The Cheshire Residential Homes Trust

Trepassey Residential Home

Inspection report

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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

This inspection took place on 3 and 4 May 2018 and was unannounced.

Trepassey 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.

During the inspection, there were 12 people living in the home. People had moved to the newly built extension the day before the inspection took place. The new extension provided 15 bedrooms over two floors and a lift was available between the floors. Due to the location, both floors led outside without the need for people to use stairs or the lift. The registered manager told us the older part of the home would now be fully refurbished.

At the last inspection in March 2017, the registered provider was found to be in breach of Regulations due to risks regarding water temperatures and ineffective audit systems. The provider completed an action plan to show what they would do and by when to improve the key questions of whether the service was safe and well-led, to at least good. We found that water temperatures were within safe ranges, however other concerns were identified and although the registered provider was no longer in breach of Regulation, we made a recommendation regarding this in the main body of the report. Systems in place to monitor the quality and safety of the service had improved.

A registered manager was in post and feedback regarding the management of the service was positive. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Not all risks had been assessed appropriately. For example, a fire risk assessment of the new building had not been completed prior to people moving in and risks posed by balconies had not been assessed prior to their use. After the inspection we received confirmation that the fire risk assessment had been completed and no major concerns had been identified. Records showed that there were a range of other internal and external checks that had been completed to help ensure the building and equipment remained safe.

Staff felt supported in their role and had completed a comprehensive induction when they started in post and had access to regular training. However, not all staff had received regular supervisions and annual appraisals had not been completed.

Most safe staff recruitment procedures were followed when recruiting staff. Relevant checks had been recorded and all but one staff member had provided a full employment history. The registered manager agreed to ensure the staff member provided this.

People we spoke with told us they felt safe living in Trepassey. Staff were knowledgeable about safeguarding processes and appropriate referrals had been made to the local authority for investigation. There were sufficient numbers of staff on duty to meet people's needs and help maintain their safety. Accidents and incidents had been recorded and reported appropriately. The registered manager maintained a log of all accidents and reviewed these every month to help identify and learn from potential themes or trends.

Medicines were ordered and administered safely. Staff had received training and had their competency assessed in this area. However, temperatures were not monitored in all areas where medicines were stored and the registered manager agreed to ensure thermometers were available in all areas. We also found that there were no protocols in place to guide staff when to administer PRN (as and when required) medicines to ensure that people received them consistently and when needed.

People at the home were supported by staff and other external health care professionals to maintain their health and wellbeing. Staff made appropriate referrals for advice and people told us they saw the doctor quickly if they were unwell.

Records showed that applications to deprive people of their liberty had been made appropriately. Two authorisations were in place and staff were aware of these. Staff had a good understanding of the Mental Capacity Act 2005 and we saw that consent was sought and recorded in line with this legislation.

People told us they had enough to eat and drink and we saw that drinks and snacks were readily available to people throughout the day. A choice of meals was always available. Risk regarding malnutrition had been assessed and measures had been put in place to reduce risk to people.

Staff were kind and caring and treated people with respect. We observed staff provide support in an unhurried and kind manner and people's dignity and privacy was protected. Interactions between staff and people living in the home were warm and familiar and it was clear that mutually respectful relationships had been developed.

Staff knew the people they were caring for, including their care needs and preferences. This enabled people to be supported by staff that knew them well and could provide care based on their individual needs and preferences. People told us they had choice regarding their care and how they spent their day. People and their relatives were involved in care planning and relatives told us they were aware of the plans.

People were supported in a way which promoted their independence. Equipment was also in use within the home when people needed them, to help maximise their independence.

There were no restrictions in visiting and relatives told us they were always made welcome. This helped people to maintain relationships made prior to moving into the home and prevent isolation.

Care plans were detailed and reflected people's current needs. They were reviewed regularly and written in a

person centred way. They included information on how people wanted to be supported, their preferences in relation to their care and what was important to them. Staff had completed 'Six Steps' training to enable them to provide effective care to people at the end of their life.

A range of activities were provided by staff both in the home and within the local community and people told us they enjoyed the activities.

