely and full employment checks were carried out prior to new staff starting work in the service. These included an application form to assess gaps in employment history, obtaining references, a disclosure and barring service (DBS) check, which would highlight any criminal record and an interview. These all helped the provider to make safer recruitment decisions.

Our observations and people's comments, indicated there was enough staff on duty to meet people's needs and keep them safe. The registered manager told us that following the last inspection they had reviewed their admissions procedures. They had taken the decision not to accept the high numbers of short term and respite placements until the improvements to the service had been made and sustained. They considered this had reduced the pressures on the service delivery. The registered manager monitored people's dependency levels and reviewed the staffing levels on a regular basis, checks on records including staff rotas confirmed this.

We saw staff were available in communal areas and worked well together ensuring there was a staff presence and that people's requests for assistance were dealt with promptly. Staff we spoke with said there were enough staff and felt there had been improvements in the way staff worked together as a team. One member of staff told us, "It's a lot better now, staffing levels are stable and staff sickness has improved. They do put more staff on if we need them."

People who used the service told us they felt safe at the service and staff treated them well. Comments included, "Of course I feel safe. They look after us and we're all together", "There are always staff around and about checking we are okay" and "I like it here because I know nothing will happen to me. Even if I have a fall, there are people around."

Relatives told us, "There is enough staff to manage alright", "Staff always available and take time and sit with [Name of person]", "When I visit staff are always about, sometimes there's a bit of delay with toileting", "The home is a safe and friendly place" and "The home is always clean and free from odours." One relative raised concerns about staff monitoring arrangements following a fall their family member had experienced; they also mentioned concerns about the timings of their family member's medicines in the morning. We passed these concerns to the registered manager who contacted the relative and arranged for a meeting to discuss the issues.

We found bedrooms and communal areas were clean and tidy. There were no mal odours. The care staff

had been trained in infection control. They were able to demonstrate a good understanding of their role in relation to maintaining high standards of hygiene, and the prevention and control of infection. Equipment used in the service was well-maintained and serviced appropriately. There was a business continuity plan which detailed the actions to take in emergency situations such as utility failure or a flood.

Good

Is the service effective?

Our findings

At the last inspection of the service in February 2017, we had concerns about staff's understanding of the Mental Capacity Act 2005 and the use of restrictive interventions and consent. At this current inspection, we found improvements in these areas.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Records showed us individual capacity assessments were carried out and there were clear records about the decisions people were able to make for themselves. For example, that they could make day to day decisions about what to wear or about personal care, but they might need support with complex care, medical or financial decisions. Any physical restrictions such as the use of bed rails and sensor alarms had been considered. When people were deemed to lack capacity, any decisions made on their behalf included relevant people; the decisions were documented as made in their best interests.

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). We saw the registered provider was working within the principles of the MCA regarding DoLS for people who used the service. Applications had been made to the local authority to deprive people of their liberty in line with legal requirements. Records showed 19 applications had been made, one application had been granted and the remainder awaited assessment by the placing authority.

Staff had received training in MCA and DoLS and were aware of the criteria used to determine if a person's liberty was deprived. In discussions, staff were also clear about how they obtained consent from people prior to carrying out care and support tasks. They said, "We give explanations and make sure people understand the choices" and "We spend time with people and sit and talk with them about their care. If they are upset we listen and reassure them. We wouldn't push anyone to accept care, we respect their decisions."

We saw people had access to health care professionals for treatment and advice when required; staff recorded in people's care files when they were seen by a health professional. During the inspection we spoke with the team leader for the community nursing team. They told us the staff informed them of any concerns or changes in people's needs. They also told us there had been issues in recent months with staff availability during their visits and that this issue had not fully resolved. When we discussed this issue with the registered manager, they confirmed they had reviewed the arrangements for staff breaks, which were now more structured and staff could no longer have their breaks together. We advised they met with the community nurse lead to check if there were any outstanding concerns.

