Bupa Care Homes (AKW) Limited

Ardenlea Grove Care Home

Inspection report

19-21 Lode Lane
Solihull
West Midlands
B91 2AB

Tel: 01217059222

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 19 April 2017 and was unannounced.

Ardenlea Grove nursing home provides nursing and residential care to a maximum of 60 people. On the day of our visit 50 people lived at the home. The home had three floors. The Emerald Unit (ground floor) provided care to people who lived with dementia. The Pearl Unit (first floor) which had provided temporary care to people discharged from hospital. The Ruby unit (first floor) provided care to people with nursing and palliative care needs; and the Sapphire unit (second floor) provided care to people with physical nursing needs.

The home had a registered manager. 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.

People felt safe living at Ardenlea Grove and thought staff were kind, considerate and caring. Staff told us they enjoyed working with people who lived at the home. They understood people's needs, wants and preferences, and treated people with dignity and respect.

There were enough staff on duty to keep people safe. The provider's recruitment practice reduced the risks of the home employing staff who were unsuitable to provide care. Staff understood how to safeguard people from harm.

People's risks were considered, managed and reviewed to keep people safe.

People thought staff had the experience and training to support them. Staff had received training to support them meet people's health and safety needs, but more specialised dementia training had still not been provided since our last visit.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were offered a choice of meals and drinks throughout the day. Specific dietary needs were catered for, and appropriate support given to people who needed extra help with their eating and drinking.

Individual and group activities were provided to people who lived at Ardenlea Grove. There had been improvements since our last visit, although the activity worker acknowledged further improvements were needed. Visitors were welcomed at the home, and there were no restrictions on the length of time visitors could stay.

Medicines were managed safely and people received their medicines at the expected time. People were referred to other health and social care professionals when necessary and in a timely way.

There were systems to monitor and improve the quality of the service provided. Regular checks and audits were undertaken to ensure people were kept safe.

People, relatives and staff thought the culture of management was open and transparent. The atmosphere in the home was happy and relaxed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff knew how to safeguard people from harm. There were enough staff to meet people's needs safely, and staff knew and minimised any identified risks related to people's care. Medicines were managed safely and staff recruitment processes reduced the risk of unsuitable staff being employed by the home.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff had received training to support them in their day to day work to keep people safe. However not all staff had received training to help them provide a specialist dementia care service. Staff were provided with on going support but did not receive planned one to one supervision meetings in their role. People enjoyed the meals provided and people's dietary needs were catered for. People received health and social care from other professionals when necessary or requested. The registered manager and staff understood the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People told us staff were caring and kind. We saw staff support people's privacy and dignity, and encouraged their independence where possible. Visitors were welcomed in the home.

Is the service responsive?

Good

The service was responsive.

Care provided to people reflected their individual needs and wants. Most people enjoyed the individual and group activities provided, although these did not always correspond to people's abilities. Complaints were investigated in line with the provider's policy and procedure, and where necessary, action had been

taken to improve the service.

Is the service well-led?

Good

The service was well-led

People, relatives and staff felt able to talk to the manager about their concerns. There was a relaxed atmosphere in the home. The manager and deputy manager provided staff with good leadership. They were supported by senior management of the organisation. A range of quality assurance audits were in place to monitor the health, safety and welfare of people who lived at the home.

Ardenlea Grove 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 19 April 2017 and was unannounced. The inspection was conducted by two inspectors 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.

Prior to our visit we gathered and reviewed information about the service. This included statutory notifications and the provider information return (PIR). A statutory notification is information about important events, which the provider is required to send to us by law. The PIR is a pre-inspection questionnaire completed by the provider which provides us a 'snap-shot' of the service.

During our visit, we spent time in the communal lounge and dining areas to see how staff engaged with people who lived at the home.

Most of the people who lived in the dementia unit were not able to tell us in detail about how they were cared for and supported because of their complex needs. We used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with 12 people and relatives, and seven staff. We spoke with the deputy manager, registered manager and regional manager.