A system was in place to manage complaints and we saw they had been investigated and responded to appropriately. Systems were in place to gather feedback from people, such as meetings and quality assurance surveys. It was clear that feedback received was acted upon. Relatives told us they were kept informed of any changes within the home.

Systems were in place to ensure the provider was kept informed and maintained an oversight of the service.

The registered manager had a good understanding of their responsibilities, including the need to submit statutory notifications about certain incidents. The registered manager had also ensured that improvements had been made to address issues that had been raised at the last inspection. Ratings from the last inspection were displayed as required.

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 always safe.

Not all risks to people had been assessed appropriately.

Most safe staff recruitment procedures were followed when recruiting staff.

Staff were knowledgeable about safeguarding processes and appropriate referrals had been made.

There were sufficient numbers of staff on duty to meet people's needs.

Medicines were administered safely but some improvements to medicines management could be made.

Is the service effective?

Good

The service was effective.

Staff felt well supported and regular training was available to staff.

Appropriate referrals were made to health professionals to maintain people's health and wellbeing.

Applications to deprive people of their liberty had been made appropriately.

Consent had been sought in line with the principles of the Mental Capacity Act 2005.

People's nutritional needs were assessed and met by staff.

Is the service caring?

Good

The service was caring.

Staff were kind and caring and treated people with respect. Staff provided support in an unhurried and kind manner and people's

dignity and privacy was protected.

Staff knew people they were caring for well, including their needs and preferences. People were supported in a way which promoted their independence.

People and their relatives were involved in care planning.

There were no restrictions in visiting and relatives told us they were always made welcome.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and reflected people's needs. They were reviewed regularly and written in a person centred way.

Staff had completed 'Six Steps' training to enable them to provide effective care to people at the end of their life.

A range of activities were provided by staff both in the home and within the local community.

A system was in place to manage complaints effectively.

Is the service well-led?

Good

The service was well-led.

New audits had been created and they identified areas for improvement.

Systems were in place to ensure the provider was kept informed and maintained an oversight of the service.

Systems were in place to gather feedback from people and actions were taken based on this feedback.

Ratings from the last inspection were on display.

The registered manager was aware of the responsibilities of their role.

Trepassey Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 3 and 4 May 2018 and was unannounced. The inspection team included an adult social care inspector 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 our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service to gather their views.

The provider had 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 any improvements they plan to make. We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the registered manager, seven people living in the home and six relatives who visited on the day. We spoke with a number of staff throughout the inspection, but spoke at length to four members of the staff team from various roles, including the chef and deputy manager.

We looked at the care files of three people receiving support from the service, three staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also

observed the delivery of care at various times during the inspection.

Requires Improvement

Our findings

At the last inspection in March 2017 the registered provider was found to be in breach of Regulations as we found that water temperatures were not always within safe limits and the safe domain was rated as requires improvement.

During this inspection we found that checks on water temperatures had been completed regularly and were within recommended temperature ranges. We found however, that not all risks had assessed appropriately. For example, the day before the inspection, people living in the home had moved into the new extension of the home. During the inspection we found that a fire risk assessment of the new building had not yet been completed. Providers are required to ensure a fire risk assessment has been completed in order to assess for potential hazards and ensure fire safety measures are in place. We raised this with the registered manager who told us the fire risk assessment was due to take place the following day. After the inspection we received confirmation that the fire risk assessment had been completed and no major concerns had been identified.

We also found that bedrooms within the new building had doors leading to private balconies. Those balconies on the first floor posed a risk of falls from height and we found there no risk assessments had been completed regarding their use. We raised this with the registered manager who informed us that they were not currently in use and would be risk assessed before keys were provided to people. However this was not correct and one person did have their door to the balcony open during the visit. We informed the registered manager who agreed to risk assess this straight away.

We recommend that the registered provider reviews its systems to ensure that risk is assessed and managed appropriately to ensure people's safety.

Records showed that there were a range of other internal checks that had been completed in areas such as fire alarms, emergency lighting, fire doors, window restrictors, nurse call bells, shower head cleaning and hoist checks. There were also external contracts in place to make regular checks on the gas, electricity, the passenger lift, water safety, lifting equipment and fire safety equipment.