People told us they were able to access healthcare professionals when needed. One person said, "Yes, my GP visits me here when I'm not well." Relatives told us, "The doctor has always attended when necessary"

and "The health of my [family member] is monitored and managed very well. They notify me straight away if there are any concerns."

We found people's nutritional needs were met. The menus were seasonal and identified a varied range of meals. Drinks and snacks were served in-between meals and we saw a selection of milk shakes, biscuits, cakes, fresh fruit and crisps readily available. People's nutritional needs were assessed and a screening tool was used to identify any concerns. Staff monitored people's weight and referrals were made to health professionals when required. Catering staff received information about people's nutritional needs.

We saw staff were attentive, offered choices and encouragement, and discreetly cut up some people's food. The food looked nicely presented and the dining tables had table cloths, small vases of flowers and condiments. People could sit and eat their meal in the dining room, the lounge areas or in their bedroom. On the first day, we saw one person chose to have their meal in the conservatory and considered they would have benefitted from assistance with eating their meal. We mentioned this to the registered manager and on the second day of inspection, we observed a member of staff provided assistance and the person's mealtime experience was much more positive. In the dining room, there were ample staff to support people and the meal was a social and unhurried experience for them.

Comments from people who used the service were positive about the meals provided and included, "The food is brilliant, it couldn't be better. It's all home made every day. We get enough food and there's always a variety. We get curry and Chinese food" and "The meals are the right size and they taste good." Visitors said, "The diet is very good. I've had lunch on many occasions and the meals have always been fresh and healthy" and "Excellent meals. Good choice and the standard is superb."

We saw staff had access to training, supervision and support. The training records indicated the courses staff had undertaken and when updates were due. Staff told us training, supervision and support had improved since the last inspection and the change in manager. The administrator was responsible for organising the training and confirmed the priority since the last inspection had been to access more training for staff in: dementia, MCA, dignity, person centred care planning and medicines. They had successfully achieved this. The registered manager explained how they had experienced difficulties in arranging a course in 'stoma care' and was continuing to look into this. We also saw competency assessments were completed on areas such as, moving and handling, hand hygiene and medicines administration. Senior staff had completed reflective discussions when any errors in medication had taken place to help prevent reoccurrence.

Records showed 73% of staff had gained a national vocational qualification in care. Staff received regular supervision with their line manager where they had the opportunity to discuss their performance, training needs and wellbeing. Staff told us they felt well supported under the supervision of the registered manager and deputy manager. Annual appraisals had been completed for 12 staff in 2016 and the registered manager confirmed the appraisal programme had been reviewed and all staff appraisals would be completed by December 2017.

People who used the service told us staff knew how to look after them. Their visitors said, "Yes they move [family member] very carefully and "Overall yes, but some staff don't know how to replace the batteries in [family member's] hearing aid" and "We have seen them using the hoist and they are confident in using it."

The premises had been adapted to support the needs of people who lived there. There was appropriate equipment such as a call system, hand rails, moving and handling items, profile beds, specialist mattresses and cushions and sensor mats. There was some use of contrasting paint colours, photographs on doors and pictorial signage to provide orientation for people living with dementia.

Good

Is the service caring?

Our findings

People told us they felt well cared for and that staff were caring. Comments included, "The staff are good, and they take good care of us. If there is anything we need just tell the staff and they'll get it", "Most of the staff are caring and talk to you", "All the staff listen to me I get on with them very well", "I think the staff are very caring", "They help you if you need anything or they'll get you anything you need, "I think they are all very friendly" and "They are understanding."

Relatives said, "Staff are lovely. Especially the younger members of staff who despite their tender age are great with [family member]", "The staff are very kind, caring and compassionate", "Staff always welcome us with a smile" and "[Name of person] says the staff are caring and always available, they sit and chat of an evening." One relative told us how caring and friendly the staff were and how exceptionally caring one member of staff was towards their family member. They described the positive rapport the member of staff had developed with their family member and how happy and content this had made them.