We reviewed five people's care plans and daily records to see how care and treatment was planned and delivered. We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each person's needs. We checked medicine records, complaints, and the provider's own checks to ensure the service operated safely and effectively to provide quality care to people.

Good

Is the service safe?

Our findings

People told us they felt safe at Ardenlea Grove. One person told us, 'I am happy living here. I don't have to cook and clean because I had burnt the carpet in my own house and on a few occasions I had left the gas on and the door open, and in this case I feel safe." People who lived at the home seemed relaxed and comfortable in staff's company which indicated they felt safe with staff.

Our previous inspection found improvements were required to maintain people's safety. At the time of our last visit the provider employed agency nursing staff because they did not have enough permanent nurses available. This meant people were cared for by staff who did not know them well. There were also concerns expressed about the levels of staff at night time.

During this visit the registered manager informed us their use of agency staff had dropped significantly. They had fully recruited to the vacant posts, and agency staff were only used to help, if necessary, cover staff annual leave. The provider had also increased the number of staff who worked at night to support people's safety.

People and their relatives told us there was enough staff to meet their needs safely. The registered manager told us five beds were empty as a consequence of a contract with a commissioning authority recently ending. They were in the process of admitting people to the empty beds. Therefore staffing levels were slightly higher than they would usually be. They told us if they needed more staff once the home was full, then they would staff the home based on people's needs and not on a pre-determined number of staff.

During our visit we saw most call bells were answered in a timely way, and whilst staff were busy, they were seen having enough time to meet people's needs. One person previously told us they had to wait long times to be supported to move as they required the use of a hoist and two members of staff. This time they said, "This does not happen very often now, thank goodness." One person told us they occasionally had to wait a long time because of their specific mobility needs and we saw this was the case during our visit. The registered manager was informed of this and said they would look into improving staff responsiveness for this person.

Staff told us there were enough of them on duty to keep people safe. They said staffing numbers were okay unless a member of staff called in to say they were ill, and it was too late to cover the rota. However, the manager and deputy manager were supportive of staff if they needed additional help during the day. One member of staff said, "We all work as a team." Another said, "[The registered manager] and [deputy manager] will help out, they can be hands on when needs be."

People were safe and protected from the risks of abuse because staff understood their responsibilities and the actions they should take if they had any concerns about people's safety. The registered manager understood the actions required of them, and notified the local authority if they had concerns a person had been abused. They also notified the Care Quality Commission if a referral had been made to safeguard people.

Staff were aware of the importance of informing senior members of the organisation or external authorities if they felt the registered manager had not taken their safeguarding responsibilities seriously. The provider supported staff to 'blow the whistle' and had a whistle blowing policy called 'speak up' with posters relating to this in the staff areas with contact details.

Staff recruitment procedures ensured all relevant checks were carried out to protect people from potentially unsafe or unsuitable staff. We looked at the recruitment records of two staff, and spoke with staff about their recruitment experience. The registered manager obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. Staff confirmed they were not able to work alone until the recruitment checks had been completed. The provider also carried out their legal duties by checking staff had the right to work in the UK.

Medicines were managed safely, and people received their prescribed medicines at the right time. Medicines were stored in line with relevant guidelines. The treatment room was always locked and the keys were held by the nurse in charge. At our last visit, we saw a nurse leave a medicine trolley unlocked when they administered a medicine to a person in their room. During this visit, we saw people were kept safe as nurses ensured trolleys were locked when they were left unattended. The provider had systems to dispose of medicines safely.

Staff accurately recorded medicines administered to people. We saw the nurse did not record medicines as given until they saw the person had taken them. If a person had not received their medicine, the reason was given on the medicine record. We checked the records for stronger medicines and found the number on the record correlated with the stock of medicines available in the treatment room.