The care files we looked at showed that staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, moving and handling, nutrition, mobility and skin integrity. These assessments were reviewed regularly and actions taken to minimise risk when any changes were identified. People who lived at the home also had a PEEP (personal emergency

evacuation plan) to ensure their safe evacuation in the event of a fire.

We looked at how staff were recruited and saw that most safe recruitment procedures were adhered to. We looked at three personnel files and evidence of application forms, photographic identification, references and Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. One person's application form did not contain a full employment history and the registered manager agreed to ensure the staff member provided this as soon as possible.

People we spoke with told us they felt safe living in Trepassey. Comments included, "Yes, it's so secure and staff are always around", "Yes, I know the people (residents) and I know the staff" and "Yes, I've been here [number] years and never had any problems." Relatives we spoke with also agreed that Trepassey was a safe place for their family members to live. Their comments included, "Yes, it's even safer now they are in the new building" and "Yes, they've got sensors everywhere. [Relative] is much safer than at home."

Staff were aware of adult safeguarding, what constitutes abuse and how to report any concerns. All staff we spoke with were knowledgeable about safeguarding processes and most had completed training recently. The registered manager had provided staff with a pocket size reference book for them to refer to when necessary. A safeguarding policy was in place to help guide staff and contact details for the local safeguarding teams were available within the home. We found that appropriate referrals had been made to the local authority and the registered manager maintained a log of all referrals made. The provider also had a whistleblowing policy in place which encouraged staff to raise any concerns without fear of repercussions.

An equal opportunities policy was also available within the service. This helped to raise staff awareness and ensure that people were not discriminated against regardless of their age, sex, disability, gender reassignment, marital status, race, religion or belief or pregnancy, as required under the Equality Act 2010. The registered manager told us there was nobody living in the home at the time of the inspection that required personalised support in relation to any of the protected characteristics.

There were systems in place for managing medicines in the home. A medicine policy was available to guide staff and records showed that all staff responsible for administering medicines had completed training and had their competency assessed to ensure they could handle medicines safely. MAR charts we viewed had been fully completed and accurately reflected medicines that had been administered. The stock balance of medicines we checked were accurate, including controlled medicines. Controlled medicines are prescription medicines that have extra controls in place under the Misuse of Drugs Act and associated legislation.

Most medicines were stored within a locked clinic room. The temperature of the rooms and the medicine fridge were monitored and recorded daily and the temperatures were within the recommended ranges. We found however, that medicines prescribed as and when required (PRN) were stored in locked safes in people's rooms. There were no temperature checks made on these medicines. If medicines are not stored at the correct temperature, it can affect how they work.

We also found that there were no protocols in place to guide staff when to administer PRN medicines to ensure that people received them consistently and when needed. For example, one person's care plan reflected that they required a PRN medicine to support them when they became agitated. However, there was no guidance as to what behaviours the person may display when they were agitated or at what point staff were to administer the medicine. This meant there was a risk the person may not receive the medicine

when they required it. We raised this with the registered manager who told us they would ensure PRN protocols were available for staff to follow. When medicines were administered covertly (hidden in food or drinks), we found that the appropriate checks and agreements were in place to ensure they were administered safely and legally.

We looked at how the home was staffed. On the first day of inspection there were three care staff, a senior carer, the deputy manager and the registered manager supporting the 12 people who lived in the home. Additional to this was the kitchen, maintenance, administration and domestic staff. The registered manager explained that although they had stopped admitting people to the home in preparation for moving to moving to the new building, they had not reduced staffing levels. Now that they had moved across to the new building, they would begin admitting new people to the home.

There were no concerns raised with us regarding staffing levels and our observations showed us that staff were available to assist people in a timely way. People living in the home told us staff were always available to help them and their call bells were answered quickly. One person told us, "I think there are enough staff and they look after me quite adequately" and another person said, "Yes, [there are enough staff] but it's difficult to say with the new building." The registered manager told us all bedrooms contained sensors which could be used if required, to alert staff when people at risk of falls were mobilising, especially during the night. This meant that staff could respond in a timely way.

We found that records relating to people's care and treatment were stored securely, but accessible to all staff to ensure they had access to relevant information to enable them to support people safely.