We found people were cared for by a stable staff team who knew them well, which gave them continuity in their care delivery. Staff were able to describe the ways in which they got to know people, such as talking to them or their relatives and reading their care files, which included information about people's preferences, their likes, dislikes and life history.

The provider had ensured that all staff had been trained in equality and diversity. Staff were aware of the individual wishes of each person, relating to how they expressed their culture, faith and sexuality. We found the assessment record did not cover all these values; the documentation was amended during the inspection. One person told us how they had raised concerns some months previously about the gender of carer support, as they preferred to receive care from female staff. We saw the concerns had been recorded and addressed with staff at meetings and during handovers. The person's care plan detailed their preference. We observed people were supported to live a life that was reflective of their individual wishes and values.

We observed care interactions were completed in a kind and sensitive way. There was obvious affection between residents and staff. We saw one person stroking a carer's face when they were chatting with them and another person gave a member of staff a hug when they met them in the corridor. We also observed staff and people joking together, and an element of fun was evident. We saw a member of staff communicating with a person that was calling out; they reassured the person and sat with them until they felt calm and relaxed. Staff gave explanations to people before carrying out tasks, spoke to them in a patient and friendly way and every member of staff knew people by their first name and knew their relatives.

Staff described to us how they preserved people's privacy and dignity by knocking on bedroom doors before entering, closing doors and curtains while providing personal care and speaking to people about things quietly, so they could not be overheard. People who used the service looked well-presented and cared for. We observed staff offering support sensitively and discreetly. People were assisted to maintain their appearance following meals to preserve their dignity. We heard a staff member asking a person, "Shall I help

you to change your blouse? You like to look nice." Staff also complimented people on their appearance, one person smiled and enjoyed being told, "I like your cream top, it looks lovely and really suits you."

The service had a dignity champion who told us they regularly completed observations of care support. In recent weeks they had focussed on ensuring staff provided appropriate support for people with needs around continence, so they continued to use the toilet facilities when they were able to do so. The member of staff told us, "I am really proud to work here and very happy with the standards of personal care provided to people."

People's wishes and preferences had been sought with regards to end of life arrangements. Where appropriate people had end of life care plans in place to help ensure people received dignified care at the end of their lives.

We found people who used the service were provided with sufficient information about the service. There were notice boards which included information about the menus, meetings, how to make a complaint, advocacy services, survey results, scheduled activities and the last inspection report. The registered manager confirmed one person was currently receiving support from an advocate who visited regularly. An advocate supports people to make decisions and speaks on their behalf.

We saw staff maintained confidentiality. They completed telephone calls and discussions about people's health care needs in private in the nurse's office or the registered manager's office. There were quiet areas to hold reviews of people's care needs or these could be held in their bedrooms. People's health and care files and medication administration records were held securely. Records were also held in computerised form and the registered manager confirmed the computers were password protected. The provider was also registered with the information commissioner's office, a requirement when computerised records were held. Staff records were also held securely.

Good

Is the service responsive?

Our findings

At the last inspection of the service in February 2017, we had concerns about how people's needs were assessed and how this had impacted on developing plans of care and managing risk. During this inspection, we found improvements in these areas although some care plans still required more detail to ensure they were sufficiently person centred and reflected people's individual needs.

We looked at six people's records. We found people's needs had been reviewed and assessed following our last inspection. The assessment records included relevant information, for example, how staff would need to support the person to maintain a safe environment, how the person communicated their needs, nutritional preferences and needs, mobility, elimination, sleep pattern, social needs, medicines, personal hygiene and dressing. There were also risk assessments to identify specific areas of concern. We found these had been completed accurately and they were linked to the care plans.

A new care recording system had been put in place and each person's care records had been rewritten onto the new format. The care records clearly outlined the care and support the person needed, along with information about how staff could minimise any identified risks. There was also information in the care records about each person's abilities, so staff knew the level of support needed and could therefore enable the person to maintain their independence. However, we noted that in some care plans the level of information about people's preferences for how they wished their care to be delivered was inconsistent. Some care plans seen contained a good level of personalised information and others less so. For example, one person's care plan detailed they liked to shower, but did not include how often or the time they preferred to have their shower. In discussions, the registered manager acknowledged some of the care plans still needed to contain more person centred information and that they were working with staff to make these improvements. All senior staff had received training on this topic and further training was scheduled.