Where people were prescribed topical creams (a cream applied to the body) and transdermal patches (patches which deliver medicines into the body via the skin), body maps showed where either the cream or the patch had been applied. Patches were rotated on each application. This is good practice because skin can become irritated if the patch is applied in the same place.

Some people were prescribed medicines on an 'as required' basis. Where these were prescribed, medicine plans (protocols) gave staff information about the reasons for the prescription and how staff should administer them safely.

The registered manager informed us that nurses were assessed on a yearly basis to check they administered medicines safely. Weekly and monthly checks were also carried out to make sure medicines were recorded and administered correctly so that action could be taken if any errors were found.

People who live in care homes may be at risk of harming or injuring themselves in some way. For example, some people might be at risk of falling, and others might be at risk of harm if they had swallowing difficulties. We checked to see if the provider had assessed the risks related to each person, and put plans in place to reduce the risk of harm occurring. We found people's risks had been assessed, and the identified actions to minimise risks had been written in people's care plans. For example, one person was assessed as being at risk of falling. Staff were informed to be observant of them when they were walking around, and to suggest and encourage the use of a wheelchair for longer distances. We saw staff being observant of this person.

Other people, who could not move independently, were at risk of damaging their skin because of putting too much pressure on it, if for example, they were sat or lying down for long periods of time in the same

position. Their risks of skin damage were reduced because equipment such as pressure relieving cushions and mattresses had been put in place for them, and staff were responsible for re-positioning people over a specified time period to take the pressure off the skin. Airwave mattresses which helped reduce the risk of pressure damage to the skin were at the correct setting according to the person's weight.

The provider undertook monthly reviews of accidents, incidents and pressure sores. Where incidents had occurred, these had been investigated and action taken to reduce the risk of them happening again.

We checked fire safety measures at the home. Fire equipment was routinely checked to ensure it was in good working order and met legal requirements. We spoke with staff about fire drills. Not all staff had undertaken a fire drill and some did not know what to do in the event of a fire. We discussed this with the registered manager who told us they would make sure all staff had been trained to know what to do if there was a fire emergency. They confirmed to us after our inspection that this had been carried out.

Requires Improvement

Is the service effective?

Our findings

People who lived at Ardenlea Grove and their relatives, told us they felt staff were suitably trained to meet their needs or those of their family member. A relative told us they had experienced difficulty in positioning their relative safely on a bed and went on to say the way they saw staff undertake this task was 'excellent' and said they must have been trained to do this so well.

At our last inspection we found improvements were required as staff had not received more specialised training to meet people's specific care needs. In particular, staff had not received training to support people who lived in the home who had Parkinson's disease. During this visit we found staff had undertaken training considered mandatory to meet people's health and safety needs. This included training to move people (with equipment) safely, food hygiene and infection control. We found that whilst the manager had contacted the Parkinson's society about training, and information about on-line training was sent and cascaded to staff; the manager was not clear about whether staff had undertaken the training.

At our last inspection, staff had received basic training to help them understand how to support people who lived with dementia, but many had not received the BUPA specialised dementia care training, or, had only completed some of the modules because their work patterns and staff vacancies meant they could not complete the course. During this inspection, through discussion with staff, we found there continued to be staff who worked at the home in the dementia unit who had not received the more advanced training. The registered manager acknowledged this had not improved.

Whilst staff had not received the training, unlike last time, we did not see this had a detrimental impact on the day to day care provided to people. One of the activity workers had undertaken the specialised training and supported staff in their knowledge of dementia care. This was evident when we saw how staff engaged with people. However, as a specialised dementia unit, the more advanced training would have helped all staff who worked on the unit have a greater understanding of how to support people with specialist dementia care.

New care staff received a week's in-house BUPA induction training. This was linked to the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. The week's training was provided by the BUPA trainer, and thereafter staff were provided with a work book which detailed different competency expectations. The member of staff went through the work book, and once they had achieved competency in their roles, this would be signed off by their manager.