We looked around the home and found that it was clean and well maintained. Records showed that staff had completed infection control training and staff used personal protective equipment such as gloves and aprons appropriately throughout the inspection to help prevent the spread of infection. Regular infection control and hand hygiene audits had been completed to help identify any areas that could be improved. People living in the home and their relatives all told us that the home was always kept clean and tidy.

We looked at accident and incident reporting within the home and found that they were recorded and reported appropriately. The registered manager maintained a log of all accidents and reviewed these every month to help identify and potential themes or trends. The reviews looked at how, when and where the accident happened, the type of injury and any actions taken following the accident in an attempt to learn from this and prevent further incidents. Staff were aware of the need to report and record any incidents and accidents.

Good

Our findings

When staff started in post they completed a comprehensive induction that was in line with the requirements of the care certificate. The care certificate is an identified set of standards that care workers have to achieve and be assessed as competent. Staff told us they felt well supported and could speak to the registered manager or deputy manager at any time if they had any concerns. However, records showed that not all staff had received a formal supervision in 2018 and no annual appraisals had been completed. The registered manager told us they had allocated senior staff to complete supervisions and they would commence appraisals.

Records showed that staff had completed regular training in areas the registered provider considered mandatory, such as fire safety, infection control, safeguarding, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, health and safety and dementia. Other person specific training had also been completed, such as diabetes awareness, epilepsy, dysphagia, end of life care, pressure area care and challenging behaviour.

People living in the home told us staff were knowledgeable and felt they had sufficient training to be able to meet their needs. One person told us, "I am not sure what training they get but they look after me really well. I have no complaints about them." Another person said, "Yes, staff are always having to do exams for NVQ's etc. They are spot on."

Care files we viewed contained plans which assessed people's physical and mental health, as well as their social needs. This showed that people's needs were assessed holistically. We also saw that people's needs had been assessed prior to them moving into the home to ensure that staff were aware of, and could meet their needs from the day they moved in.

Transfer forms were in place to ensure that if a person transferred between services, such as being admitted to hospital, all relevant information was provided to those staff to ensure the person's needs were known and could be met.

People at the home were also supported by other external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the falls prevention team, mental health team, optician, dietician and social workers. A GP from the local practice visited the home each Friday to review people and discuss any concerns the staff had regarding people's health and wellbeing. People we spoke with told us

they saw the doctor quickly if they were unwell and a relative told us that staff, "Always get professional help if needed."

The registered manager also told us they used the tele-triage computer system which provides staff with access to healthcare advice if they are concerned about a person's health. The registered manager told us this had reduced the amount of people who had been admitted to hospital following falls.

The registered manager told us that they received the CQC monthly newsletter and shared any relevant information with staff to help ensure they were kept up to date. They also shared any changes in best practice with staff.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). 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 make 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).

The registered manager told us they had made seven applications to deprive people of their liberty and two had been authorised. Staff we spoke with were aware of who had an authorisation in place. A log was maintained which detailed all applications made, date of expiry and date renewal forms had been submitted. We found that DoLS applications had been made appropriately.

Staff we spoke had a good understanding of the MCA told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we saw staff knocking on people's doors before entering and we heard staff asking for consent before providing care. When people were unable to provide valid consent due to cognitive impairment, a mental capacity assessment had been completed to establish whether they were able to make an informed specific decision. If it showed they lacked capacity then a best interest decision was recorded that involved the views of relevant people as required. We found that consent was gained in line with the principles of the MCA.

People told us they had enough to eat and drink and we saw that drinks and snacks were readily available to people throughout the day. We joined people for lunch and saw that tables were set with tablecloths, napkins and condiments. Due to the recent move into the new building, a temporary kitchen had been created outside and as the finishing touches were being completed, lunch was bought in from a local chip shop. Despite this there was still a choice of meals available, such as chips, fish, sausage, chicken, curry, gravy and rice. This was served with bread and butter and a selection of desserts were also available. We saw that staff sat with people during lunch, offered help when required and chatted to people at other times.