The care file records showed that relatives had been involved in the assessment process and provided information about people's social history, family network and previous interests and hobbies. This information was used to complete the 'All About Me' record, which the activity coordinator was working with people and their families to complete. All the visitors we spoke with said they had seen, read or contributed to their relative's care plan.

We found staff were knowledgeable about people's needs and responsive when these changed. Staff were able to describe how they recognised when people's physical and mental health was deteriorating and when to contact the district nurse or GP. They were more aware of initiatives to prevent skin breakdown, urinary tract infections and escalation of people's anxious or distressed behaviour. Supplementary records had been used when closer monitoring was required for specific people, for example with positional changes and weights being recorded. Some of the fluid intake records we checked were not completed so thoroughly and this was passed on to the registered manager to address. Staff recorded the care they provided to people during the day and at night, they evaluated the care plans each month and there was evidence that sections of the care plans had been updated when people's needs had changed.

A visiting health care professional told us they considered the staff were managing people's risk of developing pressure damage better and were providing effective care for people who had previously developed pressure ulcers, with positive results.

The service employed an activities co-ordinator and people were encouraged to join in a range of social and leisure activities. Each person had their own profile, 'My life journey'; this included their best memory, working life, hobbies, favourite food and places they had visited. There was a range of activities people could participate in which included painting, manicures, baking, bingo, quizzes, games, crafts and dominoes. Visiting entertainers provided entertainment such as music, reminiscence, themed quizzes and a ladies choir. During the inspection we observed people participating in a Tai Chi session, ball games, parachute activity, dominoes, watching a film, sing a long session and four people visited a local dementia café. The activity coordinator explained how they usually provide group activities in the morning and provided one-to–one support in the afternoons, which included general chats, reading, watching and discussing TV or films. The records identified who had participated and whether they enjoyed the activity.

Where possible people were supported to access the community and continue with their hobbies and interests, one person regularly attended various groups arranged by their local church, such as a luncheon club and Tai Chi club. They told us how pleased they were when a carer accompanied them to their church for a special mass when the priest left. A monthly interdenominational church service of hymns and readings was held at the service. There were also seasonal activities and entertainment arranged such as a summer fete in August 2017.

People who used the service confirmed there were activities to take part in and staff were responsive to their needs. Comments included, "I join in all the group activities and also like to spend time in my room" and "There is always something to do [Name of activity coordinator] is very good and gets us doing all sorts." One person told us, "I was in another room round the corner but it was boring, so they moved me here. I like this better because I can watch the squirrels outside." Relative's comments included, "Yes, my [family member] goes out to a day centre once a week and joins in activities in the home" and "The activity programme is excellent."

People told us they felt able to complain and named specific members of staff they would speak with. Relatives said, "I can raise concerns if the need is there. I have established a good network of communication with the home and care staff", "I have had no cause to complain" and "Yes I have raised concerns when necessary and they have dealt with them." The provider had a complaints policy and procedure. This detailed timescales for acknowledgement, investigation and response to the complainant. It also provided information to people on how to escalate complaints and concerns to senior management and other agencies.

Records showed that when complaints were received the management had generally followed the provider's policy to ensure the issues were managed appropriately and resolved. We found the outcome of a complaint raised by one person's relatives had not been provided in writing to them, although they had received verbal feedback. They reported this to us during the inspection. The registered manager confirmed they had overlooked this and following the inspection arranged a meeting with the family to apologise for the discrepancy and to discuss the findings of the investigation and any current concerns. The registered manager confirmed they had revised the complaint audit records to ensure the completion of complaints processes would be checked and signed off.

Good

Is the service well-led?

Our findings

At the last inspection of the service in February 2017, we had concerns about how the service was managed and overall governance. Since the inspection, there has been a change in manager and people who used the service, their relatives and staff all reported an improvement in management.