The service provided end of life care. The registered manager had just completed training in the Gold Standard Framework in palliative care for people who lived with dementia and two nurses had enrolled on the MacMillan six steps training in end of life care. We saw that medicines which provided people with pain relief at the end of their life were available in anticipation of them being required.

At our last inspection, staff told us they had received supervision to support them in their roles. At this inspection we found staff received supervision in the form of written supervisory notes. These notes were usually information about care or nursing practice that staff needed to be updated on, or were practice issues the registered manager wanted changing. There were also supervisory meetings with staff which were information sharing meetings. We attended a supervisory meeting with nurses which was held on the day of our visit. The registered manager discussed issues related to medicines, care plans and the MCA. It was educational and informal, although it was more focused on the registered manager imparting information as opposed to a two way dialogue.

Staff told us they did not have regular planned individual supervision meetings with their manager or team leader to discuss their work or practice issues. The registered manager said they would ensure this was put in place in the future. Staff said they received a yearly appraisal to support them in their work and to identify further training.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager was a qualified Best Interest Assessor, and as such understood when a deprivation of liberty was occurring and when it was in the person's best interest for a DoLS to be in place. We found where it had been assessed the person lacked capacity, and their liberty was being deprived in some way (for example, not having the freedom of leaving the home on their own), a DoLs application had been made. The PIR informed us that 10 people had a DoLS in place, and the home was waiting for more to be authorised. We saw assessments had been made about people's capacity to make decisions, and where people had the capacity to consent; they had signed care documents to demonstrate this.

Staff had received training on the MCA and understood the general requirements of the Act. They understood the importance of gaining a person's consent before undertaking a task, and undertook tasks in the person's 'best interest' following the appropriate discussions, if it had been assessed they did not have capacity to make their own decisions. A member of staff told us, "We always check first if a person wants care and get them involved in the decisions." They told us that the person might not be able to choose their clothes but they might be able to choose the colour they want to wear.

We looked at whether people had DNACPR (Do not attempt Cardiopulmonary Resuscitation) documentation. We found the new ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process had started to be used. This is intended to give a more organised approach to advanced care planning and meant the same completed form would be carried by the individual and could be used by all organisations they came into contact with.

We also found a couple of the old style DNACPR forms completed by the person's GP did not make it clear what the clinical reasons were for deciding the person would not be resuscitated. The registered manager

told us they would contact the GP and discuss this with them.

We checked people were getting a choice of meals, and whether they received the food and drink which met their dietary needs. One relative told us the food was, "Alright, there is always plenty of it," whereas another told us the food was, "Amazing." We saw a choice of meals provided to people on each of the floors in the home. We found people enjoyed their meals and most of the food was eaten. The dining rooms were set out to support people with a pleasant meal time experience. Those who required support were given this in an unhurried way, and at the pace of the person.

Where there were concerns about people's food or drink intake, the relevant professionals had been contacted and plans put in place to improve this. We saw records which showed the person's GP, and the speech and language team (SALT) had been contacted. Where people were identified as at risk, monitoring of their condition took place. This included weight checks, and charts to check the amount of food and fluids consumed. A relative said,"[Person] has swallowing problems and staff always makes sure that [person] has plenty of fluids and they always keep a record." This was to ensure the person did not dehydrate.

We looked at people's access to other health and social care professionals. People and their relations told us they were supported to see other health and social care professionals, either within their home environment or at clinics or hospitals outside of the home. One relative told us they had noticed their relation had a 'heavy chest' and informed staff. They went on to say "I was so glad to hear that staff had already noticed and booked a doctor." We saw records which showed referrals made to different health teams. For example, one person had been referred to the palliative care team, the SALT, and the community respiration team. Staff had acted on recommendations made by the various teams.

Good

Is the service caring?

Our findings

During our last inspection visit we found improvements were required. This was because we saw some instances where staff did not engage with people they supported and people told us sometimes staff would not speak with them when they provided care or were 'grumpy'. There were two occasions where staff did not support people's dignity.