People told us that they always had a choice and that if they did not like what was on the menu, they could always request an alternative. Feedback regarding the food available was mainly positive, although some people did tell us they felt the choice of sandwiches at tea time could be improved. Relatives we spoke with also told us that food was of a good standard. Their comments included, "There is a choice and staff cut food up and help [relative]", "It's lovely, [relative] doesn't eat much but they've had a nutritionist in who ordered special drinks" and "It's very good. If there was something [relative] doesn't like, they will cook something else."

We spoke with the chef who was knowledgeable regarding people's dietary needs and had access to information on a range of cultural and religious dietary requirements should they be required. They told us they were aware of feedback regarding sandwiches and had made different one's recently, but was due to sit down with people who lived in the home and discuss a new menu with them.

Records showed that if staff were concerned regarding weight loss, they made referrals to the dietician and we saw that this advice was incorporated within care plans. Staff also maintained diet and fluid charts if there was a concern about a person's intake. This showed that people's dietary needs were monitored and met.

The new building had been designed to meet the needs of people living in the home. As well as automatic lighting and temperature controlled water, the home had wide spacious corridors with handrails to support people with mobility issues. The new garden contained a safe, heated and lit pathway and seating areas to enable people to spend time outdoors if they chose to.

Good

Our findings

People who lived in Trepassey told us staff were kind and caring and treated them with respect. Their comments included, "[Staff] are just very good to me; no one is horrible and they know what I like", "They are kind without a doubt", "I don't need much but if I do they are there straight away" and "Yes, they are very kind and we have a laugh and joke and they are lovely." Relatives we spoke with agreed and told us, "Staff have a kind approach and work as a team. [Relative] is very happy and staff know [relatives] likes and dislikes" and "Yes, staff seem very dedicated." Other relatives described the care provided as, "Outstanding" and "Marvellous."

During the inspection we observed staff provide support in an unhurried and kind manner. Interactions between staff and people living in the home were warm and familiar and it was clear that mutually respectful relationships had been developed. We heard staff spoke to people in a way they could understand.

People's dignity and privacy was respected by staff during the inspection. For example, staff knocked on people's doors and waited for a response before entering. Staff asked for consent before providing care, explained and offered reassurances and personal care was always provided in private, with doors closed. Staff responded in a timely and compassionate way when people requested support and they were not kept waiting. As there were adequate numbers of staff on duty, we saw that they had time to sit and chat with people and listen to any questions they had. This was particularly important due to the recent change of environment. We heard people ask staff lots of questions about the new building and staff were patient in their manner. The registered provider's statement of purpose reflected that one of the aims of the service was to respect privacy and dignity at all times.

It was clear that staff providing support knew the people they were caring for, including their care needs and preferences. For example, staff were able to tell us about people's individual needs and to describe these fully. Staff told us they were always kept informed of any change in people's care needs. Care plans we viewed reflected people's preferences in areas such as meals and drinks, times they liked to get up and go to bed, gender of staff they prefer to provide their personal care and activities they liked to take part in. This enabled people to be supported by staff that knew them well and could provide care based on their individual needs and preferences.

Care files we viewed showed that people were supported in a way which promoted their independence. For example, one person's plan informed staff the person could brush their own teeth if they put the paste on

the brush for them and another person's personal care plan reflected they required support with personal care, but that staff were to allow them to do what they could for themselves before offering support.

Equipment was also in use within the home when people needed them, to help maximise their independence. This included the use of walking frames, wheelchairs, bath hoists and electric beds. One person used a beaker with a lid and handle to drink from to enable them to continue to drink independently. This helped to ensure that people's independence was maintained.

We looked at the service user guide and statement of purpose which were available within the home. These contained information about the service and what could be expected when a person moved in. It also included information regarding the complaints and safeguarding processes. This showed that people were given information and explanations regarding the service.

People told us they had choice regarding their care and how they spent their day. One person told us, "Yes, I get up for breakfast and get dressed myself. I decide what to wear." Another person said, "I get up as late as possible and have my breakfast in my room." This showed that people had choice and that when able, were involved in making their own decisions.