The registered manager had been in post since February 2017 and registered with CQC since July 2017. They had many years of experience in managing care services. They were also the operations manager for the organisation and supported by a trainee manager and team leaders at the service. The deputy manager had been promoted to the position of trainee manager and a development plan was in place to support their increased knowledge and competence in managing the home on a day to day basis. We found their interest in the inspection process was limited and this was fed back to the registered manager.

People, staff, relatives and professionals told us that the registered manager and trainee manager were approachable and helpful. We observed them spending time out of the office, checking staff and people were okay.

All staff we spoke with confirmed they had a clearer understanding of their roles and responsibilities. They described a more open and transparent culture at the service, where they could make suggestions and felt listened to. They considered the service was better managed and there was a stronger team work ethic. Comments from the staff team included, "There is more stability with the staffing. It's been very stressful but the improvements with care plans and medicines have been really good. Communication and team work are much better, everyone is a lot happier now" and "Lots of things have improved; the handovers are thorough and the team leaders are on the floor more. Team work is a lot better, we work together now. The managers are supportive and issues are dealt with."

Relatives said, "Lovely home and lovely staff. [Family member] is very well looked after and we are kept well informed", "Standards have been maintained since it was refurnished. There seems to have been improvements in staffing levels and staff training", "We think the manager is always available" and "My [family member] is very happy here."

There were improved systems in place to monitor the quality and safety of the service. The registered manager had provided CQC with regular updates to the action plan since the last inspection, this showed how the improvement work was prioritised and completed. The registered manager had introduced new governance systems and carried out a number of monthly audits, which included checks of health and safety, the environment, infection control, care records, dignity, meals, activities, medicines, weights, pressure damage and accidents. We saw that where checks had picked up shortfalls, action had been taken to address these. This showed the audit system was generally more effective and the improvements were service led. More effective audits of accidents and incidents had resulted in a reduction in falls. The registered manager had identified there was a prevalence of falls in people's rooms, between the hours of 1pm and 3pm and the staff deployment during this time had been reviewed and altered. The improved staff monitoring has resulted in less accidents and incidents during these times.

We found the audit processes had driven satisfactory improvements overall to areas of concern identified at the last inspection, in relation to care records and MCA. We found the new medicines audit in place was limited in scope and required some further development to ensure all areas of the system were reviewed effectively to identify any shortfalls. Following the inspection we received confirmation that a new, more comprehensive medicines audit had been put in place.

Meetings were held for residents and relatives in order to gain their input and views of the quality of the service. Records showed these were well attended and topics discussed usually included activities, meals, information and issues. Recent concerns about items of missing laundry had been addressed through better labelling. People had requested more participation in daily living activities and changes to the tea time menu which had been addressed.

People who used the service, their relatives, staff and professionals were also involved in completing questionnaires about their experience of the service and any improvements they would like. We found the results of recent surveys completed by people who used the service in September 2017 were in the process of being reviewed. The seven returned so far were mostly very positive about the service, with only one negative comment from a person in relation to feeling rushed at times by the staff. The registered manager confirmed they would be following this up with staff.

Surveys completed by five visiting professionals in June 2017 scored positively with an overall score of 95%. Comments included improvements needed to staff support during their visits and handover meetings between shifts for staff. The action plan showed how this had been addressed, with professionals being consulted about staff support during their visit and further improvements made to the handover records. For example, handover records were exchanged between staff on each shift and contained satisfactory levels of information about people's needs and any changes in their care and support.

There were regular staff meetings and shift handovers to ensure staff had up to date information about issues affecting the service and people who lived there. We saw information was given and discussions held around topics such as CQC inspection findings, management of admissions, standard of recording, complaints and concerns raised, staff roles and responsibilities, staff breaks, meal times, communication and all aspects of care. Staff were able to participate in the meetings, express their views and make suggestions.

Statutory notifications had been sent to CQC in line with legal requirements. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.