At this inspection people were more positive about their care workers. One person said, "Staff here are very passionate about their jobs," and another said, "Care workers are lovely, I can't fault them and they are also very polite. Sometimes they (care workers) are busy but they never neglect the residents." One relative told us, "I see the home day in and day out. The care here is fantastic. It feels like it is not just a job. It is all about them (people) and their needs." Another told us their relation had lived at the home for three years and was, ''Really happy here."

During our visit we spent a lot of time seeing how people and staff engaged with each other. We saw good communication, and staff responded to people's needs in a kind and caring way. For example, we saw a care worker sensitively attend to a person who was upset and crying. The care worker gave the person a hug and reassured the person they were not alone. Another care worker, on seeing a person sleeping with their glasses on, took them off the person and whispered gently, 'you don't need to wear the glasses while you are sleeping.'

Staff had a good understanding of people's needs. We asked staff questions about the people they supported, and they were able to tell us of the person's care and support needs. They told us about the people they supported with warmth and affection. Staff we spoke with told us they enjoyed being with people who lived at the home. One member of staff told us, "People need loving." Another said, "I love my job, I love the residents and their families."

We saw staff played a game of bingo with some people who lived at the home. People who played the game did not have the capacity to understand what was happening, however they enjoyed the engagement with staff who were cheerfully referring to them throughout the game, and making some of them laugh with their comments.

During the day we saw people made their own decisions about their care. Many people were still in bed asleep when we arrived and had their breakfast when they wanted to. We saw people had choices at meal times, and chose whether they wanted to sit in the communal lounges with other people, or enjoy their own company in their bedrooms.

Care plans had detailed information about people's needs, and relatives told us they were involved in the care provided to people. One relative said, "Staff are very kind and always keep us informed."

One relative told us they had two relations who lived at the home. They said one of their relations used to live in a different care home, and the staff there would call the person 'demanding'. They explained how

reassuring it was to them that the staff at Ardenlea Grove had told them they thought their relation was 'lovely.' They told us they had been fully involved in decisions about both their relation's care.

Staff told us they supported people's privacy by knocking on their bedroom doors before entering, and by making sure curtains and doors were closed before they undertook personal care. We saw one person's visitor arrive at the time staff were supporting them with personal care in their bedroom. We saw staff politely asked the visitor to wait in the lounge or outside their bedroom whilst they finished providing personal care. This ensured the person's dignity and privacy was maintained.

There were no restrictions in place for relations or friends to visit the home. One relative said, "My [relation] wasn't well and we were here until late at night and staff kept coming in and out to see if we needed extra help." Another told us they thought their relation's care was "Amazing" and they could visit any time they wished.

We saw staff encouraged people to be independent. On the dementia unit, people were encouraged to use condiments such as salt and pepper and to use the gravy boats to determine how much gravy they wanted on their meals. People who wanted to get out of their chairs and walk were not discouraged from doing so, rather, they were observed by staff to ensure they remained safe. One person had been admitted to the home for palliative (end of life) care and had been unable to get out of bed. We saw this person had significantly improved and was walking around the dementia unit on the day of our visit.

Good

Is the service responsive?

Our findings

At our last inspection, we found people's needs, wants and preferences had been recorded in their care plans but we did not see staff always respond to these. People in the dementia unit had little engagement with staff until after lunchtime and there was no discussion with them about the meals which had been served.

During this visit we found staff responded to people's needs. The home continued to record people's needs, wants and preferences. They recorded, 'My day, my life, my story.' This included, where possible, people's family trees and past history. In the morning we saw staff engaged well with people who lived in the dementia unit. There was a friendly atmosphere and people and staff were sat chatting to each other. Staff knew people's histories and talked with them about their past. For example, one person used to be a dancer. We heard a member of staff talking with them about this.