It was clear from the care files we viewed that people and their relatives were involved in care planning. This was evident through signed consent forms, recorded best interest decisions that families had been involved with and from the detail and personalised information available within people's files. Relatives we spoke with told us they were aware of care plans. One relative told us, "I've seen the care plan and signed it" and another relative said, "I know about [care plans] but my [family member] does all of that."

We observed relatives visiting throughout both days of the inspection. The registered manager told us there were no restrictions in visiting and relatives we spoke with agreed. This helped people to maintain relationships made prior to moving into the home and prevent isolation. The registered manager told us they were aware how to access advocacy services if a person did not have friends or family to support them, but that nobody living in the home required these services at the time of the inspection. An advocate is a person that helps an individual to express their views and wishes, and help them stand up for their rights.

Good

Our findings

Care files we viewed contained care plans in areas such as medicines, communication, mobility, nutrition, mental health, personal care, continence, skin integrity, social needs and consent. The plans were detailed, reflected people's current needs and were written in a person centred way as they reflected how people wanted their support to be provided. For example, one person's personal care plan reflected the time they preferred to bath and the products they liked to use. Another person's medicine plan reminded staff not to provide the person with chilled water with their medicines as they did not like it.

Care files also included a summary of each person's typical day. This provided information as to what a good day looked like for people, as well as a bad day and what was important to people. They also included a personal history, which informed staff of people's backgrounds, family members, previous jobs, hobbies, relationships and where they have lived. This helped to ensure that staff knew people they were supporting as individuals.

We found that planned care was evidenced as having been provided. For example, one person's nutritional plan reflected that they required their diet and fluid intake to be monitored due to recent weight loss. Daily diet and fluid intake charts had been completed comprehensively and the total amount drank each day had been calculated to ensure the person had received sufficient drinks.

Care plans had been reviewed regularly and had been updated whenever there had been changes in people's care needs. For instance, one person who had lost weight had been referred to the dietician for advice. Following the visit the dietician's advice had been added to the plan of care to ensure all staff had access to up to date information regarding people's needs. Staff told us they were always kept informed of any changes and could read the care plans at any time. They were also kept informed through daily verbal and written handovers.

Systems were in place to support people at the end of their lives. Staff had completed 'Six Steps' training to enable them to provide effective care to people at this time. This is a locally recognised training course that aims to provide staff with the tools and knowledge to plan and provide the best possible person centred care to people at the end of their lives.

Technology was used within the service to help ensure people's safety and wellbeing. For example, call bells were available in bedrooms and bathrooms to enable people to call for help when they needed it. Staff had pagers that alerted them when a call bell had been activated and enabled them to respond quickly. The new

building also had built in pressure pads, door sensors and bed sensors that could be switched on if people were at risk of falls. There was also automatic lighting that came on when people got out of bed and a water mist system that activated in the event of a fire. This helped to maintain people's safety within the home.

There was no activity coordinator employed at the time of the inspection and activities were provided by staff. Records within people's care files showed that they had participated in activities such as baking, a magic show, singing, bingo, films, reminiscence, chi gong and quizzes. People we spoke with told us they often went to activities in the local community, such as a tea dance. People also told us they had visited the cinema recently. On the first day of the inspection staff hosted a quiz which most people joined in with, as well as their relatives who were visiting at the time.

The deputy manager told us they had been focusing on making links within the local community. They had arranged for children from a local school to visit and do some gardening with people who lived in the home. The registered manager also told us that they were in the process of arranging a coffee morning to include members of the local community.

We looked at how complaints were managed within the service. A complaints policy was available and the registered manager maintained a log of any complaints received, along with the outcome of the complaint and confirmation that complainants were satisfied with the response received. People we spoke with told us they were able to raise any concerns they had with staff and knew that they would be listened to. We found that the system in place to manage complaints was effective.

Good

Our findings

At the last inspection in March 2017 the provider was found to be in breach of Regulations as systems in place to monitor the quality and safety of the service were not always effective.

During this inspection we looked to see if improvements had been made to the quality monitoring systems within the home and found that they had. The provider had made the improvements they told us they would make following the last inspection. The provider was no longer in breach of Regulation regarding their quality monitoring systems.

There was a registered manager in post and feedback regarding the management team was positive. People we spoke with all knew who the registered manager was and told us they could go to them with any concerns. The registered manager was described as, "Approachable", "Really supportive", "Friendly" and "Not overbearing." One person living in the home described the deputy manager as, "Marvellous" and told us, "He gets things done."

New audits had been created since the last inspection and checks were now recorded in areas such as accidents, the environment, infection control, dignity, kitchen, mattresses, dining experience, medicines, personnel files and care plans.The audits were effective and identified areas that could be improved and some included information as to what actions had been taken to address the issues highlighted. For example, a dining experience audit identified that not all staff were observed to wash their hands before or after serving meals. The action plan reflected that hand hygiene would be discussed at each handover that week to ensure all staff received an update. A medicine audit showed that there was an excess stock of creams in the home. Actions taken had been recorded and we saw during the inspection that there was no longer an excess stock of creams.

We found however, that it was not always clear whether actions had been taken to address all of the issues highlighted within the audits. For example, the care file audit we viewed showed that one person's personal history document was blank. There was no further information to indicate whether this had been done, but when we reviewed the care file, we saw that it had been updated. A dignity audit identified that not all staff were fully confident in identifying and reporting safeguarding issues. There was no action identified on the audit, but the registered manager told us they had addressed this with individual staff members through supervision and training. We saw records of the safeguarding scenarios that the registered manager had used during these training sessions.

The registered provider was kept informed and maintained an oversight of the service. A monthly committee meeting was held and records showed that areas such as complaints, safeguarding and staffing were discussed. Members of the committee also visited the home regularly and provided feedback to the registered manager at the end of their visit. Records showed that they spoke with people living in the home to gather their feedback, monitored the environment and joined people for lunch. Actions were recorded based on their findings and the registered manager signed these off once they had been addressed.

We asked people about the atmosphere of the home. People living in the home told us they were happy and enjoyed living there. Relatives told us, "It's lovely; we don't feel as if we are coming into an unsettling place", "Everyone seems content here. Wouldn't criticize it at all", "Nothing negative to say. If someone has to come into a care come it couldn't be better here. It's just fabulous" and "It's joyful. [Relative] enjoys the company of other residents, they are lovely. I am so happy that [relative] is here, [relative] is so happy".

Staff also told us that they were supported in their roles. They had access to a range of policies and procedures to help guide them and staff we spoke with were aware of the vision of the service. There was always a senior member of staff on call if staff required any further advice. Staff told us they all worked as a team and that they enjoyed their jobs. One staff member told us the registered manager was, "Never too busy for you, she really does make time for you."

Regular team meetings were held and staff were encouraged to share their opinions and their ideas were taken on board. We saw that the last staff meeting had been held in April 2018 and a range of areas had been discussed, such as activities, meals, confidentiality, building work and training. This helped staff to feel valued and included.

Relatives told us that they were kept informed of any changes within the service. For instance, they had received regular newsletters to update them on the progress of the new building whilst the work took place. Although they felt well informed and told us they could speak to staff about any issues they had at any time, we found that the last meeting for relatives and people living in the home had been held in January. One relative told us they hoped these would be more regular now the building work had been completed.

Feedback received from people was analysed and steps were taken to address any issues raised. For example, following quality assurance surveys completed by people living in the home in January 2018, changes were made regarding access to the home as not all people were happy with the arrangements that had been in place. This showed that systems were in place to gather feedback from people and listen to their views.

As well as making links in the local community, the registered manager had also developed links with external agencies such as the Local Authority to ensure high quality, joined up care is provided to people. Good relationships had been forged with GP's and they visited the home each week. The registered manager also attended local registered manager forums where guest speakers provided information on various areas of care and best practice.

The registered manager had a good understanding of their responsibilities, including the need to submit statutory notifications about certain incidents. They had notified the Care Quality Commission (CQC) of events and incidents that occurred in the home in accordance with our statutory requirements. This meant that CQC were able to monitor information and risks regarding the service. The registered manager had also ensured that improvements had been made to address issues that had been raised at the last inspection.

Ratings from the last inspection were displayed within the home as required as copies of the last report were

available for people to read. The provider's website also reflected the current rating of the service. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.