A relative told us both their parents lived at the home. They told us that staff had got to know their parents well and had worked with them to make sure their needs as individuals were met, but also ensured their parents spent time as a couple. Another relative said, "Staff know what [person] likes and dislikes and one of the care staff brings chocolate buttons for them." The relative went on to say, "I wish we could have bought [person] here earlier." We were informed that another person had been supported by staff to attend the wedding of their grandson.

All care plans included information to help staff support people with their physical, social and emotional needs. These included plans for 'senses and communication', 'healthier happier life', 'washing and dressing', and' mental health and well-being'. We talked with staff working in each of the units at Ardenlea Grove. Through our discussions they demonstrated they understood people's needs well, and these corresponded to the information contained in people's care records.

Most people we spoke with felt staff knew what care they needed and did not feel they needed to be involved in their care planning or reviews. Some people were involved with monthly care plan reviews. A relative also told us there was a diary kept in the person's room. This helped with communication between staff and the family. Staff wrote information about the person's condition, and if the family needed to discuss anything, they could write this in to the diary. They said it was, "A good communication channel for our family as [person] doesn't talk much apart from 'yes' and 'no' responses."

We discussed with the manager and deputy manager how responsive the home was in relation to equality, diversity and human rights; and how it promoted inclusion for people of all religions, cultures and sexuality. The registered manager told us they had a diverse staff group who comprised of different religions, cultures and people from the LGBT community (Lesbian, gay, bi-sexual and transgender). They told us people from the LGBT community would be welcome in the home but acknowledged they had not considered how they could ensure people would know they would feel included and welcomed. After our inspection visit, the registered manager contacted us to inform us they had found a guide for organisations which worked with older people, to help the organisation become more inclusive for people from the LGBT community. They

told us they were going to use this guide, and were looking for staff training to support this.

The building was well designed to meet the needs of the people with dementia and with physical disabilities. Corridors were well lit to aid visibility, the bedrooms were a good size, and provided ample space if staff needed to support people with moving equipment. Some of the bedrooms had kettles, small fridges and their own telephone line. Memory boxes were outside the doors of people who lived with dementia, to help them identify their own bedrooms.

We saw people's daily routines were based around people's needs and wants. People told us there was no prescribed time for getting up or going to bed, and they could do this when they wanted. Some people preferred to stay in their rooms and others preferred to join others to sit in the communal lounges. People were asked if they wished to join in with pre-planned activities and could choose not to be involved if they were not of interest to them.

At our previous visit there was only one activity worker at Ardenlea Grove. During this visit, we found another had been recruited and two activity workers supported people with their emotional and social needs.

One of the activity workers had undertaken the BUPA specialised dementia care training, and was a trainer in this for other staff. They told us about the individualised activities they provided as well as the activity programme available to people. The individualised activities included sitting and talking with people in their bedrooms, using information in the care folders to reminisce with the person about their past, manicuring nails, and reading newspapers.

One of the staff at the home also had a small farm holding. They had brought into the home some fertilised hens eggs. These had hatched and people who lived at the home were enjoying watching the baby chicks grow.

Although most people were satisfied with the activities available, some people we spoke with did not think the activities were relevant or useful to people. One person told us they did not feel the activities available were meaningful to them, but went on to say they kept themselves occupied by watching films and stories on the television, reading the newspaper and doing crosswords. A relative, who was very complimentary of the care provided, told us they were less pleased with the activities. They told us their relation sometimes found the activities unsuitable. One person we spoke with told us very few activities happened in the Pearl unit.

We saw a planned activity which took place in the Emerald dementia unit. We found the planned activity was not meaningful to the people who were present, and resulted in staff being the only ones taking part because people did not have an understanding of the game being played. After this, we spoke at length with one of the activity workers, who demonstrated a passion for wanting to provide good emotional and social support for people who lived with dementia. After our visit they contacted us and told us of the changes they were making in response to our feedback. They had contacted a number of different organisations and were looking at how activities could be more relevant to people who lived with dementia in the home.

The home encouraged people to provide feedback about the service and to be involved. In reception we saw a poster which commented, 'You said, we did'. This showed that in response to information from a resident and relatives meeting, new activities were bought.

None of the people we spoke with had complained about their care, but they told us if they had a problem they would speak to a care worker, nurse or the manager.

The provider had a complaint policy and procedure. We checked the registered manager was following the company's procedure when investigating complaints made. Since our last inspection there had been seven complaints. There was no consistent theme in relation to these and not all had been upheld. For example, one had been about the quality of food, one about jewellery which went missing, and another about staff attitude. The registered manager had investigated each one thoroughly, and taken appropriate action. For example, the complaint about missing jewellery resulted in the police being contacted. The home had also received 25 compliments about the care and support provided to people who lived there.

People told us they were encouraged to share their opinions in how the service was run. In the main foyer of the home was a suggestion box to enable people and others to leave feedback.

Good

Is the service well-led?

Our findings

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC).

Relatives and most people we spoke with knew who the manager was and felt they could approach them with any problems they had.

Staff told us the registered manager was open and approachable. They told us they felt able to speak with the registered manager if they had any concerns, and the manager was also 'hands on' and provided additional staff support when necessary. On the day of our visit we saw the manager support staff at meal time so people received their meals on time.

At our previous inspection, the registered manager had worked for most of the time without a deputy manager to support them. They were actively recruiting for the position. At this inspection, a deputy had been working at the home for almost a year. Staff told us the deputy was also approachable and supportive. Both the registered manager and deputy manager worked well to support each other and the team of nurses and care workers who worked at the home.

The atmosphere in the home was relaxed and most staff told us they were happy with their work. One staff member told us, "We have wonderful staff and work well as a team." Another said, "I love my job, I like working here, I love my residents and families."

The manager and deputy manager were responsible for checking the work care and nursing staff had undertaken to make sure people who lived at the home were safe. This included medicines checks and care plan checks. Where areas for improvement were identified, these were followed up with staff. For example, recent care plan checks identified staff were not writing care plans or updating them according to the organisation's policies and procedures. This was followed up with a staff group supervision session which resulted in the manager agreeing staff could take time 'off the floor' to rewrite the plans without being disturbed. This meant the registered manager was proactive in supporting staff to improve the service.

There were regular resident and relatives meetings held at the home. The last meeting had discussed the activities in the home, and as a consequence of people's input and requests, new board games were purchased, as were plants and seeds for people to pot and grow. One of the relatives we spoke with was aware of the meetings and said they hoped to go to the next one in May 2017. They told us there was information about these in people's bedrooms and in the home's lift. We also saw information in the reception area.

At our last inspection, one person commented that they hardly saw the manager. The registered manager was surprised by this because they felt they were visible and engaged a lot with people who lived in the home. They decided to keep an 'engagement log' to demonstrate the contact they had with people or their relations. This showed the registered manager spent time on all three floors with people who lived there.

The registered manager told us they had tried to encourage people and their relatives to be involved in the staff interview process however nobody was interested in taking part.

The organisation's regional director supported the registered manager and their team. They visited the home on a monthly basis. During these visits the director undertook detailed checks to see if the home was complying with the expectations of the organisation, and reviewed whether identified areas of improvement had been made. They also spoke with a sample of people and staff at the service and listened to their views.

The provider sent out a yearly quality assurance survey to people and their relatives. The last survey had a low response rate however, those who completed the survey were positive about the care provided at Ardenlea Grove. A staff survey was also completed. Staff were not required to take part in the survey, and they could take part anonymously. Despite reassurances of anonymity, the numbers completing this were also low, but those who completed the survey said they felt supported in their work.

The registered manager had a legal obligation to notify us of any incidents, accidents or deaths which occurred at the home. They met their legal requirements. The provider had a legal requirement to inform the public of the home's rating. They had informed the public on their website they had previously been rated as overall 'Requires Improvement', and a poster with their ratings was displayed in the reception area of the home.